LONDON BOROUGH OF BARNET

SAFER COMMUNITIES PARTNERSHIP

Keeping Barnet Safe

DOMESTIC HOMICIDE REVIEW

Learning from the Review into the Homicide of Zoltan

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LEARNING FROM A DOMESTIC HOMICIDE REVIEW

1 Background to the Homicide:

1.1 Zoltan was in his mid-20's when he died from a stab wound inflicted by his girlfriend Molly who was in her early 30's. Zoltan was employed in the construction industry; Molly was in receipt of benefits. The names used in this document are pseudonyms to protect the parties identities and that of their families. It is believed that the couple had been in a relationship for approximately 2 years, but their relationship was turbulent and affected at times by the occasional use of alcohol and illicit drugs.

1.2 During an 11 month period the Police attended 13 domestic abuse incidents between the couple; calls were made by both Zoltan and Molly, and there were frequent contradictions in statements given to the Police. On two occasions Zoltan received injuries caused by Molly including a cut to his head on one occasion, and knife wounds to his leg and back on another. During hospital treatment to his leg, he was offered referral to domestic abuse support services which he declined. Twice he was identified as a victim but declined to answer Police risk assessment questions. He consistently declined to make a complaint against Molly stating that he loved her. The Police put in place a Domestic Abuse Protection Order (DVPO) in an effort to keep Zoltan away from Molly, but this was breached by them both, and Molly told Police she did not mind Zoltan being in her home. Zoltan would stay both with friends and with Molly, until she decided did not want him there. This was frequently the catalyst for arguments and fights.

1.3 Molly was predominantly viewed as the victim. She was referred to MARAC[1] and received the support of an Independent Domestic Violence Advocate (IDVA). Full information about Zoltan and his injuries was not discussed at MARAC. Molly become pregnant and due to concerns about domestic abuse and her safety and that of her unborn child, child protection procedures were invoked. Efforts were made to find alternative accommodation for Molly, but she declined a refuge place and temporary accommodation. She wanted to stay in her flat therefore security measures were put in place via Sanctuary Scheme[2]. Molly then decided she wanted to move nearer her family in another area and the process to try and find an alternative property in her chosen area commenced.

1.4 As part of the child protection plan Molly attended a programme for victims of domestic abuse and was referred to Mental Health Services due to experiencing depression and anxiety. Molly had experienced adverse life events in her teens and twenties including a relationship with a previous partner who was controlling, and past involvement with Children's Services. However, Molly did not respond to appointments offered, and she declined to see mental health practitioners when they made home visits. The plan also required that she not have contact with Zoltan, however she continued contact and attended anti-natal appointments with him.

1.5 Due to increasing concerns Children's Services obtained an Interim Care Order, and when the baby was born, Molly and the baby moved into a Mother and Baby Unit for a 3 month assessment. There were difficulties in contacting Zoltan at this time, but he eventually met with a social worker for an assessment to arrange contact with his child. Molly appeared to find it difficult to meet the rules and expectations of the Mother and Baby Unit and she

[1] Multi-Agency Risk Assessment Conference: A meeting of agency representatives with the aim of sharing information to put in place a safety plan to reduce risk to a victim assessed as high risk.

[2] Sanctuary Scheme is a service whereby security enhancing measures are fitted to the home of a domestic abuse victim to increase their safety.

exhibited behaviour which raised staff's concerns about her mental health. To assist the assessment Molly was assessed by a psychiatrist. There was a further significant incident which resulted in Molly leaving the Unit. The psychiatric assessment raised concerns about the safety of the baby if left in Molly's care resulting in the Court making a full Care Order, and the baby was placed in foster care. Separate supervised contact arrangements were made for Zoltan and Molly. The psychiatric assessment also identified Molly as experiencing depressive illness and anxiety in addition to PTSD due to a rape reported by Molly the year before she met Zoltan. The report explained PTSD could increase Molly's risk of violence due to the irritability and weariness which can accompany the condition. In Molly's case this could increase risk of violence to any partner, or in any situation where she felt under threat from a man. A further risk factor identified was Molly's extreme sensitivity to criticism or constructive guidance which could result in her becoming angry and dismissive. This could form a risk to other people. The risks identified within this assessment where not shared.

1.6 Unknown to agencies Molly returned to her flat. This was eventually discovered when her IDVA managed to speak to her on the phone. Agencies consistently experienced difficulty in contacting Molly. The IDVA shared this information with the Police Community Safety Unit and called Housing and Children's Services for an update.

1.7 A few days later a 999 call was received to attend Molly's flat when it was reported that a 26-year-old male (Zoltan) had been stabbed by the caller (who was later identified as Molly). Molly told the operator that Zoltan was punching her arm and she got angry; she felt cornered and stabbed him. Tragically, Zoltan died of his injury in hospital.

