

# **Domestic Homicide Review**

**Cydney/2011**

## **Overview Report**

**Author: Greg Barry**

**Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership**

Ref: Cydney / 2011



# Overview Report

## 1. Introduction

- 1.1 On 10<sup>th</sup> September 2011 a woman and her baby died in an arson attack at her parent's house in Medway. The woman's father died ten days later from the injuries he sustained, her mother and brother were also injured. The estranged husband of the woman, his girlfriend and a male friend of his were responsible for the fire. Until April 2011 the woman had lived with the offender and their baby in Coventry. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004 the Kent and Medway Domestic Homicide Review Core Panel agreed that this homicide should be subject to a review. Medway Council is a unitary authority situated within the geographic area of Kent which has a county council. Many of the agencies such as the police are responsible for services across the two local authority areas. The two councils work together on some joint initiatives including Domestic Homicide Reviews.
- 1.2 The terms of reference for the review can be found in Appendix A. The main purpose of a Domestic Homicide Review is to establish lessons to be learned by examining the way that individuals and organisations work to safeguard victims. The review was undertaken in accordance with the Home Office Guidance 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' issued in April 2011 and the Kent and Medway Domestic Homicide Review Protocol published in September 2011.

## 2. The Review Process

- 2.1 The review was carried out by a multi-agency panel that was independently chaired. The panel considered reports of Individual Management Reviews (IMRs) compiled by the various agencies who had been involved in providing services to the family in Medway and Coventry. The IMRs were carried out by a combination of an examination of relevant records and interviews where appropriate, with members of staff who had been involved with the family. The reports contained factual information and an analysis of the service provided by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency basis. A list of the contributing agencies, IMR authors and panel membership is detailed in Appendix B.
- 2.2 The panel was in disagreement over two issues that were identified in the IMRs and as a consequence the Community Safety Partnership in Coventry sought the views of the Coventry Safeguarding Children Board

over one matter and their views have been incorporated into this report. The second matter was considered by a representative of the Co-ordinated Action Against Domestic Abuse and their conclusions have also been included in this report.

- 2.3 The decision to hold a review was made on 6<sup>th</sup> October 2011 and the panel met four times to consider the reports and agree the final report which was written by the Independent Chair. The review was delayed as further information had to be obtained from a number of the agencies and to obtain expert advice regarding the challenges to some of the comments contained within the draft final report.
- 2.4 As this homicide involved the death of a child, consideration was given by the Coventry Safeguarding Children Board (CSCB) as to whether they should carry out a Serious Case Review in accordance with Chapter 8 of Working Together to Safeguard Children 2010. The CSCB concluded that as the child was no longer resident in the area they were not the appropriate board to make that decision. Medway Safeguarding Children Board (MSCB) also considered this matter and they concluded that the criteria for a serious case review were not met. The reasoning behind this decision has not been shared with the author of this review, however Ofsted were informed of the decision and they were satisfied that the DHR would be the appropriate process within which to review agencies involvement with the family and take forward any actions and necessary learning. The Chair of the MSCB did write to CSCB recommending consideration of a review of information sharing across health professionals in Coventry. The Coventry and Warwickshire Partnership NHS Trust carried out a root cause analysis of the mental health services provided to the offender in this case and this report was considered by the author of their IMR.
- 2.5 This report is anonymous and for the purposes of this report the following pseudonyms have been used:-
- Female victim – Cydney  
Baby victim – Solomon  
Offender – Derek
- 2.6 This review only examined the services provided to the woman, her husband and their child. The time period examined by this review was 1<sup>st</sup> January 2007 until 11<sup>th</sup> September 2011.
- 2.7 On completion of the criminal trial the family of the victims were invited to contribute to the review and they provided additional information. On completion of the draft final report the family read the report in the presence of the Independent Chair. They made some requests for minor

changes which have been incorporated into the report. The family are content with the findings of this review and hope it will help prevent further incidents of domestic abuse and improve domestic abuse services.

### **3. Background**

#### **3.1 Cydney and Solomon**

Cydney was 20 years old when she was murdered. She met Derek when she was 14 years old and soon after commenced a serious relationship with him. When she was 16 years old and had left school, she moved from Medway where she had lived all of her life to live in Coventry with Derek. They lived together for a year or so with Derek's brother before moving to privately rented accommodation. They were married in 2009. In May 2010 she gave birth to Solomon who was 15 months old when he was murdered. She was White British with no recorded disabilities.

#### **3.2 Derek**

Derek was 23 years old at the time of the homicide. He was Asian of Middle Eastern background and had come to the UK in 2005 as an asylum seeker. Derek was granted indefinite leave to remain in the United Kingdom. He lived in various locations in England. After starting a relationship with Cydney they moved to Coventry in 2007 and they were married in 2009. As a result of the marriage Derek became a UK citizen. He had no recorded disabilities, although he did have a history of depression/self-harming from 2008 and anger management problems from 2010. He also reported heavy alcohol intake in 2005, and in 2011 he was a regular user of cannabis.

#### **3.3 Accommodation**

Whilst living in Coventry the couple initially lived with Derek's brother and then moved to privately rented accommodation. When they separated Derek remained in the accommodation, and Cydney and Solomon lived with her parents in their privately owned house in Medway.

#### **3.4 The Relationship**

The family of the victims have described the relationship as being in the main very loving however they were not aware of all of the domestic abuse incidents. The pregnancy was not planned; at the time of the pregnancy she was undergoing medical tests and Cydney believed she would not be able to have children. Cydney only reported one incident of domestic abuse whilst she was living in Coventry which led to her immediately moving with Solomon back to live with her parents in

Medway. Details of the violent relationship were disclosed after she moved to Medway. The subsequent investigation into the murder revealed other incidents of domestic abuse. Some agencies were aware of Derek's violent outbursts.

- 3.5 It is the view of Cydney's family that Cydney could not take the risk of Derek harming Solomon and it was because of this concern that she left him and she had taken advice regarding divorce proceedings. It is possible that the relationship would have continued if there had not been a baby. After their separation in April 2011 Derek had regular contact with Cydney and Solomon, spending time with both of them although arguments and domestic abuse did continue.

#### **4. Area Information/Context**

##### **4.1 Medway**

The population of Medway is about 260,000 with 87.2% being White British and 12.8 % being of Black and Other Minority Ethnicity. There were 3879 incidents of domestic abuse in Medway reported to the police in 2010/2011 and 4248 in 2011/2012. Between 2007 and 2012 there were five domestic homicides including the three victims of this homicide.

##### **4.2 Coventry**

The population of Coventry is about 316,900 with 74.1 % being White British and 25.9% being of Black and Other Minority Ethnicity. In 2011 the police recorded 4717 domestic abuse incidents. Between 2007 and 2012 there were four domestic homicides.

- 4.3 There are similarities in both areas with a mixed and in some parts a transient/changing population with some degree of deprivation. Reports of domestic abuse in both areas are high and this report acknowledges that research has shown that domestic abuse is often significantly under reported.

#### **5. The Homicide**

- 5.1 At the time of the murder Cydney and Solomon were living with her parents in their house in Medway having separated from Derek in April 2011. Also living at the house was her brother. Derek was still living in Coventry and he had commenced a new relationship with another woman in the city. He was having regular contact with Cydney and Solomon both in person and by telephone.

