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CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Jasmine

March 2017

Independent Chair and Author of Report: Althea Cribb

Associate Standing Together Against Domestic Violence

Date of Final Version: July 2018

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Croydon Community Safety Partnership domestic homicide review panel in reviewing the homicide of Jasmine who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members. Victim: Jasmine, aged 38 at the time of her death. Jasmine was of mixed black Caribbean/white European ethnicity; it was recorded that she believed in God and the 10 commandments but was not religious and did not attend church. Perpetrator: Eric, aged 23 at the time of the homicide, of Black/African British ethnicity.

1.1.3 Criminal proceedings were completed at the end of 2017 and Eric was convicted of Jasmine's murder. He was sentenced to life imprisonment with a minimum term of 16 years.

1.1.4 The process began with an initial meeting of the Croydon Community Safety Partnership when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Jasmine or Eric prior to the point of death were contacted and asked to confirm whether they had been involved with them.

1.2 Contributors to the Review

1.2.1 This Review has followed the statutory guidance for Domestic Homicide Reviews (2016) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. Thirteen agencies submitted Independent Management Reviews (IMRs) and chronologies, and two agencies submitted chronologies only due to the brevity of their involvement. Two further agencies provided information in support of the Review. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

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

Agency	**Contribution**
AIR Network	IMR and chronology
Croydon Health Services NHS Trust	Chronology
Croydon Clinical Commissioning Group (for the General Practices)	IMR and chronology
Multi-Agency Risk Assessment Conference (MARAC, coordinated by Croydon Family Justice Centre)	Information

London Ambulance Service	Chronology
London Borough of Croydon Adult Social Care Services	IMR and chronology
London Borough of Croydon Children's Social Care Service (including Looked After Children and Leaving Care Services)	IMR and chronology
London Borough of Croydon Housing Services	IMR and chronology
London Borough of Lewisham Adult Safeguarding	Information
London Community Rehabilitation Company	IMR and chronology
Metropolitan Police Service	IMR and chronology
National Probation Service	IMR and chronology
South London and Maudsley NHS Foundation Trust	IMR and chronology
Turning Point	IMR and chronology
Victim Support	IMR and chronology

1.2.3 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs received were comprehensive and enabled the panel to analyse the contact with Jasmine and/or Eric and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Panel Member	Job Title	Organisation
Althea Cribb	Independent Domestic Homicide Review Chair	Standing Together Against Domestic Violence
Alison Finlay	Team Leader & Deputy Safeguarding Lead	Turning Point
Andrew Nwosu	Regional Head of Allied Health Professionals (NHS England representative)	NHS England
Antony Rose	Head of Ealing, Harrow & Hillingdon Cluster	National Probation Service
Cheryll Wright	Partnership and Intelligence Manager, Community Safety	London Borough of Croydon

Chris McCree	PMH Lead Centre for Parent & Child Support	South London and Maudsley NHS Foundation Trust
Fiona Bauermeister	Deputy Chief Executive	Air Network
Fiona MacKirby	Service Leader, Leaving Care	London Borough of Croydon
Jennifer Hoyle	Senior Operations Manager	Victim Support
Lucien Spencer	Area Manager, London South-East	London Community Rehabilitation Company
Myrna Harding	Trust Facilitator	South London and Maudsley NHS Foundation Trust
Nicola Funnell	Psychiatrist	South London and Maudsley NHS Foundation Trust
Rachel Blaney	Designated Nurse Safeguarding Adults	Croydon Clinical Commissioning Group
Russell Pearson	Review Officer	Metropolitan Police Service
Shade Alu	Deputy Medical Director (Safeguarding)	Croydon Health Services NHS Trust
Steve Hall	Quality Assurance Manager, Children's Social Care	London Borough of Croydon
Tanya Johnson	Practice Manager	Croydon Family Justice Centre
Yvonne Murray	Head of Tenancy, Housing Services	London Borough of Croydon

1.3.2 *Independence and expertise*: Agency representatives were appropriate in relation to their independence from the case; their level of seniority in their organisation; and their expertise in relation to their own service areas, multi-agency working and the issues pertinent to this case.