1.8 Molly was charged with Zoltan's murder and remanded in custody. Following psychiatric assessment Molly was found guilty of manslaughter on the grounds of diminish responsibility. She was sentenced to 5 years in prison.

2. Key Issues Arising from the Review:

Gender bias when identifying who was the victim:

2.1 Despite the physical evidence available to show that Zoltan received increasingly serious wounds inflicted by Molly she was never charged and prosecuted. Indeed, she remained the focus of support services as the victim of domestic abuse. Although Zoltan was recognised as a victim on two occasions, when officers attempted unsuccessfully to complete a DASH risk assessment with him, he declined to answer questions. A hospital nurse clearly assessed him as a victim of his girlfriend's abuse when his stab injury to his leg was treated and offered him the support of an Independent Domestic & Sexual Violence Advocate (IDSVA) which he declined, but for a majority of the domestic abuse incidents Molly was seen as the victim.

2.2 Whilst it is true that Zoltan consistently refused to make a complaint against Molly when he was injured, maintaining that he loved her, there was medical evidence which could have supported a prosecution as well as Police body camera footage. Evidence in the form of the knife from the scene when he was stabbed in the leg by Molly, and Molly's admission that she had stabbed him was not used. There was also a marked difference in size between the two, Zoltan was of slim build and short stature, Molly was taller and twice Zoltan's weight. Molly's statements meant the injuries were treated as self-defence, even though she had no injuries from the assaults she described, and the CPS recognised inconsistencies in her evidence. Domestic Violence Protection Orders (DVPOs) were taken out on Zoltan, when Molly's actions and the consequences from those actions suggested she was the aggressor causing the most significant injury.

Frequency and Escalation in Incident Seriousness

2.3 The high number of incidents and escalation in the seriousness of injuries suffered by Zoltan appear not to have been appreciated as a whole. An increase in incident frequency and escalation are factors in identifying high risk victims of domestic abuse at risk of homicide, hence an incident by incident assessment of risk is dangerous.

2.4 There can be little doubt that Zoltan and Molly's relationship was difficult to manage. Both ignored the DVPO, and bail conditions put in place not to have contact with one another. Inaccuracies in information at times, along with conflicting statements, added to the difficulties faced by professionals. However, the substantial number of callouts to the Police and the significant, but unsuccessful resources and support involved with Molly in particular, could have triggered a review of their situation and an examination of the incidents in their entirety. This would have revealed the escalation and growing seriousness of the injuries Zoltan sustained and reconsideration of who was the victim at greatest risk.

2.5 **Information Sharing & Recording:**

2.6 Agency representation at the MARAC meetings was not always consistent and Housing provider representation, which could have benefited the MARAC process by sharing their information, was not included. Representation at MARAC appeared to lack a formal process for a knowledgeable deputy to step in when the substantive representative was unavailable. This affected the participation, recording, and sharing of information, most notably within the Mental Health Trust,

2.7 Inter-agency information sharing was generally good, however when this review's combined chronology was viewed it became apparent to some contributing agencies that gaps in sharing information existed. For example, Children's Services held more detail about Molly's health difficulties than her GP, knowledge of which could have better informed their approach to her treatment. Molly's IDVA also noted information gaps between her service and the Police and Children's Social Care.

2.8 As Molly was predominantly seen as the victim the information shared unintentionally distorted who was seen as the victim at risk so that Children's Services, Mental Health Services, Midwifery, Molly's GP and her IDVA all viewed her as the victim. This had the effect of drawing attention away from considering Zoltan as a victim and chances of offering him support services for male victims of domestic abuse were missed, and Molly's aggressive behaviour, possession of a knife outside the home, and serious assaults went unchallenged.

Reassessment of Risk

2.9 An assessment undertaken of Molly by a psychiatrist for the Family Court proceedings contained information which identified the potential risk she posed towards men with whom she had a relationship, or by whom she felt threatened, or even with whom she might argue. This was an important piece of information for reassessing risk, especially when Molly left the Mother and Baby Unit. The importance of this psychiatric assessment in terms of the increased risk Molly posed was not considered or shared.

2.10 When Molly's time at the Mother and Baby Unit ended and she returned to her flat this was a significant change in risk level. It is not unreasonable nor unrealistic to assume that she and Zoltan would once more be in contact, but this time with the added stress and potential for conflict and recrimination concerning their baby being removed. Until her IDVA once more made contact agencies appeared to be unaware that she had returned to her flat. Such major changes called for a reassessment of risk and an immediate referral to MARAC, but this did not take place.

2.11 Reports that Molly had men coming to her flat, a social worker's concern that she could not protect herself, plus intelligence of drug dealing from her flat were not fully investigated and cannot therefore be confirmed. However, it is worth highlighting this scenario as suggestive of 'cuckooing' where drug dealers target vulnerable people and either by threats, or by befriending them, take over their homes to use and deal drugs, While there is no confirmation that this was taking place, such a situation would have put Molly and her neighbours at significant risk and should have been investigated.