- 5.2 In the early hours of Saturday 10<sup>th</sup> September 2011 Derek and a friend went to Cydney's parents' house and sprayed petrol through the letter box and set light to it. This resulted in a major fire and when it was extinguished the bodies of Cydney and Solomon were discovered in a front bedroom. Subsequent post mortem examination established they had both died from smoke inhalation. Cydney's father, mother and brother were also injured and ten days later her father died from the burns he suffered.
- 5.3 A murder enquiry was commenced by the Kent Police assisted by Kent Fire and Rescue Service and as a result Derek, his girlfriend and a man were arrested. The three of them were charged with a number of offences in connection with the homicide. After a trial at the crown court Derek was convicted of several offences including the murder of Cydney and Solomon and was sentenced to life imprisonment. His friend was also convicted of the same offences and was sentenced to life imprisonment. Derek's girlfriend was convicted of other offences and was sentenced to fourteen years imprisonment. An inquest was opened and adjourned after the deaths were reported to the coroner. After the trial at the crown court the coroner decided there was no requirement to hold a full inquest.

## **6. Additional information obtained during homicide Investigation**

- 6.1 As part of the murder investigation it has been established that Derek had been violent to Cydney on previous occasions by punching her and on one occasion he had thrown Solomon onto the sofa. None of these incidents had been reported to any of the agencies. There is no information to indicate when the abuse commenced.
- 6.2 The family have stated that after the separation Derek had been frequently in contact with Cydney by telephone and in April 2011 Derek had 'kicked off' and threatened to take his son. They also said that on another occasion Cydney had travelled with Solomon to see Derek in Coventry and when they met Derek he 'lost it' and was shouting and screaming at Cydney and kicked out at property. It was at this time Cydney told Derek that the separation was final. The family also said that after this time Derek cut his wrists although this has not been substantiated. At some stage the family became aware that Derek's new girlfriend had started sending Cydney abusive texts.

## **7. Analysis of incidents and services provided by agencies**

- 7.1 A chronology of contact by the agencies with this family can be found in Appendix C. The following analysis is of incidents and services linked to domestic abuse, there is no analysis of other services. However they are included in the chronology to indicate the level of contact with agencies

- and opportunities for either Derek or Cydney to provide information, and for professionals to enquire about domestic abuse if relevant. It is acknowledged that research has shown some victims of domestic abuse experience 35 incidents before contacting the police (Jaffe 1982).
- 7.2 The first indication of a mental health issue with Derek was when he saw GP 1 in June 2008 and then GP 2 in August 2008 when Derek presented himself with depression and episodes of self-harming. The GPs gave appropriate advice as Derek declined both medication and a referral to adult mental health services. The GP also provided details of a local mental health charity. GP 1 concluded on the first occasion that Derek was anxious rather than positively depressed and on the second appointment the assessment by GP 2 concluded 'no biological depression'. The GPs understood Derek to be single at the time, which was not true.
  - 7.3 During the time that Derek lived in Coventry he attended the same large GP practice that employed a high number of GPs with a high volume of patients in a multi-cultural area. Derek saw a total of ten GPs over three years and five different GPs dealt with him for his mental health issues. Cydney was also registered with the same GP practice but at a different surgery.
  - 7.4 In October 2009 Cydney saw a Midwife for the first time and then had regular appointments until the birth of Solomon. There were no health issues for Cydney during the pregnancy and she did not raise any concerns with the Midwife about her relationship with Derek. It was not policy for Midwives in Coventry at this time to ask any questions about domestic abuse. Since this homicide the policy has been changed and now questions regarding domestic abuse should be routinely asked of all pregnant mothers and a system of stickers is used in the records to assist in this process. As it is unknown when the abuse started it is impossible to know if this was an opportunity missed by the midwifery service.
  - 7.5 On 2<sup>nd</sup> February 2010 Derek reported to GP 3 that he felt tired all of the time and had become 'angrier with his wife' over the last month or so but no violence. This is the first possible indication of domestic abuse however it was not recognised as such by the GP. It appeared that the GP did not explore the reasons for the anger nor did he establish that Derek's wife was pregnant. The GP then made a referral to the local psychological service but was unaware that they no longer provided anger management programmes. The GP's response was in accordance with the guidance issued in 2007 by the British Medical Association (BMA) to direct patients who disclose that they are perpetrating domestic abuse, to appropriate specialist support services. The GP was also unaware that it was no longer accepted practice to refer perpetrators of domestic abuse to



- anger management programmes however the GP was unaware of any other suitable programmes available locally. The GP was of the view that by making the referral it may provide protection for Cydney as it would address Derek's feelings of aggression.
- 7.6 When the community mental health team received the referral from the GP that was graded as routine it described the reason for referral as 'increase in uncontrollable anger which has led to heated argument with wife but no actual violence '. The community mental health team passed it to the psychological service for screening and psychological input. They in turn passed it back to the GP recommending that a referral to the community mental health team was more appropriate as the service did not deal with anger management problems and no longer offered anger management programmes. Also they were of the view that Cognitive Behavioural Therapy (CBT) was not appropriate for Derek. The community mental health team did send Derek a number of appointments however he did not attend any of them.
- 7.7 On 8<sup>th</sup> February 2010 the GP received correspondence from the psychological service advising them that they did not provide anger management services and advised the GP to make a referral to the community mental health team. Then a week later the GP was informed by the community mental health team that Derek had been referred for CBT.
- 7.8 On the 8<sup>th</sup> March 2010 Derek saw GP 9 complaining that he was tired all of the time. No treatment was recorded on the notes however it was noted that Derek had a letter from the psychological service with him.
- 7.9 On the 15<sup>th</sup> March 2010 the GP received a copy of a letter that had been sent by the psychological services to Derek providing details of their services and advising him to make contact to arrange an appointment within two weeks.
- 7.10 In April 2010 Derek was written to by the single point of entry (SPE) for adult mental health services asking to make contact and if he failed to do so then the case would be closed and he would be referred back to the GP. The GP was sent a copy of the correspondence. Derek did not make contact and so the case was closed in line with the service's protocols.
- 7.11 At the time the mental health services in Coventry were not a combined service with the community mental health team being separate from the psychological services. There was no single point of contact/referral and they operated separate electronic recording systems even though in some locations they operated from the same building. The community mental