1.3.3 The Review Panel met a total of three times, with the 1st panel meeting in August 2017 and the final meeting in May 2018.

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

1.4 Involvement of Family

1.4.1 The Review Panel agreed that it was essential to attempt to involve Jasmine's family. The independent chair approached Jasmine's mother, father and (adult) child, for whom contact details were held by police. The letters were given to each person by the police Family Liaison Officer, so that the contact details were not shared.

1.4.2 No response was received from Jasmine's father.

1.4.3 Jasmine's mother informed the independent Chair, through the Victim Support Homicide Service, that she did not wish to participate in the Review but wanted to receive updates on its progress. The independent chair emailed Jasmine's mother in February and June 2018 to provide updates and offer different ways to engage with the Review if she wished to, including reading and commenting on the Overview Report. No response was received.

1.4.4 Jasmine's (adult) child informed the independent Chair, through the Victim Support Homicide Service, that they did not wish to participate in the Review but wanted to receive updates on its progress. The independent chair emailed them in April and June 2018 to provide updates and offer different ways to engage with the Review if she wished to, including reading and commenting on the Overview Report. No response was received.

1.5 Chair of the DHR and Author of the Overview Report

1.5.1 The Chair and Author of the Review is Althea Cribb, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received Domestic Homicide Review Chair's training from STADV and has chaired and authored twelve reviews. Althea has twelve years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

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

1.5.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

1.5.4 *Independence:* Althea Cribb has no connection with the Croydon Community Safety Partnership or any of the agencies involved in this case. Authors of Individual Management Reviews were independent of line management of the staff working with the individuals in this case.

1.6 Terms of Reference for the Review

1.6.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2013 to the date of the homicide. This date was chosen as it covered the period of

Jasmine's and Eric's most significant contact with agencies. Agencies were asked to summarise any relevant contact they had had with Jasmine or Eric outside of these dates.

1.6.2 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in the 2016 Guidance and identified and considered the following case specific lines of inquiry:

(a) Analyse the communication, procedures and discussions, and co-operation and joint working, which took place within and between agencies in relation to Jasmine and/or Eric.

(b) Analyse the opportunities to identify, assess and respond to individuals with the following issues:

- Domestic abuse perpetration (Eric)
- Mental health (Jasmine)
- Substance misuse (Jasmine & Eric)
- Rent / housing issues or homelessness (Jasmine & Eric)
- Looked after child / leaving care (Eric)

(c) Analyse agency responses in relation to the characteristics of Jasmine and Eric, including how they intersected:

- Race (Jasmine & Eric)
- Religion / faith (Jasmine & Eric)
- Mental health (Jasmine)
- Substance misuse (Jasmine & Eric)
- Looked after children / leaving care (Eric)

(d) Analyse what policies, procedures and training are in place for the agency to address the issues identified in the above two points.

(e) Analyse organisations' access to: specialist domestic abuse agencies for victims or perpetrators; mental health services; substance misuse services.

1.6.3 The Review Panel felt that the membership of the following would adequately address the expertise required on the above issues: Family Justice Centre (domestic abuse service); Turning Point (drug and alcohol agency) and South London and Maudsley NHS Foundation Trust (mental health provider). Additionally the independent chair sought the expertise of the Chief Executive of Croydon MIND, who contributed to the Review and read the Overview Report.

1.7 Chronology and what was known by agencies: Jasmine

1.7.1 During the Terms of Reference timeframe, Jasmine's main involvement with agencies was with the mental health services provided by SLaM. This had begun in 2002 (when she was aged 23) and had previously involved times when she was managed in the community as an outpatient and periods when she was detained as an inpatient under the Mental Health Act. In 2014 Jasmine's presentation deteriorated and she was also in contact with police (MPS) due to two episodes in