3. Conclusions:

3. 1 The conclusions and lessons learnt below are written with the intention of trying to encapsulate what we need to learn from the very tragic events which unfolded in this review. The author and the Panel members recognise that the contents of the review would be difficult for Zoltan's bereaved family to hear, and we would like to stress that we are not trying to move responsibility for Zoltan's untimely death away from Molly; Zoltan was the victim, and the Court has already found Molly guilty of his manslaughter. This document contains more about Molly than Zoltan as this reflects their contact with services and therefore the information available. The Panel has endeavoured to examine the factors which may have impacted on what took place, and to look for ways in which services and their practitioners can recognise the risks in similar cases to prevent other families suffering such loss.

3. 2 What stands out is the fact that although Zoltan suffered increasingly serious injuries due to assaults by Molly prior to the fatal assault, yet as a man he was never fully viewed by agencies as a victim, let alone a high risk victim of domestic abuse. As women are primarily the victims of domestic abuse and domestic homicide, much agency training is focussed on women as victims. This can inadvertently affect the mindset of those working with incidents of domestic abuse which risks stereotyping victims and the risk to men is underestimated. This happened in Zoltan's case.

3. 3 The Review highlighted the complexity of the elements to consider when trying to assess risk where conflict and violence is alleged by both parties. We know that mental illness, alcohol, and illicit drug use contribute to risk factors in domestic abuse, hence they feature in the DASH risk assessment tool[3], and these were present in the lives of Zoltan and Molly. What we also have in this case are two victims of domestic abuse in the context of what Professor Michael Johnson defines as 'situational couple violence'[4]: Zoltan, whose misplaced 'obsession' with Molly led to possessive behaviours such as excessive telephone calls (which Molly also reciprocated) and a constant wish to be with her, and Molly who appeared to change her mind about whether she wanted Zoltan living with her or not. When she did not want him with her this caused the situation which most consistently formed the catalyst for arguments and fights, frequently enflamed by alcohol, which triggered violence by Molly from which Zoltan suffered increasingly serious physical injuries, and which ultimately resulted in his manslaughter by her.

3. 4 Molly was vulnerable due to her past traumas and mental health disorders, one impact of which was to increase her risk of being violent to male partners when she felt under threat, although this was not known by agencies at the time of their interactions with her during 2016-17. Molly was also volatile when challenged by staff in the Mother and Baby Unit, but she consistently avoided attempts to achieve a mental health assessment which may have constructively informed help for her. Both Zoltan's and Molly's mothers had serious misgivings about the couple's relationship and did their best to advise against it continuing, but they were powerless to stop it.

[3] Dash risk checklist quick start guidance FINAL.pdf (safelives.org.uk)

[4] Johnson M.P. (2008) A typology of Domestic Violence, intimate terrorism, violent resistance, and situational couple violence, Northeastern University Press, Boston.

3. 5 Admittedly with the benefit of hindsight, on reading the psychiatric assessments referenced in the Review for Family Court and the Criminal Court trial, a degree of clarity and understanding emerged when considering the assessments alongside the information in the Review. The theoretical explanation for why Molly acted as she did makes unsettling sense. Sadly, the accurate risks identified within the confidential psychiatric report for the Family Court regarding Molly's possible threat to male partners was not shared before Molly killed Zoltan. The report was to inform family proceedings, and the value of its wider implications for ongoing risk assessment and support work with Molly were not considered or recognised. As a consequence, no application was made to the Court to share the information on the risks Molly posed.

3. 6 Apart from contact being arranged for Zoltan and Molly with their baby after Molly left the Mother and Baby Unit, it feels as though Molly was cut adrift by Social Care with no support for herself, apart from her IDVA who had no knowledge of Molly's diagnosis or the risk she posed. Such knowledge could have been important for informing how the IDVA progressed with Molly. The significant change in Molly's circumstances once she left the Mother and Baby Unit should have resulted in a referral to MARAC; the safety plan needed review when she returned to her flat as a transfer of accommodation had still to take place. Having lost custody of her child the chances were high that Zoltan would make contact and not be happy about the removal of their baby into care. The risks of conflict were high.