- health team often operated out of GP surgeries as they did in this case so face to face communication was possible.
- 7.12 There was a lack of a coordinated approach between the mental health services and may have been confusing for a well person to comprehend. It is possible that it may have been confusing for Derek and the GP as to exactly what service was being offered and why. It is also of a concern that neither service had seen Derek nor had there been any direct communication recorded between either of the services and the GP other than the referral letters and copying of letters sent to Derek. Furthermore both the GP and the two mental health services were not aware that anger management was no longer suitable for the treatment of individuals who are responsible for domestic abuse. In addition there was also confusion between the two services as to whether CBT was suitable for Derek.
- 7.13 The access for all mental health services in Coventry has been modified since this homicide and they now operate through a single point of contact. However they still operate separate electronic file systems which are separate from the GP records although when the Community Mental Health Nurse (CMHN) saw Derek at the GP surgery details of these appointments were recorded on the GP system which was beneficial as it permitted the GP to be aware of treatment plans and issues.
- 7.14 In addition the standard of record keeping by both the GP and both of the mental health services has made it difficult to fully understand exactly what happened and when during this period both in terms of contact between the agencies and with Derek.
- 7.15 On 25<sup>th</sup> May 2010 Solomon was born at term in hospital by normal delivery and was discharged with Cydney. Solomon and Cydney were seen by health visiting and other medical staff for both routine reviews and when Solomon was ill; no concerns were raised by Cydney or identified by any of the medical personnel. Cydney was reported to be a very good mother and only missed one appointment.
- 7.16 On 16<sup>th</sup> June 2010 a second referral for Derek was received from GP 3 by the community mental health team for identical reasons to the previous referral in February 2010. There is no record of this referral in the GP records and therefore was not included in the GP IMR.
- 7.17 This referral was significant as it detailed the full name of Derek's wife and stated that he had suffered mild anxiety depression in 2008. The referral also stated that Derek was keen to seek help to get this under control before it led to any further problems. It did not include the fact that there had been a previous referral in February 2010. However the GP and the community mental health team did not recognise this as possibly domestic

- abuse and therefore did not take any action to protect Cydney. If there had taken some proactive action or even any probing they may have identified that there was a three week old baby in the house who may have been at risk.
- 7.18 On the 24<sup>th</sup> June 2010 Derek saw GP 10 with conjunctivitis but there was no record of any discussion about his anger issues or to see if he was engaging with the mental health services.
- 7.19 Derek did not attend any appointments offered to him by the community mental health team and at some stage an 'Opt in' letter was sent by the Community Mental Health Worker (CMHW) to Derek and as he did not reply the case was closed on 30<sup>th</sup> July 2010. There was no information provided to this review regarding details of any attempts to contact Derek or his GP or any discussion about the decision to close the case.
- 7.20 In September 2010 Cydney and Solomon started regular attendance at a children's centre in Coventry where they went to a variety of groups. The staff did not identify any concerns about Cydney or the care of Solomon.
- 7.21 The first and only time the West Midlands Police in Coventry had any dealings with this family was on the 1<sup>st</sup> April 2011 in the early hours when they were called by a friend of Cydney. The call was because Derek had assaulted Cydney during an argument that had started when she did not want to have sexual intercourse with him. He spat and punched her several times during the assault and she did try to fight him off. Cydney had a scratch to the side of her neck but no other visible injuries and had experienced pain when she was punched. Initially when the police attended Cydney did not want Derek arrested; she just wanted to be able to leave him and so he was arrested to prevent a breach of the peace. When she made her statement; details of the assault were disclosed and he was then also arrested for assault. He was kept in police custody and when interviewed the following morning he admitted the assault. Derek was then cautioned for common assault and released from custody.
- 7.22 The domestic abuse policy of the West Midlands Police stated that a caution in domestic abuse cases was rarely appropriate and should only be administered if the suspect admitted the offence, has no previous convictions and that there would be sufficient evidence to prosecute the case at court but the victim is reluctant to attend court. The view of Cydney regarding attendance at court is not recorded on the police papers therefore it is not possible to conclude whether the caution was in line with the policy. Cydney was contacted and updated with the outcome of the investigation and the records suggest that she was content with the result. As the police had decided to dispose of this case by way of a caution

there was no requirement to refer the case to the Crown Prosecution Service.

- 7.23 The investigation and arrest of Derek in this case was in accordance with local and national good practice in terms of positive action at the scene and the gathering of evidence. The decision to caution Derek was understandable as it was unlikely that he would have received any significant punishment if the case had gone to court. The officers who dealt with the case were appropriately trained and there was no requirement to involve specialist officers.
- 7.24 It was the policy of the West Midlands Police published in February 2011 for a risk assessment to take place of all victims of domestic abuse involving intimate partners where a crime has occurred. The process uses the DASH (Domestic Abuse, Stalking and Harassment and Honour Based Violence) risk assessment form (see Appendix D for explanation). This did not occur after this offence as the officer had misunderstood the changes to the policy which had come into effect in February 2011 which permitted some flexibility in using the risk assessment. Even though the officer had attended a briefing on the changes to the policy they were of the view that there was some confusion over when a risk assessment should take place. When the officer who attended the assault was spoken to as part of this review they stated that there was no information available to them at that time that would have given them any cause to believe that any assessment grading should be anything other than standard. Had Cydney been asked the detailed questions contained within the DASH risk assessment more information about the history of the domestic abuse may have been revealed and a full assessment of risk leading to interventions may have taken place.
- 7.25 The police officer that attended the incident did complete a vulnerable and intimidated witness log and they submitted the form to the police public protection unit. It was received on the 5<sup>th</sup> April 2011 by the support staff and they recorded the details on the electronic crime recording system and forwarded it to the Child Abuse Investigation Unit (CAIU) where it was stamped as being received on 22<sup>nd</sup> April 2011.
- 7.26 Since August 2009 all vulnerable and intimidated witness logs involving domestic abuse and where children are normally resident in Coventry are subject to a multi-agency screening process. Regular meetings between a police officer, social worker and health professional are held to share information held by the agencies and to jointly screen incidents. The group uses a multi-agency screening tool developed by Barnardos and further action is taken if the level of risk warrants it.

- 7.27 Due to the high volume of workload in the CAIU this log was not subject to the multi-agency screening process and was not considered by a member of the CAIU until 14<sup>th</sup> August 2011. When it was considered; a decision was made to refer the incident to a single agency however the police did not record which agency the details were passed to. It is known through information from other IMRs submitted to this review that the other agency was the health visiting team in Coventry, even though the police were aware that Cydney intended to move to Medway. At the time there were eight hundred logs waiting to be examined in the CAIU. Since this time an additional member of staff has been seconded to the CAIU to deal with the build up of reports and the IMR submitted by the West Midlands Police stated that there was no longer a back log.
- 7.28 This delay in considering such incidents did prevent the timely sharing of information with other agencies and highlights the limitations of single agency working in a sensitive and complex area where information sharing is vital to preventing further abuse. This lack of sharing of information meant that children's social care did not have this information when they were contacted by the psychological services and therefore did not have all the information that should have been available to them when the referral/contact was made. In addition the delay meant that the Health Visitor in Medway did not receive this information until after the murder had occurred.
- 7.29 When the police dealt with Cydney she stated that her intention was to move back to Medway to her aunt's house. There is no policy either nationally or in the West Midlands Police to guide officers about the sharing of information when a domestic abuse victim moves from one police force area to another. Therefore the West Midlands Police did not inform Kent Police, accepting that the address given was different from the one that Cydney did in fact move to. Although not policy it is the practice for the West Midlands Police to inform other police forces if a high risk victim moves into their area from the West Midlands. Although no risk assessment took place by the police it is the view of the West Midlands Police that this was not a high risk case and therefore they would not have informed the Kent Police.
- 7.30 On the 1<sup>st</sup> April 2011 Cydney and Solomon were collected by Cydney's mother. When they went to the house they said they found a search record left by the police which stated that cannabis had been found. No mention of this was contained in the IMR from the West Midlands Police. They moved into Cydney's parents privately owned house in Medway. On the way Cydney attended the children's centre in Coventry and she informed the staff of the incident and that she was moving back to Medway with Solomon to live with her parents. She provided them with a