which she had to be detained under the Mental Health Act and taken to SLaM inpatient services. Each time Jasmine was in contact with police, officers sent notifications to London Borough of Croydon Adult Social Care; these were not acted upon (as per procedure) as Jasmine was under SLaM's care. On the first occasion she was recorded as having two children with her (grandchildren of hers); Croydon Children's Social Care were involved to ensure the children were cared for. Following the second inpatient episode Jasmine was managed as an outpatient. During that time she had contact with London Borough of Croydon Housing due to rent arrears, which were resolved. In May 2016 Jasmine informed SLaM workers that she would not continue with her medication; later that month she was admitted as an inpatient due to signs of relapse and non-compliance with medication. In June 2016 Jasmine called police twice due to altercations with a neighbour; assistance was provided but no crimes were reported. In July 2016 Jasmine attempted suicide and was detained under the Mental Health Act. While she was an inpatient she made an allegation of sexual assault against another patient. Police engaged with SLaM staff and the incidents were responded to by SLaM (no further action was taken by police due to lack of evidence). Police referred Jasmine to Victim Support; no contact was made by that service. The notification made by police to London Borough of Croydon Adult Social Care was passed to London Borough of Lewisham Adult Social Care due to the location of the alleged incident; that service forwarded the notification to SLaM but it was not received by the safeguarding team (it was nevertheless being dealt with by those responsible for Jasmine's care). At the end of August 2016 Jasmine alleged to police that she had been assaulted by her boyfriend (not Eric); he was arrested and taken to court. In September 2016 Jasmine called police claiming that another mental health patient wouldn't return her property; police spoke with the other person who provided evidence that they had offered to return the property already, and no further action was taken. In December 2016 Jasmine's GP attempted to call her twice, the records did not state why. At the third attempt to call Jasmine, in January 2017, a male answered the number and told the GP they had the wrong number. Jasmine remained engaged with the Psychosis Community Mental Health Team, and her mental state appeared to be stable. In February 2017 Jasmine informed SLaM that her (adult) child was her full time carer; following this SLaM's contact was primarily with them. On the day of her last attendance at the Team Jasmine called and was initially angry with staff because they would not attend her home for the medication to be administered; she called back to apologise and stated she was "*very anxious because my friend is threatening to harm me because I asked her to leave my flat*". Staff advised her to call police. Later that day Jasmine walked to the Team's office for her medication; she stated she had no money because she was paying off debts incurred by a "*friend*" who was living with her (it was not clear if this was the same or a different friend to the female friend referred to above). She was recorded as appearing calm and stable in her mental state. She did not want the matter (with regard to the friend/friends) taken further and no action

was taken. This was the last contact the Team or any other service had with Jasmine before she was killed.

1.8 Chronology and what was known by agencies: Eric

1.8.1 From 2013 to 2015, Eric had contact or was known to police (Metropolitan Police Service), London Borough of Croydon Children's Social Care and the Multi-Agency Risk Assessment Conference (MARAC, coordinated by the Croydon Family Justice Centre) in relation to domestic abuse against his then partner; this included allegations and convictions related to verbal abuse, threats, physical violence and sexual violence. In 2013 Eric was convicted of (non domestic related) assault. In 2014 (January to May) Eric had contact with London Borough of Croydon Housing Services and with his London Borough of Croydon Children's Social Care (Looked After Children) keyworker due to his continued rent arrears. In January 2014 he was convicted of possession of cannabis and given a conditional discharge for 12 months. Also in January Eric disclosed to his keyworker that he was a father of a child, and would be again, and that he wanted to be a "*good father*" to both children. In May 2016 Eric was convicted of domestic-related assault. Probation completed a pre sentence report that recommended a Community Order with supervision requirements and a requirement to attend the Integrated Domestic Abuse Programme (IDAP; an offending behaviour programme aimed at men who had been abusive in their relationships aiming to change those behaviours; since replaced by Building Better Relationships). Probation recorded that this sentence had been imposed. In June 2014, due to Transforming Rehabilitation[1], Eric's case was transferred from the National Probation Service (NPS) to the London Community Rehabilitation Company (CRC). From May to September 2014 the NPS and then the CRC attempted to engage with Eric in supervision and in attendance at IDAP. Due to his non-attendance at supervision and other appointments, in September CRC moved to take enforcement action against Eric and return him to court. During this process the court notified CRC that the sentence given to Eric was a fine, not a Community Order; as a result CRC's contact with Eric ended. In May 2014 Eric was referred to Victim Support following an incident with his then partner (both made allegations of assault). Eric was spoken with and provided with support; his case was then closed. In June 2014 Eric's case was closed to the Leaving Care service because he had reached 21 years of age. In December 2014 Eric pleaded not guilty in court to assault against his then partner; no evidence was offered and the case was dismissed. Following a process in which London Borough of Croydon Housing Services attempted to support Eric to manage his rent arrears, with the support of the Leaving Care service, Eric was evicted from his home in May 2015. He sought help from