3. 7 The limited agency information about Zoltan evident in this document mirrors the findings in other Reviews i.e., the absence of fathers or male partners from scrutiny and detailed assessment. Zoltan had limited engagement with Children's Services. For the most part he did not respond to the social worker's attempts to engage him in assessments regarding his child, therefore his 'voice' is absent concerning his view of his involvement with Molly and whether he wished to be considered as the carer of their child. Molly reported in an assessment that Zoltan was the only man who had ever been happy about her pregnancy,

3. 8 The part alcohol played in this case was not acknowledged or assessed in detail. Zoltan had reported in one interview with a social worker that he had lost the opportunity to be a professional footballer because of his drinking, and he admitted it affected his ability to control his anger. However, the opportunity to signpost him to alcohol services was missed. Tests evidenced that Molly too had been using excessive alcohol, but this appears not to have been picked up until the Family Court assessment. However, it must be acknowledged that problematic drinkers can be adept at covering up their drinking. Molly also appears to have told different stories to different agencies and used a degree of 'disguised compliance', especially in her dealings with social workers, for example saying she would see a solicitor for a Non-Molestation Order, but never carrying this through. In line with her psychiatric assessment, there are many examples of Molly failing to take responsibility for her actions or to undertake tasks she needed to complete; instead, she relied on others like her mother and her IDVA, or blamed others including Zoltan, and she was not held to account or challenged about her inaction, primarily because she was erroneously seen as the high risk victim.

3. 9 There were some particularly good examples of joint working evidenced in this Review, as well as times when there was an inexplicable lack of information sharing where gaps should not have existed. A slowness to act when the high risk status of the case required fast action was also evident at times, particularly concerning is the management transfer for Molly's accommodation. Whilst acknowledging that she left the Mother and Baby Unit earlier than expected, how different things might have been had Molly come out of the unit with accommodation near her family instead of returning to her flat in Barnet we will never know. This accentuates the importance of housing provision, and the role of housing services.

4. Lessons to be Learnt:

The Importance of Avoiding Stereotypes and Identifying Who is the Victim At Risk

4.1. This case is a reminder that all may not be as it seems when dealing with domestic abuse. There were 13 incidents, plus the fatal incident, involving Police contact with Molly and Zoltan. Of these the first 5 incidents between January 2017 and May 2017 evidenced that Zoltan was the person receiving increasingly serious injuries. Although risk assessments were undertaken following a majority of the incidents only 2 were attempted with Zoltan, however, he declined to answer the DASH questions. As a man Zoltan was overlooked as a high risk victim of domestic abuse, even when he was the person with very visible injuries caused by Molly. Had the injuries been to Molly instead of Zoltan he would undoubtedly been prosecuted. As a man involved in domestic abuse incidents Zoltan was stereotyped as the perpetrator when the evidence suggested otherwise. Even when Molly's statements to the Police were found to be inconsistent or untrue and Zoltan's judged more realistic, there was no shift in perspective to see her as the main perpetrator as there should have been.

4.2. Gender bias was also in evidence given the fact that Molly was questioned in the street after she had hit Zoltan on the head, and a large knife was found in her handbag by a Police officer, yet she was not prosecuted for its possession. There was also no consideration given to a DVPO for Molly after she stabbed Zoltan in the leg nor prosecution pursued. Such inequality in treatment was unjust, and the opportunity was missed to seek community orders, such as a Mental Health Treatment Order, via the Court which may have seen Molly engage more meaningfully with support, particularly Mental Health Services. Court action can have positive outcomes.

4.3. The complexities in cases such as this require a degree of sophistication and reflection to draw out what is going on between the couple, who is the primary victim at risk, and how to mitigate that risk. There was no evidence of coercive control evident in the interactions between the couple. If there was a power imbalance it was due to Molly having her own accommodation, whilst Zoltan appeared to have no fixed address after his family moved. This, plus his declared love for Molly, made keeping the couple apart difficult. On examining the situations leading to the calls to the Police, a majority concerned arguments and fights because Molly wanted Zoltan out of her flat when she changed her mind about the relationship. Thus, it is valid to suggest that situational couple violence as defined by Professor Johnson's typology of domestic violence[5], helps us to a theoretical framework within which to explore the complexity of mutual assaults and contested claims arising from incidents.

4.4. It is important that all practitioners reflect on the evidence and all available information held to ensure they are not falling into the trap of stereotyping the abuser and the victim. Whilst statistically women are more likely to be victims of domestic abuse[6], men can be at risk of domestic abuse too and this Review demonstrates the additional risks when alcohol and mental health issues are present.

Raising Awareness of Support for Male Victims

4.5. Whilst it may be argued that Zoltan would not have recognised himself as a victim of domestic abuse, it is clear from the level of his injuries that he was the primary victim at risk of harm. Whether he would have accessed support services is debatable, however this is not a rationale to justify doing nothing to promote the men's specialist services which are available.

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[5] Johnson M.P. (2008) A typology of Domestic Violence, intimate terrorism, violent resistance, and situational couple violence, Northeastern University Press, Boston.

[6] Homicide in England and Wales: year ending March 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018#how-are-victims-and-suspects-related

This should not only include helplines, but also sources of practical face to face support available locally. Practitioners also need to have knowledge of these services and be able to constructively encourage access to them (see Appendix B for sources of support for men).