- forwarding address and the worker advised her to join a children's centre in Medway.
- 7.31 Cydney telephoned the Medway Council Housing Department at 08.35 hours on 4<sup>th</sup> April 2011 and having explained her housing situation the officer offered her an appointment with an Independent Domestic Violence Advisor (IDVA) who are employed by the Citizens Advice Bureau who is contracted by Medway Council's Homelessness Unit to provide a housing IDVA service. They do not take any other referrals. The aim of the service is to offer timely and appropriate advice to those approaching them for assistance. This interview took place at 09.00 hours the same day which is good evidence of the provision of an efficient service.
- 7.32 During the interview Cydney disclosed that Derek had sent her sixty eight texts since leaving her saying 'I love you', 'I'm sorry' and 'come back'. Cydney also stated that Derek had used a variety of weapons on her when he had abused her in the past. Cydney also stated that Derek was due to visit her and Solomon on 8<sup>th</sup> April 2011. Cydney also confirmed that Derek knew she was living at her parent's house. When the IDVA assessed Cydney's circumstances using DASH-RIC (see Appendix D) her risk of being subject to domestic abuse was scored at ten out of a maximum twenty four, therefore being of medium risk of further abuse. This was the first time that Cydney had disclosed the extent of the domestic abuse that she had suffered. The IDVA concluded that it was not safe or reasonable for Cydney to remain in her present accommodation or even in the local authority area and that it was probable that remaining in the area would lead to further incidences of domestic abuse. The IDVA suggested to Cydney that she should consider moving into a refuge, Cydney declined to do so. The focus of the assessment was on Cydney as the victim of domestic abuse and it should be recognised that the DASH-RIC is not designed to assess risk to children. The DASH Risk Identification Checklist makes it clear that if the professional completing the checklist is concerned about risk to a child then a referral should be made to ensure a full assessment of their safety and welfare is made. The checklist also highlights the presence of children increasing the wider risks of domestic abuse.
- 7.33 Despite this conclusion the IDVA did not refer the case to any other agency nor did they discuss the case with the housing officer who spoke to Cydney after her meeting with the IDVA to discuss housing options. This was an example of single agency interventions and failure to share information. This was an opportunity to obtain further information to enable risk assessments to be made based on all available information. The IDVA could have informed Medway Childrens Social Care (CSC) as there was a baby who may have been at risk. In addition they could have informed the health visiting team and this would have enabled the Health

Visitor to have prioritised a visit as the family would have been classed as being new to the area as Solomon had been born in Coventry. If this information sharing had taken place then both of these agencies would have been able to establish any risk to Solomon and consider further information sharing. The IDVA did advise Cydney to consider approaching other councils for accommodation, civil legal options and promised to send her a variety of information on financial and legal matters.

- 7.34 The IDVA did discuss with Cydney whether she wished to be referred to the Sanctuary Scheme. The Sanctuary Scheme is where the local authority can carry out adaptations of premises by the installation of security including the creation of a safe room and anti-arson devices such as a lockable letter box. Cydney declined this service.
- 7.35 It is not known if the IDVA shared their concerns regarding Cydney's safety with her or the outcome of the DASH-RIC assessment.
- 7.36 The IDVA then completed a record of the interview and action taken however; they did not discuss the case with the housing officer or provide the housing officer with a report. It was the practice at this time for the IDVA only to speak to the housing officer after any meeting with a victim if any actions were required. As no actions were required by the housing department no report for the housing service or liaison took place. This practice has changed as a result of this review and the IDVA is now required to feedback to the housing officer on all individual cases.
- 7.37 On review the DASH-RIC risk assessment was correct however it does show the rigidity of such risk assessment tools. As the risk was assessed as being medium risk the case did not automatically fulfil the criteria for referral to a Multi-Agency Risk Assessment Conference (MARAC) as the policy in Medway is for the MARAC to automatically consider all high risk cases. Professionals can refer cases that in their view require discussion at the MARAC even though they have not been assessed as being high risk. The DASH-RIC guidance contains clear advice to professionals regarding risk assessment and the use of professional judgement in making decisions for onward referral to MARAC and or another agency. It has not been possible to identify why the IDVA came to the conclusion that it was not safe for Cydney to remain at her parent's house or even within the local authority area. In light of such a conclusion it would be accepted practice to raise those concerns with a manager in order to discuss referring the case to the MARAC and taking further steps to reduce the risk for Cydney and Solomon. The IMR author for the IDVA service has stated that the IDVA service have attempted to refer cases not meeting the criteria and where they have concerns on previous occasions however they have often been rejected by the MARAC coordinator. No

evidence to support this issue has been provided to this review. The CAB representative on the review panel has stated that there are no longer any issues regarding MARAC referrals when the IDVAs use professional judgement as their rationale for a referral to MARAC.

- 7.38 The IDVA and the housing officer were the only professionals in Medway who knew that she was living with her parents and had been a victim of abuse. This was an opportunity missed to refer to another agency and this was particularly important as there was a child who may have been at risk.
- 7.39 The IDVA as they were concerned about Cydney's safety could have discussed the case with other domestic abuse specialists from the police or the MARAC coordinator to see if there were any other options available and to share information as part of the safety plan for Cydney.
- 7.40 As a consequence of this homicide the CAB have carried out their own review of the IDVA service and have formulated new policies revised their forms regarding case work and information sharing. They have also improved their understanding and links to other agencies and processes including the Kent Police, Medway CSC and the MARACs. In addition the CAB and the Medway Council Housing Department have discussed their relationship and responsibilities with a view to ensuring clarity of role. Medway CAB is also considering participating in the CAADA Leading Lights Programme.
- 7.41 The interview with the IDVA lasted about an hour after which Cydney spoke to a Housing Information Officer from Medway Council. Advice and options regarding alternative accommodation including temporary accommodation were provided. Details of the refuge coordination service were also given. Cydney declined to accept temporary accommodation and she did not make a housing application.
- 7.42 On the 4<sup>th</sup> April 2011 a worker from the children's centre in Coventry telephoned Cydney to make sure that she was safe and Cydney informed them that she was ok and happy to be staying with her parents. It was normal practice to discuss any significant cases at a fortnightly meeting (at the time held monthly due to staff shortages) held between the children's centre staff and the local Health Visitor. For a number of personnel and personal issues the meeting in April did not occur and when the May meeting was held as Cydney had left the area her case did not appear on the agenda. Since this case the meetings have been held every two weeks. The procedure now is that all cases of children who have left the area will be discussed so that agencies are aware and can take positive action in informing other agencies where appropriate and maintain accurate records. On the 5<sup>th</sup> April 2011 a worker from the children's



centre carried out a check on their database on the family and the check revealed that no concerns were recorded.