[1] https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf [accessed 15 April 2018]

Housing in September 2015 and Leaving Care in October 2015 and was given advice. From July to October 2015 Eric attended outreach (sport and wellbeing) sessions with AIR Network. They referred him to Turning Point to address his cannabis use and housing issues; he was assessed and then did not attend any appointments, so his case was closed in December 2015. In May 2016 Eric pleaded not guilty in court to domestic related offences against his then partner; no evidence could be offered. Eric had no contact with services from then until August 2016 when he again contacted the Leaving Care service for advice in relation to his homelessness. Advice was again given. In October 2016 Eric re-referred himself to Turning Point; he did not attend the assessment appointments and his case was closed. Eric contacted the Leaving Care service in November 2016 for advice in relation to contact with his child; advice was given. In 2017 Eric attended AIR Network sport and wellbeing sessions in January and February. A week after his attendance at a session, AIR Network referred Eric into Turning Point but that service was unable to make contact with Eric and his case was closed. Eric did not attend AIR Network again.

1.9 Conclusions and Key Issues Arising from the Review

1.9.1 The only evidence of domestic abuse from Eric to Jasmine was the homicide itself; there was no information presented to this Review, or gathered within the police investigation, to suggest there had been abuse in the relationship prior to this.

1.9.2 Jasmine's mental health led to regular contact with SLaM who monitored her and responded to fluctuations in her presentation. Just before she died, Jasmine could have been identified as a vulnerable person at risk of being abused or exploited, through her disclosure that a female "*friend*" had allegedly been taking her money and threatening her; and her statement that she had no money due to paying off the debts of a "*friend*" who was living with her (who might or might not have been the same person as in the first disclosure).

1.9.3 Eric was known by some agencies to be perpetrator of serious domestic abuse related offences against a previous partner; and by other agencies as someone who misused drugs and alcohol. His contact with these agencies was at different times which meant that some agencies were unaware of his history.

1.9.4 Agencies reviewed their contact with Jasmine and/or Eric carefully in response to the Terms of Reference and the key lines of enquiry, including identifying good practice as well as areas for improvement, in response to which recommendations have been made.

1.10 Lessons to be Learned

Learning for individual agencies (from IMRs)

1.10.1 *AIR Network*: IMR recommendations have been made in relation to the need for staff to receive health and wellbeing / social care training such as mental health issues (in addition to the

mandatory safeguarding training they receive). Action is also being taken to ensure that referrals to Turning Point are made promptly. AIR Network highlighted that, due to the nature of their service (self-referral) the issues they are aware of among their clients are largely due to self-report. As a result they knew little of Eric's current situation or background (Eric's known substance misuse was managed through referral to Turning Point and the ongoing work of the programme). This will be reviewed, in particular to aim to ensure that the service receives and shares key risk information about clients. A review is also taking place of what staff record about clients' attendance: at the time Eric attended, only the fact of his attendance was recorded.

1.10.2 *Croydon Clinical Commissioning Group (for the General Practices)*: The IMR makes a recommendation in relation to learning that contact between the GP and SLaM was not consistent, and requests from SLaM for the GP to undertake health checks were not acted upon. The IMR also identified learning and recommendations in relation to opportunities the GP had to enquire with Jasmine about her mental wellbeing, partner and family situation. The CCG informed the Review that they introduced a safeguarding self-assessment for GPs and that this will soon become a mandatory audit for all GPs. They are also developing a template and guidance for ensuring all practices have appropriate and adequate safeguarding children and adults policies, which include domestic abuse pathways.