Assessment of Patterns of Behaviour, Escalation, and the Need to Take Prompt Action

4.6. Zoltan was stabbed in the leg demonstrating a clear escalation and this serious incident should have triggered a MARAC referral with Zoltan as the victim. Failure to check intelligence when the Police system was down also led to a further incident of abuse (Zoltan's verbal abuse alleged by Molly in the street), and the breach of bail being missed. As a result, Zoltan's behaviour was not challenged in court for a breach of order to enable the consequences of his actions to be made clear to him. This may have reinforced that he should stay away from Molly to reduce the conflict which occurred between them. No escalation in Molly's violence towards Zoltan was recognised. It appears that the situation was being judged on an incident by incident basis, and no assessment of the pattern or escalation in violence effectively took place, which is surprising considering the volume and frequency of the calls for Police officers to attend. There was a need for oversight of the incident history between Zoltan and Molly. Unconnected to their relationship, Zoltan assaulted a woman who was a family friend outside a pub when drunk, this was also relevant as it gave an indication of his ability to be violent toward a woman when he had been drinking.

4.7. Whilst recognising the challenge agencies faced in contacting Molly, her inaction in following advice to apply for housing, and the scarcity of housing resources at the Housing Department's disposal, in addition to the high risks inherent in this case, including to Zoltan and Molly's unborn child, appeared to be under estimated. Child protection proceedings were taken shortly before their baby's birth. The perception that Molly would not successfully separate from Zoltan negatively influenced her housing transfer to be nearer her family support and postponed her move. This perception was reinforced by Molly's continuing contact with Zoltan. There were clear indications that Molly relied on the support of her mother during times of crisis. Her mother was proactive in supporting her, in addition to being a contact point for services when Molly could not be reached. Had the move nearer to her family been expedited there is a chance that fears of Molly reuniting with Zoltan would have been unfounded. Action was required much sooner.

Agency Attendance and Relevant Information Sharing at MARAC

4.8. MARAC meetings were very well attended. However, Mental Health were missing from the first MARAC as the representative was unavailable and a substitute representative did not attend. It is important that agencies identify a deputy MARAC representative to cover for annual leave or other occasions, and for the MARAC coordinator to be informed.

4.9. Molly's housing provider was not invited to the MARAC and given the vital importance of housing in this and many domestic abuse cases, this left an important gap in discussions and actions for her case. This was to some extent mitigated by liaison with housing officers by Molly's IDVA, however, their first-hand involvement would have been beneficial. Whilst mindful of staff time constraints, it would be useful for virtual attendance at MARAC via secure online means to be found for housing provider's to attend when relevant.

4.10. Not all relevant information was shared at the MARAC both as a consequence of absence of some agency representatives from the meeting, and not all attendees bringing the latest updates available. Somewhat surprisingly, the information provided that Zoltan had been 'bottled' and stabbed by Molly did not result in the MARAC recognising him as a victim at risk and the seriousness of the assaults by Molly was escalating. The gaps in information, and lack of consideration of what was available concerning Zoltan as a victim defeats the purpose and usefulness of MARAC to assess risk and to construct a comprehensive safety plan. It is therefore important that MARAC representatives check their records carefully so that information sharing is effective. Actions from the two MARACs held were limited and lacked

consideration of any further harm to Zoltan by Molly. Partnership meetings outside of MARAC should be considered to deal with complex cases where more time is required to safely analyse and identify risk and to whom the greater risk applies.

Information Sharing & Record Keeping

4.11. Even when services believe their information sharing and joint working is good, as it was mainly in this case, the Review identified that when all information was brought together in the combined chronology, it illuminated when information had not been shared and the implications for practice. Gaps can influence perceptions which can bring about misplaced optimism, or perhaps impede a realistic assessment of the degree of cooperation which genuinely exists within the working relationship with a service user as in Molly's case.

4.12. Both the MARAC and the MASH[7] which are specifically designed to facilitate information sharing and joint working, were shown to be inconsistent in achieving this. Gaps in recording were identified, for example in noting MARAC notification and recording details of housing transfer processes. Information was not always shared with Molly's IDVA by Police and Children's Social Care. Molly's GP also identified gaps in their knowledge about her mental health and substance use as she did not discuss this with her GP, but this information was held by Children's Services and Molly's GP felt this was relevant for treating Molly's mental health and should have been shared. In a pressured working atmosphere of large caseloads, limited resources, and time constraints it is easy to overlook the importance of record keeping, but repeatedly in Reviews gaps in records and information sharing are shown to be a significant cause of inadequate risk assessment or protective actions being taken.

The Need for Reassessment of Risk.