- 7.43 On the 7<sup>th</sup> April 2011 Derek saw GP 4 in Coventry and disclosed the incident leading to his arrest and separation from his wife and child. He also informed the GP that he had not attended for the CBT. Derek also stated that he was drinking at least six pints of alcohol a day and using marijuana. The GP made a referral for anger management/CBT services to adult mental health services. Derek stated that he wanted to engage with services and his goal was to be reunited with his wife. The GP was also of the view that Cydney and Solomon had been afforded protection by the separation and because they were living with her parents.
- 7.44 This was the third referral by another GP again from the same surgery for Derek to the Single Point of Entry (SPE) for adult mental health services. The referral detailed irritability and anger as the reason for the referral and also explained that Derek's wife had left him after he had hit her and she was now living with her parents in Medway. The referral also stated that Derek had substance misuse issues and requested 'anger management/CBT'. Again the agencies involved did not recognise that this was a case of domestic abuse and that it was not appropriate to refer the case for anger management.
- 7.45 The referral was received by the SPE for adult mental health services on the 7<sup>th</sup> April 2011. On the 13<sup>th</sup> April 2011 the SPE tried to telephone Derek as he had not attended appointments but the number was not in use. After checking with the GP that this was the only contact number, they sent Derek an 'Opt in' letter and informed the GP. Derek responded to the letter and on the 19<sup>th</sup> April 2011 the SPE made contact with him by telephone. Derek informed them that he had hit his wife three weeks previously and she had now left him. Derek also stated that he was drinking alcohol and smoking cannabis every night of the week. The clinical notes stated there was 'no significant risk history' and it was recorded that leaflets regarding the community drugs team and community alcohol service were to be sent to Derek for him to self refer to these services. There was no discussion regarding the domestic abuse issues and his anger. The case was then closed and the GP was also informed of this decision by letter.
- 7.46 This was the third time in fourteen months that Derek had been referred to the mental health services in Coventry because of his anger issues coupled with his continued alcohol and drugs misuse and his violence. Derek had not been diagnosed with suffering from mental ill health and this was an opportunity for mental health services to liaise with the GP and other agencies with a view to try and address his issues and more importantly to protect Cydney and Solomon.

- 7.47 On 26<sup>th</sup> April 2011 Cydney registered herself and Solomon with a GP in Medway, and Solomon was seen the same day by the GP because of a fever. No concerns were raised or identified at this appointment.
- 7.48 Derek attended the GP surgery in Coventry on the 27<sup>th</sup> April 2011 and saw GP 8 when he disclosed irritability and anger, also that he continued to smoke cannabis. Derek told the GP that he had been given an appointment with the mental health service and had been given leaflets regarding alcohol and drug use. The GP prescribed anti-depressant medication. The GP referred him to the psychological services even though the psychological service had already informed the GP surgery that they were not the appropriate service. The GP still did not recognise this as a case of domestic abuse and continued to inappropriately refer him to the psychological services without discussion or apparent consideration of the history of Derek and his continued failure to fully engage with services.
- 7.49 Six days later on 3<sup>rd</sup> May 2011 Derek contacted the GP surgery in Coventry asking for the telephone number of the crisis mental health service and as a result a referral to the adult mental health service requesting anger management therapy was faxed to adult mental health services. The referral form stated that Derek had been arrested 'a couple of times'. The source of this information which is incorrect was not recorded. The referral priority was marked as 'crisis'. There was no record of the mental health services ever receiving this referral.
- 7.50 On the 16<sup>th</sup> May 2011 Derek again contacted the GP surgery in Coventry asking for an appointment. He was spoken to by the receptionist and Derek was told that a referral had been made to adult mental health services and that an appointment would be made. Derek then stated that he felt he would harm himself or another person and as a result he was given the telephone number of the crisis mental health services by the receptionist and advised to make contact. Two of the GPs when interviewed as part of this review were of the opinion that the receptionist who dealt with Derek would normally seek the advice of the duty GP before giving that advice however this was not recorded in the notes if that actually took place. It was inappropriate for the receptionist to have dealt with this matter. This was an urgent situation that required a medical professional suitably trained in dealing with people in crisis to respond to such an incident. In any case to give such advice to a person who is in need of help is inappropriate especially when Derek had a history of failing to engage.

- 7.51 On the 16<sup>th</sup> May 2011 when the SPE responded to him making contact as a result of his contact with the GP, Derek was recorded as being very tearful. He also stated that he had hit and punched his wife in the last two months and that she had left the family home. It was recorded that this was the second time he had hit her. In addition he had also hit the television and self harmed by cutting and burning with cigarettes. He reported that he felt angry 'all the time' and that he could not control himself when he was angry and felt better when he had punched something. He denied any suicidal ideation.
- 7.52 Derek did report that he had experienced visual and auditory hallucinations over the last two months consisting of seeing animals and hearing his son crying even though he was not there. He stated that he was drinking two or three beers a week and using cannabis on a weekly basis. The SPE worker stated that they would make a referral to the community mental health team for routine review and they faxed it to them the same day. It was received by the community mental health team on the 17<sup>th</sup> May 2011. Although not explicit in the IMR it appears that an appointment was made for Derek to see a worker on the 9<sup>th</sup> June 2011. Although this was an appropriate response there was no consideration of any risk posed to Derek's wife or their baby, but it was known that they were no longer living with him. The fact that they had separated did not necessarily mitigate any risk and in some cases can increase the risk. There is no record of whether the mental health services or any of the GPs enquired of Derek whether he was still in contact with his wife. It is known from the family and the IDVA that Derek was still telephoning Cydney and visiting her and Solomon.
- 7.53 On the 16<sup>th</sup> May 2011 the health visiting team in Medway sent a letter to Cydney advising her of the clinic times and how to contact the team. The letter also informed Cydney that Solomon's records had been requested from Coventry and once they had been received a home visit would be arranged.
- 7.54 On the 20<sup>th</sup> May 2011 Derek made contact with the psychological service stating that he had been in telephone contact with the crisis team although it is believed that this was in fact the contact with the SPE on the 16<sup>th</sup> May 2011. A telephone assessment was carried out and Derek stated that he had been violent to his wife in the presence of their one year old son and that he had received a police caution. It was recorded that she and their son had moved out to her parent's house and that he has had no contact with them which was not true. In addition he disclosed incidents of self harming through cutting but with no suicidal intent. He also disclosed giving his son 'a little slap' when he wouldn't stop crying. The records showed that an explicit discussion with Derek regarding consideration of a referral to social care took place but no explanation of why a referral was

not made. This disclosure regarding slapping Solomon is significant as Solomon was only eleven months old at this time and it was not known how old he was when Derek slapped him. Further contact with Derek was planned in four weeks for telephone assessment. The failure to refer this disclosure of physical abuse to social care immediately is contrary to accepted practice. It showed a lack of understanding of risk that this man posed to others in terms of violence as well as his mental health issues and his alcohol and substance misuse.