1.10.3 *London Borough of Croydon Children's Social Care Services (Looked After Children and Leaving Care Services)*: The IMR outlines good practice in relation to the Leaving Care Personal Advisor's attempts to engage with and support Eric throughout his time in the service; and their engagement with other agencies. The IMR identifies that it was inappropriate for Eric to be allocated a Croydon property due to his vulnerability at that time (he had just turned 18 and had been in the care of the local authority for some years) and the view now is that he may not have been in a position to maintain that level of responsibility. This type of allocation no longer takes place; alternative options are considered.

1.10.4 *London Borough of Croydon Housing Services*: The IMR identified good practice from the service in proactively engaging with the Leaving Care service to support Eric around his rent arrears. The IMR author also took the opportunity of this review to identify best practice learning, even though it would not have impacted on their contact in this case. Three recommendations are made to: complete an audit of local procedures and guidance; review the procedures for eviction of Leaving Care client; and ensure that staff have refresher training on domestic abuse.

1.10.5 *National Probation Service London Region (NPS)*: The IMR author outlines that there could have been consideration, when completing the pre sentence report, given Eric's young age and previous history of offending, of categorising him as high risk (rather than medium risk) of harm. This would have resulted, if he had been sentenced to an Order, in him being allocated to NPS. The IMR highlights the issues in relation to the error in recording Eric's sentence that led to his

contact with probation and the CRC that had not in fact been required by the court. Two recommendations are made to ensure that this is not repeated.

1.10.6 *London Community Rehabilitation Company*: The IMR also analyses the situation that led to Eric being inappropriately under the CRC, and sets out that a clear allocation framework now exists to determine the allocation of cases from London NPS to the London CRC at sentencing, that work alongside the professional judgement of probation officers. The IMR also identifies learning, and makes recommendations, in relation to following up on information received about MARAC discussions, and ensuring that exploration and responses takes place in response to disclosures made by offenders about their children.

1.10.7 *Metropolitan Police Service*: The IMR outlines that police responded appropriately to Jasmine in relation to her mental health, including notifications (Merlins) being made to Adult Social Care in all but one incident. Police have acted upon and developed their response to mental health issues including a tool kit for officers on responding to someone who has mental ill health. Police also acted appropriately in response to domestic abuse offence allegations against Eric, and offering support (referrals) to his then partner.

1.10.8 *South London and Maudsley NHS Foundations Trust (SLaM)*: The IMR concludes that staff managed Jasmine's care as effectively and sympathetically as possible, making appropriate judgements as to the correct course of treatment and care and working to engage her in that. Staff recognised Jasmine's substance misuse as a factor in her mental health and worked to address this with her. Jasmine's care coordinator in CMHT was the substance misuse lead for the team and therefore had the appropriate experience and knowledge to address these matters with Jasmine. Staff were proactive in contacting Jasmine's GP, and at times police, to ensure relevant information about Jasmine was shared. The IMR identifies learning in relation to staff being more proactive in identifying and acting on potential safeguarding issues. On one occasion there should have been consideration of potential child safeguarding issues. The second was when, two weeks before she died, Jasmine reported that someone had been taking her money and threatening her. She also had to walk to the team's office because she had no money due to paying off the debts of a "*friend*". A safeguarding alert should have been considered even though Jasmine did not want to matter taken further. Interviews as part of the IMR process suggested "*the team demonstrated a reasonable knowledge of the procedures involved in raising a safeguarding alert, but not necessarily what circumstances should trigger one*". Recommendations are made.

1.10.9 *Turning Point*: Eric's first contact with the service led to an assessment that identified Eric's issues and goals (with the exception that his prior offending history was not asked about or recorded); subsequently staff were proactive in trying to engage Eric in the service. The IMR sets out learning in relation to child safeguarding, and makes recommendations: specifically that staff should have considered following up on information that Eric had a child, to ensure the welfare of that child.