4.13. When Molly left the Mother and Baby Unit it felt as if all bar her IDVA forgot about the domestic abuse risk and the fact that Molly's case had previously been heard at MARAC. However, there was no reassessment of risk and no MARAC re-referral as there should have been with this major change in circumstance. Importantly, no agencies were alerted to the risk that Molly posed which was identified in her psychiatric assessment for the Family Court. This was a significant piece of information which should have triggered a comprehensive reassessment of risk. The fact that Molly and Zoltan's child had been taken into care was also a significant change in circumstances which presented the likelihood that they would be in contact with one another, possibly in a situation of recrimination and volatility. Such significant changes and important information which updates risk levels should result in a MARAC referral, and Zoltan should have been contacted to alert him to the newly identified risks, especially as their child was no longer in Molly's care.

The Importance of Care for Mothers Whose Children have to be Removed.

4.14. Molly was not provided with appropriate therapy and support following a previous similar involvement with Children's Services. Neither was this factored in for her after the removal of the baby into foster care. These experiences, plus other traumatic events in her early life, were identified by two consultant psychiatrists as requiring an appropriate level of skilled long-term therapy. It was identified during the Review that Molly's personality traits and metal disorders meant she meets criticism with denial, anger, and projection of blame to others. Her 'learned helplessness' and resultant inability to take responsibility for her actions or follow instructions will not change without help. Nor will her risk to future partners unless therapy is provided.

4.15. The Barnet Health and Wellbeing Board Strategy 2015-2020 (p17)[8] recognises that domestic abuse, along with parental mental ill health and substance abuse, are the most common

[7] Multi-Agency Safeguarding Hub

[8] https://www.barnet.gov.uk/sites/default/files/joint_health_and_wellbeing_strategy_2015_-_2020_booklet_1.pdf

causes of referrals into Social Care and result in the poorest outcomes for children and young people. We have all three issues in this case, plus the impact and trauma of losing custody of a child which affected not only Molly and her family, but Zoltan and his family. Mothers who have had their children removed may not be a large group in the population, but as this case showed, providing no after care for their mental wellbeing can have long-term catastrophic effects not just for the parents, but for those around them. Thus, any full Care Order made by the Court should automatically involve a trauma informed practice approach and instigate therapeutic support for the child's parent/s, particularly the mother.

5. Recommendations from the Review:

5.1 The recommendations below have been developed from the learning arising from this Review and from Panel discussions. They are followed by agency Individual Management Review recommendations.

Recommendation 1:
Staff domestic abuse and safeguarding training should include the complexities of situational couple violence to enable staff to think about risk to both parties, and the necessity to apply risk assessments. Those providing this training should include this Review as a case study to raise awareness of:
(a) the elements of bi-directional violence / situational couple violence in relationships,
(b) overcoming stereotypes and identifying male victims, and
(c) highlight the importance of reviewing the history of incidents and events to identify who is the primary victim.

Recommendation 2:
A review should take place of the Sanctuary Scheme procedures to ensure that protective measures can be taken as quickly as possible, coordination of the Scheme is staffed at all times, that there are agreed lines of communication and processes in place to gain Registered Providers' consent for work to be undertaken without delay.

Recommendation 3:
After initial contact has been made agencies using withheld telephone numbers when phoning service users should review their procedures, and where necessary, include the practice of texting or emailing to pre-warn of the phone call to reduce difficulties in establishing contact, and agree with the service user their preferred method of communication. In cases involving domestic abuse checks should be made to ensure the method of communication is safe.

Recommendation 4:
Agencies should consider the mental health of women who have had children under their care removed, and their GP should be notified to enable them to consider a referral for women with this experience to access psychological therapies or trauma related counselling programmes.

Recommendation 5:
Where agencies involved in undertaking medium to long term assessment processes identify alcohol and/or drug use as a contributory factor in domestic abuse cases, this must be given sufficient weight as a high risk factor in risk assessments, and efforts should be made to gain consent for a referral to appropriate services in an attempt to reduce or manage the risk caused by substance misuse. Where first responder services become aware of substance misuse issues this should be highlighted in onward notifications to services.

Recommendation 6:
The MARAC steering group should review the quality, effectiveness, and completion of actions offered by agencies at MARAC, and consider an annual appraisal meeting of MARAC partners to assess:
(a) which actions are or are not effective,
(b) which agencies are or are not consistently contributing actions when relevant to the case and why,
(c) whether there is scope for more creative actions to be taken to enhance safety plans.

Recommendation 7:
The MARAC protocol should be reviewed to check that the criteria for a repeat referral to MARAC is clear to participating agencies and the MARAC coordinator, the importance of information sharing is reinforced, and where the responsibility lies for sharing information outside of MARAC meetings. Updated information guidance setting this out should be circulated to MARAC members.