- 7.55 On the 3<sup>rd</sup> June 2011 a therapist from the psychological services contacted Derek to discuss treatment options and Derek informed them that he had been offered an assessment from the community mental health team in the coming week. Derek stated that he had an appointment with Relate on the 6<sup>th</sup> June 2011 regarding attendance on a project for perpetrators of domestic violence. The therapist informed him that the service would now close the case. It is of concern that the psychological service was unaware of the involvement of the community mental health team and did not share any of the information they held with them either prior to or after this contact.
- 7.56 The same day the 3<sup>rd</sup> June 2011 the therapist made telephone contact with Coventry Children's Social Care Referral and Assessment Service. The rationale for making contact at this time is not documented. The telephone conversation detailed some of the history including the information that Cydney and Solomon were now living in Medway as a result of the assault. The therapist did not include the information about Derek self harming. The psychological service was not aware of Derek's alcohol and substance misuse although the community mental health team were. The therapist was informed by social care that the information would remain on file and be treated as a contact. They were told it was unlikely that CSC would take any action as the family were not known to social care and Derek was seeking help, also his wife and baby were not residing in the family home at the time. This contact with social care was in line with the Trust's Domestic Abuse Policy. The social care records indicated that the enquirer was informed that the family were not known to them and that there was no record of the incident involving the police however the report may still be with the police. Coventry Children's Social Care (CSC) was never informed by the West Midlands Police regarding the assault until after the homicide had occurred.
- 7.57 The therapist then completed a multi-agency referral form and faxed it to the social care assessment team although the safeguarding team for the trust do not have a copy of the contact as set out in the trust's policy. The referral form included additional information about Derek having once given his son a little slap when he would not stop crying and that he had also physically abused his wife the previous weekend which was in

- addition to the assault which led to the police caution. This additional information does not appear to have been shared during the telephone conversation or identified by children's social care as it was not added to the electronic record.
- 7.58 The procedure followed by both the therapist and the Social Worker at the assessment team was not in accordance with the multi-agency guidance as the therapist should have been advised to make contact with Medway Children's Social Care as that was where Cydney and Solomon now resided.
- 7.59 The panel could not agree on whether Coventry CSC should have informed Medway CSC about the allegation that Derek had slapped his son. The representatives on the panel from Coventry were of the view that even if they had passed the information to Medway CSC it is unlikely based on their experience that Medway CSC would have had the capacity or inclination to respond to a family that seemed safe; had taken reasonable steps to safeguard their child and if the roles had been reversed they would not have taken any action. The panel members from Kent and Medway and the Independent Chair were of the view that Medway CSC should have been informed either by the psychological service or Coventry CSC. If they had, this would have enabled Medway CSC to obtain details from all of the agencies that had been involved with the family such as the police, GP and community mental health team and would have given them the opportunity to decide if they should assess any risk to Solomon. In addition there would have then been an opportunity to make Cydney aware as there is no evidence to indicate that she knew Derek had slapped Solomon.
- 7.60 The review panel acknowledged that CSCs do have different thresholds for intervention as a result of the numbers of referrals made to them and the resources available to respond. The panel also acknowledged that professionals have to make difficult decisions based on sometimes little information which maybe third hand. The panel agreed that the separation of Cydney and Derek may have been interpreted as a false positive by CSC, the GP and mental health services. The panel concluded that these circumstances highlighted the issue of the level of understanding by professionals of domestic abuse and the links to children's safeguarding as well as the importance of information sharing.
- 7.61 The therapist did not make any contact with the West Midlands Police to obtain information about the assault. In addition the worker did not inform the community mental health team that they had made a referral to social care.

- 7.62 The Coventry CSC referral service recorded the contact on their electronic system however they did not include the additional information about the slapping of Solomon when he would not stop crying which was included on the written referral and the information about Derek self harming. This was poor practice not to accurately record the information.
- 7.63 At this stage no agency had an accurate picture of how this family was functioning. The individuals were known to several agencies in both Coventry and Medway however the majority of them only had contact with either Cydney or Derek and so had to base any decisions on that interaction. Most of the agencies were unaware that Derek and Cydney were in regular communication by telephone as well as meeting up so Derek could have contact with Solomon.
- 7.64 Derek did not attend his appointment with Relate on 6<sup>th</sup> June 2011 regarding attendance on the perpetrators project.
- 7.65 Derek attended his first appointment with the Community Mental Health Nurse (CMHN) at the GP surgery on 9<sup>th</sup> June 2011 and he reported that he was feeling low since his separation from his wife and that recent contact with his wife and son had not been good and he planned to see his son when 'able'. He also stated that he had no intention to self harm, however he was using alcohol and marijuana. He was assessed to be 'insightful' and aware that the feelings would become less intense. No visual or auditory hallucinations were noted. The CMHN discussed the option of taking medication. He was also given the number of the Samaritans. He was also advised to contact them or the GP surgery if further support was required and Derek agreed to have a further assessment on 23<sup>rd</sup> June 2011.
- 7.66 On the 9<sup>th</sup> June 2011 Solomon's health records were received in the child health department in Medway and forwarded to the local health visiting team who made an appointment to carry out a home visit on the 18<sup>th</sup> July 2011. The home visit was not prioritised as the Health Visitor was unaware of the domestic abuse that Cydney had suffered and so was treated as a routine new to area visit. If they had been aware of all the information that was available and in particular the possible risk to Solomon then the visit would have taken place much earlier. At this time there was no consistent practice within the health visiting service in Medway regarding when new to area visits were carried out. Some teams waited for the records to arrive before they arranged the home visit, others visited before the records arrived. As a consequence of this review, a review of this process has taken place to ensure a consistent approach. As soon as a health visitor base is informed of a new child they are allocated to a Health Visitor within one week of notification. The home visit is then arranged as soon as practicable and without waiting for the

- records to arrive. There is a plan to audit this process in 2013. In addition the new to area pack for parents has been updated to include information about domestic abuse services.
- 7.67 On the 17<sup>th</sup> June 2011 Cydney submitted her application for local authority housing in Medway however she did not include being the victim of domestic abuse as a supporting factor.
- 7.68 On the 23<sup>rd</sup> June 2011 Derek saw the CMHN at the GP surgery in Coventry and stated that there had been some improvement but he still felt low, tearful and had difficulty sleeping along with loss of appetite. He also stated that he had 'fleeting' thoughts of self harm with no intent. The CMHN discussed a range of mental health and social concerns that were consistent with the experience of relationship breakdown as they had on the 9<sup>th</sup> June 2011. The CMHN explored with Derek a range of techniques to manage these feelings including medication, counselling and self help options. One of those options was attendance at the local community project for perpetrators of domestic abuse, Derek stated that he could not afford the £40 fee but would go for the initial interview. He never did attend the project.
- 7.69 On 24<sup>th</sup> June 2011 Cydney made her first of ten bids for accommodation as part of the Medway Council's Choice Based Letting Scheme.
- 7.70 Derek did not attend his next scheduled appointment on 14<sup>th</sup> July 2011 and the CMHN recorded that as Derek had been planning positively for the future and taking appropriate steps to improve his mental health and overall situation such as decreased substance use an 'Opt in' letter would be sent. This letter was sent asking the Derek to make contact by 12<sup>th</sup> August 2011 if he still required the service.
- 7.71 At no stage was it recorded by the CMHN that this case was being dealt with as an incidence of domestic abuse and the only attempt to address the violence that he had shown to his wife was to try to get him to attend the local perpetrators of domestic abuse project. This was more than a case of marital breakdown. Here was a man who had become increasingly angry and violent to others, to property and to himself. However the rule of optimism was applied and the case was closed as he had failed to engage rather than result in any escalation or the taking of any proactive action.
- 7.72 On the 18<sup>th</sup> July 2011 the Health Visitor attended Cydney's parent's house in Medway to carry out a new to area visit and as part of that process they carried out a Family Needs Assessment. This assessment includes violence and abusive behaviour under the dimension that deals with the family history. Both Derek and Cydney were present and they appeared