1.10.10 *Victim Support*: The IMR outlines the issues relating to the fact that no contact was attempted with Jasmine following her referral from police; and extensive internal investigation was undertaken to try to understand what happened. The IMR concludes it was human error, impacted by the systems and processes in place at the time, which have now changed to make the likelihood of such an error occurring again much less likely. The IMR identifies good practice shown by the Victim Contact Officer in attempting to gain more information from police about Eric when he was referred, in light of the information on the referral that both he and his then partner had been arrested. This good practice was not reflected in response to the second referral. Recommendations are made.

Multiple Domestic Homicide Reviews

1.10.11 The independent chair and Review Panel were mindful of, and discussed at the Panel meeting, the fact that Croydon had already published two Domestic Homicide Reviews, and there were an additional four currently ongoing.

1.10.12 In addition to the themes and recommendations identified below, the Review Panel felt strongly that there is a need to bring all past and current DHRs together by the multi-agency partnership in Croydon, including the Community Safety Partnership, the Local Safeguarding Children's Board and the Adult Safeguarding Board. Themes should be identified across them all, with a resulting action plan to ensure that the learning is acted upon. The Croydon Community Safety Partnership informed the Review that this work was now underway: the Croydon Domestic Abuse and Sexual Violence Board has begun a monitoring process for all Reviews with a new tracker for recommendations and actions. This will be reported on to the Community Safety Partnership. This development is welcome.

1.10.13 The learning from the Review and recommendations are outlined here.

Equality and Diversity

1.10.14 The Review Panel identified the following protected characteristics of Jasmine and Eric as requiring specific consideration for this case, including how they may have intersected:

1.10.15 *Sex*: This factor is relevant due to the nature of homicide. Women are more at risk of domestic homicide than men; and men are more likely than women to be the perpetrators when domestic homicide occurs. In this case also, Eric was known to agencies as a domestic abuse perpetrator against a previous partner; serial perpetration by male abusers is well established in cases where they do not engage with support to change their behaviours. Eric was recognised as a perpetrator of domestic abuse, and where possible he was held accountable for his abuse through the criminal justice process. When convicted of assault, probation recognised the need for a specific domestic abuse programme, although the court did not take up this recommendation. Had he come to the attention of police for alleged abuse against Jasmine or another partner, this history would have been taken into account by agencies in understanding the risk he may have posed, while

recognising that he had not been proven guilty of some of the allegations. If Jasmine or someone supporting her had had concerns over his behaviour (NB there was nothing to suggest she or anyone else had concerns), she or they could have made a 'right to ask' request to police under the Domestic Violence Disclosure Scheme, which, if granted would have provided information about Eric's history.

1.10.16 *Race*: This factor was included due to Jasmine being of mixed ethnicity, and Eric having immigrated from an African country. Race/ethnicity have been shown to potentially impact on an individual's ability, willingness and confidence to engage with services, and to impact on how someone is treated by professionals. There was nothing in any of the agency records to suggest that this had impacted on Jasmine's or Eric's experiences of services. As it has not been possible to speak with family members as part of the Review, we cannot check this against their lived experiences.

1.10.17 *Religion / Faith*: This characteristic was included by the Panel due to the ways in which Jasmine's mental health need often presented: she would refer to her religious beliefs repeatedly and this formed part of her Care Programme Approach summary of need with SLaM. Agencies interrogated their records in relation to this and nothing of significance was found.

1.10.18 *Race and religion/faith*: The Review Panel discussed the fact that, for these protected characteristics, there were no agency records indicating that they had impacted in any way on their interactions with services or the care/support they had received. Given the information the Review Panel had about Jasmine and Eric, it seemed surprising that there was no discussion from the support agencies (e.g. SLaM, AIR Network, Turning Point) about how their racial, ethnic or religious identities and beliefs may have intersected with their other characteristics and impacted on their lived experience. It may be that they did not have any additional or different needs in relation to this, and it is important in the absence of any other information not to make assumptions about their lives; but discussions could have been appropriate. At the request of the Review the Looked After Children service re-reviewed their records to look specifically at this issue (as their contact had been outside of the Terms of Reference) to identify if there were potentially any issues for Eric that agencies could or should have picked up on. The Panel member found that there were a number of incidents or issues in Eric's past that could have impacted on his life course, and interaction with services, most pertinently that he had moved to the UK from his country of origin aged 10, did not speak English at that time, and changed family settings at the same time. The service outlined that, in addition to many other developments in the service, "*there is more robust analysis of the circumstances of young people becoming looked after and planning for their permanence*".