Recommendation 8
In recognition of the limited time available at MARAC to fully reflect on and analyse complex cases, including those where counter allegations or mutual violence may make identifying the primary perpetrator difficult, the holding of a domestic abuse professionals meeting to enable more detailed discussion should be an action considered by the MARAC. Such a meeting should be minuted and the outcome reviewed and discussed at the next MARAC.

Recommendation 9:
The availability and promotion of services for male victims of domestic abuse to be reviewed in the area and steps taken to ensure they are visible, accessible, and referral pathways are clear to professionals and male victims alike. Services should be reviewed annually to ensure the resource information is up to date.

Review Recommendation 10:

With respect to the operation of DVPOs the Metropolitan Police Service to ensure that:

a) There is effective communication with Barnet CSP partner agencies regarding the arrangements in place for the management of DVPN's and DVPO's (and future DAPOs).
b) Local Policy documents for DVPN SPOC's include clear guidance that when a DVPO (or future DAPO) is granted, officers consider sharing the existence of the order with relevant agencies providing a service to the victim or perpetrator to assist in the monitoring of the order. The officer's decision will be informed by Article 8 of the Human Rights Act, in addition to the Crime & Disorder Act 1998 Section 17.

Recommendations from Individual Management Reviews

Police

Recommendation 1: for CASO - Sapphire - SLT
It is recommended that CASO SLT debrief the officers and supervisors involved in this incident to remind them of the importance of ensuring risk has been adequately identified and managed.

Recommendation 2: Overarching Recommendation Barnet BOCU – SLT
It is recommended that Barnet BOCU SLT debrief the officers involved in this incident to remind them of the importance of ensuring risk has been adequately identified and managed in all cases. Officers should be reminded of the importance of completion and supervision of risk assessments in line with MPS domestic abuse toolkits.

Recommendation 3: Barnet BOCU – SLT
It is recommended that Barnet BOCU Senior Leadership Team (SLT) remind all staff of the requirements of the National Crime Reporting Standards, with regards to prompt recording of allegations of crime.

Recommendation 4: Barnet BOCU – SLT
It is recommended that Barnet BOCU SLT debrief the officers involved in this incident and in particular remind them of the importance for consideration of victimless prosecution in DA cases, including appropriate recording of rationale if this is not a viable option for Police.

Recommendation 5: Barnet BOCU SLT
It is recommended that Barnet Borough SLT debrief the decision makers involved in this case to ensure the learning from this review is shared.

Recommendation 6: Overarching Recommendation Barnet BOCU SLT
It is recommended that Barnet Borough SLT debrief the Officers involved in this call to remind them of MPS DA Policy including intelligence checks required and recording of incidents.

Recommendation 7: Barnet BOCU – SLT
It is recommended that Barnet BOCU SLT debrief the Officers concerned with this incident to ensure safeguarding Policy is adhered to on future domestic calls in terms of all occupants being seen by Police and information sharing regarding vulnerable adults with partner agencies.

Barnet Family Services:

Recommendation 1
Encourage and support staff attendance across the partnership at multi-agency MARAC training.

Recommendation 2
Promote and encourage joined up working with Children Services in assessments and care planning among safeguarding leads in adult services (Mental Health, Substance Misuse Services, Probation).

Recommendation 3
Promotion of specialist services and expertise available in the borough for all professionals.

Recommendation 4
Increase collaboration and use of specialist services (Solace, RISE) to support casework with families experiencing domestic abuse.

Recommendation 5
To promote training for all agencies on the risks of the trigger trio, disguised compliance, and non-engagement and how to work in a joined-up way to mitigate risks.

Recommendation 6
Multi-agency safeguarding and training to identify with fathers as domestic abuse victims and how better to engage in work with them.

Recommendation 7
Where a resident in a Mother and Baby Unit is a tenant of a Housing Association or similar provider, their landlord should be informed when they leave to return to their provided accommodation.

Victim Support

Recommendation 1
It is recommended that the existing searching of the case management system process is enhanced to ensure that upon receiving a referral, a thorough search of the case management system is conducted on the address for the referral subject to check whether there are related cases to ensure all known risk information is available to enable appropriate allocation of cases.

Recommendation 2
Ensure that all Victim Support staff are aware of the timeframes stipulated in the DA Operating Procedure and provide training in areas where this practice has not been adopted. Managers to continue to address this with their teams, through team meetings and one to one supervision.

Recommendation 3
Ensure that present day Victim Support procedure and practice is adhered to through continued use of dip-sampling and case review and feedback to staff. This is already being actioned through the introduction of an improved case review and auditing process throughout the organisation on a national level. The Victim Assessment and Referral Centre staff should be included in this explicitly.

Solace Women's Aid

Recommendation 1
Solace to review how frequently RIC assessments for IDVA cases should be reviewed in light of recent Safe Lives Leading Lights guidance.

Recommendation 2
Full rollout of service manager and senior manager case dip sampling and service dip sampling (including staff supervision records).