- happy and relaxed with Solomon who related well to both parents. They both communicated well and indicated that they wanted the best for Solomon. The Health Visitor was aware of the marriage breakdown and she did not observe any concerns however she was unaware of the domestic abuse and the abuse of Solomon. Neither Derek nor Cydney disclosed any abuse issues. In accordance with practice the Health Visitor did not ask any direct questions regarding domestic abuse as both partners were present. If there had been any information regarding domestic abuse or if the Health Visitor had identified any concerns during the visit she would have arranged another visit to see Cydney alone.
- 7.73 The visit by the Health Visitor was the last time that any agency had direct contact with Derek, Cydney or Solomon. According to Cydney's family, in August 2011 Cydney started to receive texts and communication via Facebook from Derek's girlfriend.
- 7.74 On 2<sup>nd</sup> September 2011 Cydney made her last bid for accommodation to Medway Council.
- 7.75 Derek did not respond to the 'opt in' letter sent to him by the CMHT therefore a decision was made on 6<sup>th</sup> September 2011 to close the case.
- 7.76 The family have stated that on Wednesday 7<sup>th</sup> September and Thursday 8<sup>th</sup> 2011 Cydney and Solomon spent time with Derek in London including a visit to the zoo. Cydney and Solomon stayed with Derek's brother and Derek stayed elsewhere. Derek then returned them to Cydney's parent's house before returning to Coventry. There were no reported issues.
- 7.77 In the early hours of Saturday 10<sup>th</sup> September 2011 Derek and a friend went to Cydney's parent's house where they sprayed petrol through the letter box and set fire to it. This resulted in a major fire killing Cydney and Solomon. Cydney's father suffered serious burns and died a few days later. Cydney's mother and brother were also injured. A murder investigation was commenced by the Kent Police assisted by the Kent Fire and Rescue Service.
- 7.78 On the 15<sup>th</sup> September 2011 a copy of the vulnerable and intimidated witness log was received by the health visiting team in Medway having been forwarded by the health visiting team in Coventry.



## **8. Summary of agencies response**

### **8.1 Coventry GP**

Derek saw or had contact with his GP on nineteen occasions between June 2008 and June 2011. Eight of those contacts were regarding his mental health. The first time that the GP was aware of Derek's possible depression was in June 2008 when appropriate advice regarding a local counselling service was provided. The GP was not aware of his marital status and believed him to be single until February 2010.

- 8.2 The GP practice did attempt to get specialist help for Derek who failed to fully engage and despite this the GP continued to refer him to specialist services even though he had not attended appointments on 13<sup>th</sup> April, 27<sup>th</sup> April and 3<sup>rd</sup> May 2011. This with continued alcohol and drug abuse as well as the violence did not seem to raise any concerns or cause any escalation or alternative approach. Derek was seen by a total of ten GPs from the same practice in a three year period and five different GPs saw him regarding his mental health, this is not uncommon in large city GP practices however Derek would have had the choice of waiting for an appointment with the same GP. However there was little evidence of review/communication or follow up between them. All the communication with the mental health services was by letter and there did not appear to be any attempt at joint working. It is accepted that Derek did not engage fully either with the GP or the mental health services however he did seek medical assistance on a regular basis both for his mental as well as physical ill health. There is no documented evidence of the GPs trying to ascertain why Derek did not attend the appointments with the mental health services.
- 8.3 The GPs who were interviewed as part of this review were unaware that it is no longer appropriate practice to refer perpetrators of domestic abuse for anger management programmes as these programmes do not address the underlying issues and may in fact heighten the risk of harm to victims. That aside the various GPs that saw Derek recognised that he did need specialist help in line with the guidance issued by the British Medical Association in 2007 regarding perpetrators of domestic abuse and did try to access this by referral to adult mental health services.
- 8.4 The GPs did not inquire with Derek if his wife was pregnant nor did they make any attempt to identify the wife and baby even though they were registered with the same GP medical group albeit at a different surgery from Derek. As a consequence Cydney's GP in both Coventry and Medway were unaware of the assault. When interviewed the GP stated that they did not have sufficient time to carry out such research and the author of the IMR has stated that the GPs did not have enough

- information to identify them even though they were registered using the same address. It is the review panel's view that a simple search of the address would have revealed their identity.
- 8.5 Although there were several referrals by the GP to mental health services there is no documented evidence of reflective consideration in regards to the direct emotional effects of aggression upon Derek's wife or their baby. When interviewed the GP who saw him in February 2010 did recognise the potential impact on his wife and that was one of the reasons for the referral to psychological services. One of the GPs also felt that as Cydney had left Derek then she was protected. However the GP accepts that they were relying on Derek's word that they were separated and that he had no intention of following her to commit further abuse. They were also of the opinion that Derek had displayed positive intentions to change his behaviour and work with services.
  - 8.6 One of the GPs interviewed as part of this review stated that time constraints of appointments restricts the ability of practitioners to fully address the holistic nature of clients presenting complaints and the wider family/environmental factors. This GP also stated that since this incident they have implemented a system of monitoring patients who miss appointments and then send reminders for new appointments. The same GP stated that there were no on going threats of violence or aggression by Derek towards his wife and so it was not considered that there was an on going risk to her following the separation. There was no recognition that separation may in fact increase the risk.
  - 8.7 The GP surgery in Coventry only shared information with the adult mental health services. One of the GPs when interviewed stated that had Derek's wife remained in the area then a referral would have been made to children's social services regarding child protection concerns however as they were now living with their extended family and out of the area they were of the view that this offered protection and support. This view is of concern especially as the GP had sparse information about the family and this had all been provided by Derek.
  - 8.8 The GP surgery was the only agency that knew he had been angry with his wife prior to the assault on the 1<sup>st</sup> April 2011 and was seeking help.
  - 8.9 At this time none of the GPs at this surgery had attended the safeguarding children training in Coventry which included an input on domestic abuse.
  - 8.10 As a consequence of this review the Primary Care Trust (PCT) has updated their guidance to GPs regarding the treatment and referrals of perpetrators of domestic abuse and the need to consider the protection of victim's families by appropriate information sharing. This review has taken

into account the guidance issued by the Royal College of General Practitioners (RCGP) and Coordinated Action Against Domestic Abuse (CAADA) in May 2012, The RCGP and CAADA guidance has been sent to all GPs in Coventry. In addition guidance on identifying signs of domestic abuse and considering 'anger issues' in context of domestic abuse as part of differential diagnosis has been discussed by the local medical committee. Staff at GP practices and walk in centres have been made aware of the option to direct perpetrators of domestic abuse to the Respect (national domestic abuse service) helpline and their website.

8.11 The PCT is reviewing guidance to administrative staff and GPs regarding patients who threaten to harm themselves or others to ensure that only appropriately trained medical staff should deal with such matters and that the police should be involved if necessary. The patient should be seen and the risks identified and recorded as well as protection plans for anyone identified as being in danger. All GPs in Coventry have been informed of this incident and advised to review their practice and the local medical committee has been asked to consider the matter.