1.10.19 As a result of the Review Panel discussion, a recommendation (1) is made for all the agencies that had ongoing and sustained contact with Jasmine and Eric to reflect on their agency approaches

and responses to the protected characteristics of their clients/patients to ensure that they are not just recording data but are having meaningful discussions to ensure they understand the experiences and needs of individuals. It is important that staff are supported in these discussions with adequate training.

1.10.20 The Review Panel heard that the Croydon BME (Black and Minority Ethnic) Forum (http://www.cbmeforum.org) is an umbrella organisation for Croydon's Black and Minority Ethnic voluntary and community sector that may be a source of information and support.

Identification of Adults at Risk and appropriate referral

1.10.21 SLaM identified in their IMR that a safeguarding adults alert should have been made for Jasmine when she attended the mental health team shortly before her death. While Jasmine stated she did not want the matter taken further, it would have shown good practice for this action to be taken in light of the potential vulnerability brought about by Jasmine's mental health. Whether this would have identified Eric as her partner at the time, and whether he was involved in either of the two disclosures Jasmine made that day, cannot be known. It may have been that, if Eric had been identified, and information sought from police about him, that staff could have worked to understand any risk he posed to Jasmine.

1.10.22 When Jasmine made an allegation of sexual assault, at a time when she was an inpatient with SLaM, the notification to adult social care never reached the appropriate team. Staff working with Jasmine were aware of the allegation and could therefore address it with her; but had this not been the case, then the notification would have been a missed opportunity to support her. It is essential that referrals are sent to 'generic' email inboxes and not to named people within a team. A recommendation (2) is made for this learning to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

Responses to perpetrators of domestic abuse

1.10.23 Police responded positively to allegations of domestic abuse related offences against Eric, made by his then partner. He was arrested and charged, and where possible prosecuted. Referrals were made to MARAC and specialist support services to ensure that the victim was safeguarded.

1.10.24 That Eric was given a fine for common assault and battery, rather than the probation-recommended IDAP programme and supervision, was a missed opportunity to hold Eric to account for his abuse and offer him a route to choose to behave differently. The Review heard that there is currently no Specialist Domestic Violence Court in Croydon (a pilot had previously been in place); a recommendation (3) is made for the Domestic Abuse and Sexual Violence Board to review this situation and taken action if required.

1.10.25 The agencies that Eric was in contact with later (in the time that he is now understood to have been in a relationship with Jasmine) were unaware of his history.

Identification of children by services working with adults

1.10.26 Both Jasmine and Eric came into contact with agencies that should have considered taking action to ensure children associated with them were safeguarded (SLaM for Jasmine and the CRC and Turning Point for Eric). The emphasis in this learning is on the need for agencies, particularly those working primarily with adults, to 'think family' and consider the other people who may reside or be linked to a household in which there is a person who may pose a risk. A recommendation (4) is made for the learning to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

1.11 Recommendations from the Review

1.11.1 This Review expects that all Review Panel member agencies will share the learning internally with all levels of staff once the DHR is published.

1.11.2 The Overview Report recommendations are:

1.11.3 **Recommendation 1 (see 1.10.19)**: All agencies that had sustained contact with Jasmine and Eric to reflect on their agency approaches and responses to the protected characteristics of their clients/patients to ensure that they are not just recording data but are having meaningful discussions to ensure they understand the experiences and needs of individuals; including ensuring staff are supported in these discussions with adequate training.

1.11.4 **Recommendation 2 (see 1.10.12)**: This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

1.11.5 **Recommendation 3 (see 1.10.14)**: Croydon Domestic Abuse and Sexual Violence Board to review the previous pilot Specialist Domestic Violence Court and why it came to an end; and to take action where required including any training requirements for court staff and magistrates on domestic abuse.

1.11.6 **Recommendation 4 (see 1.10.16)**: This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.