Recommendation 3
Scrutiny should take place of current partnership agreement of Solace co-location in Barnet MASH.

Recommendation 4
Staff supervision files should be centralised.

Recommendation 5
A review should take place of training and refresher training provided to existing staff.

Genesis Housing Association

Recommendation 1
The Housing Association to liaise with the Police to agree a process whereby information is shared on the imposition of Domestic Violence Protection Order's or injunctions that are in place to enable the landlord to report to Police any breaches of these orders or injunctions.

Recommendation 2
Where housing needs is part of any risk management process, the landlord should be invited to MARAC from the outset.

Recommendation: 3
Introduce criteria for opening a React case to ensure that where Police are called to a property more than once over a defined period of time a case is opened.

Recommendation 4
Refresher training for Customer Service Centre staff on Domestic Abuse Procedure. This will ensure that cases are referred straight to the ASB Officer in future. Actioned on 14 August 2018.

Recommendation 5
Refresher guidance for Neighbourhood Managers to be provided on when a domestic abuse case should be logged on SHUB.

Recommendation 6
Where Concierge's are on site, a system is to be introduced to record people that have been asked to leave the premises and why. Log to comply with GDPR requirements.

Recommendation 7
Explore/Review how risk assessment reviews can be more easily identifiable in ASB case management.

Royal Free London NHS Foundation Trust

Recommendation 1
The learning from this Review to be included in safeguarding children and adult level 3 training.

Recommendation 2
Review the criteria for cases to be discussed at the weekly emergency meeting

Recommendation 3
Ensure that the emergency department documentation set identifies patients where a 'Think Family' approach is required.

Barnet Homes

Recommendation 1
Evaluate the training needs of all frontline housing officers related to domestic violence; housing and support options for victims of domestic violence; referral routes; and referral thresholds for relevant partner organisations

Recommendation 2
Maintain a Log which identifies the training undertaken by frontline housing officers to ensure all necessary training delivered by Barnet Council, Barnet Homes, and/or partner agencies is up to date. The training log should be reviewed a minimum of annually at staff appraisal.

Recommendation 3
Induction pack to be created for all new starters related to domestic violence, referral thresholds, and the available housing and support options

Recommendation 4
Domestic Violence procedure and referral processes to be reviewed in line with Barnet Council's VAWG Strategy.

APPENDIX A

College of Police Practice Guidance[9]

Determining the primary perpetrator and dealing with counter-allegations

Officers should avoid jumping to conclusions about which of the parties in the relationship is the victim and which the perpetrator. This applies to all types of relationships, whether heterosexual, same sex, transgender or familial (non-intimate partner). They should probe the situation and be aware that the primary aggressor is not necessarily the person who was first to use force or threatening behaviour in the current incident. They should examine whether:

- the victim may have used justifiable force against the suspect in self-defence
- the suspect may be making a false counter-allegation
- both parties may be exhibiting some injury and/or distress
- a manipulative perpetrator may be trying to draw the police into colluding with their control or coercion of the victim, by making a false incident report.

Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator.

If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one.

When investigating counter-allegations, officers should note and record:

- body language
- comparative severity of any injuries inflicted by the parties
- whether either party has made threats to another party, child or another family or household member
- whether either party has a history of abuse or violence
- whether either party has made previous counter-allegations
- whether either party acted defensively to protect him or herself or a third person from injury
- what any third party witnesses say.

Conducting a thorough investigation into the incident will help officers to determine the facts of the situation.

Dual arrests should be avoided.

SEE ALSO:

Respect Toolkit: for Work with Male Victims of Domestic Abuse (2019 edition) Section 4 'Identifying who is doing what to whom and with what effect' p.37
Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf (hubble-live-assets.s3.amazonaws.com)

[9] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/first-response/#determining-the-primary-perpetrator-and-dealing-with-counter-allegations

APPENDIX B

NATIONAL SOURCES OF SUPPORT FOR MALE VICTIMS OF DOMESTIC ABUSE

For help and support for male victims of domestic violence and abuse, the following services provide free helplines:

- **Men's Advice Line** for men experiencing abuse: Monday-Friday 9am-5pm: 0808 801 0327 https://mensadviceline.org.uk

- **National LGBT Domestic Abuse Helpline**: 0800 999 5428 www.galop.org.uk/domesticabuse

- **National LGBT Domestic Abuse Helpline form Young People** 0800 999 5428. https://www.theproudtrust.org/national-lgbt-domestic-abuse-helpline

- **RESPECT Phoneline**: Confidential helpline offering advice, information, and support to anyone concerned about their own or someone else's violent or abusive behaviour. Monday-Friday 9am-5pm: 0808 802 4040 https://www.respect.uk.net

- **Men Reaching Out**. Links for referrals and advice: Men Reaching Out • NCDV