8.12 A training programme for GPs and other health staff regarding domestic abuse is now in place in Coventry.

#### 8.13 **Coventry Health Visiting and Midwifery Services**

During the pregnancy and the baby's short life no concerns were identified by any of the health services who came into contact with Cydney and Solomon. Although pregnancy is known to be a time when domestic abuse either starts or does not stop none of the staff involved with the family recorded whether they asked Cydney if she was suffering domestic abuse even though it has been recognised as good clinical practice to do so.

#### 8.14 **Coventry Mental Health Services**

The mental health services received a number of referrals from the GP regarding Derek and saw him on two occasions between February 2010 and June 2011, in addition they spoke to him by telephone on several occasions. Derek was never diagnosed as suffering from any mental illness.

8.15 There was no coordinated approach and no evidence of discussion between psychological services and the community mental health team. Despite there being several referrals there is little documented evidence of reflective consideration in regards to the direct emotional effects of aggression upon Cydney or Solomon. Both the mental health services

and the GPs relied on written communication and referral letters as the only means of communication regarding Derek.

8.16 The mental health services appear to have dealt with each of these incidents in isolation and tried to treat each of the symptoms separately e.g. providing information on drug misuse programmes. None of the services involved in treating Derek had the full picture of what had happened as they did not share any information or seek any information other than the contact with children's social care. Therefore, none of them were able to fully assess the risk that he posed to his wife and baby. For example only the community mental health team and the GP were aware of Derek's alcohol and substance misuse; the psychological service was unaware. Communication between services purely by the copying of referral letters is standard practice in the health economy. The response to Derek's possible alcohol and substance misuse by encouraging him to self refer to services is also standard practice. None of the mental health services identified this as being a case of domestic abuse until after the assault in April 2011.

#### 8.17 **Coventry's multi agency response to this review**

The response to the issues identified for the health services in Coventry are being considered by a sub committee of the Coventry Safeguarding Children Board who are also developing an overall domestic abuse health strategy in conjunction with adult health safeguarding. Monitoring and assurance of these plans are being carried out by the children and adults safeguarding boards.

8.18 The domestic abuse joint screening process has been reviewed. The information sharing process is under review as part of Coventry's Safeguarding Children Board Serious Case Review Action Plan.

8.19 Coventry's Domestic Abuse Strategy has been updated and the existing commissioned service for perpetrators has been decommissioned. There is an area wide service review underway and the PCT is involved with service developments and the commissioning of new services. This review is being monitored through the Coventry Community Safety Partnership. Update: Since April 2013, the responsibility for commissioning health services has transferred to NHS England and Coventry and Rugby Clinical Commissioning Group. Both new commissioning organisations remain involved in further developing Coventry's domestic violence and abuse strategy.

8.20 The action plan for health from this review is being monitored monthly within the PCT and their successors the Clinical Commissioning Group (CCG) and reported to the Executive Nurse Lead by the Designated Nurse

Child Protection. This will include activities relating to providers and independent contractors to identify health economy wide activity. Update: The action plans for health agencies from this review were monitored to completion by the PCT and completed prior to April 2013 when the responsibility for commissioning health services transferred to NHS England and Coventry and Rugby Clinical Commissioning Group. Both new commissioning organisations have systems in place to monitor the services they commission.

#### **8.21 Coventry Children's Social Care**

Coventry CSC had minimal involvement with the family. They were not known to CSC until the contact by the psychological services. No concerns regarding either Cydney or Solomon were identified by staff at the children's centre where they attended on a regular basis. The processes for registration at the centre were robust and the checks that were carried out identified that there were no concerns logged by any agency. When Cydney informed the staff that she was leaving the area with Solomon because of the domestic abuse; they acted appropriately by advising her to join a children's centre in Medway. In addition they displayed good practice by making a follow up call to Cydney three days after she had left the area to check that she was safe.

8.22 When the referral and assessment service were contacted by the psychological service they treated the telephone call as a contact. They did not record the additional information about the slapping of Solomon and that Derek was self harming which was included in the written referral from the psychological services. The decision not to pass the information about this family onto CSC in Medway is questionable.

#### **8.23 Medway Children's Social Care**

The CSC in Medway was never informed that a vulnerable mother and baby had moved into their area. If they had been informed by any of the agencies in Coventry or the IDVA in Medway then they would have had the option of commencing an assessment with a view to establishing any risk to Solomon. In addition consideration could have been given to sharing information with other agencies in Medway such as the health visitor and signposting the family to local services.

#### **8.24 Medway Health Visitor and GP**

When Cydney and Solomon were registered with the GP and subsequently the health visiting team they were unaware of the assault and potential risks to Cydney and her baby. The home visit was only carried out once the records were received from Coventry which was three

months after they had moved back to Medway. Derek was present at the home visit and so there was no opportunity for the health visitor to enquire about possible domestic abuse. The health visitor was aware that the marriage had broken down however she did not know of the incident that had led to the separation.

8.25 If the health visitor had been aware of the circumstances of the separation or that Solomon may have been at risk from Derek then she may have carried out the visit prior to the records being transferred and attempted to speak to Cydney when Derek was not present.

#### 8.26 **Medway IDVA Service and Housing Department**

The housing and IDVA service responded very quickly to Cydney's request for assistance and they provided her with appropriate advice and information on sources of further help. It was unfortunate that the IDVA who was a specialist domestic abuse worker did not share the information they possessed with other agencies which may have resulted in further services being offered to protect Cydney and Solomon. If they had shared that information at least the other agencies would have been aware that she and her baby had moved into the area and if Cydney had asked for help they would have had knowledge of the background information. In April 2011 it was the policy for IDVAs to pass a report to or discuss with a housing officer only in cases where action was required. This policy has now changed and the IDVA provides feedback on all individual cases to a housing officer.

#### 8.27 **Kent Police**

Neither Cydney nor Derek had come to the attention of the police in Medway for any matters that involved domestic abuse or any other incidents that would have had any bearing on this case.

8.28 The police in Medway were unaware that a victim of domestic abuse with a baby had moved into their area and therefore were not in a position to offer any advice or support to her or her family.

#### 8.29 **West Midlands Police**

The police in Coventry responded effectively and efficiently to the initial call regarding the assault on Cydney. However the processing of the information in connection with the case was not of an acceptable standard. The failure to carry out a DASH-RIC risk assessment by the attending officer and then the delay in assessing the vulnerable and intimidated witness log meant that a full assessment of risk and appropriate and timely information sharing did not take place. There was

no requirement for them to inform the Kent Police that Cydney was moving to live in their area.

### **8.30 Medway Education Service**

When Cydney started her relationship with Derek she was still in full time education. The education service has checked their records and made enquiries; however there is no information held by them that has any relevance to this review and so they have not carried out an IMR.

### **8.31 Kent Fire and Rescue Service (KFRS)**

The fire and rescue service only became involved with this family after the deaths when they worked with the police to identify the cause of the fire using their specialist fire investigators.

8.32 In the event of an agency identifying a victim of domestic abuse then one option open to them is to refer the victim to the fire service for a home visit to carry out a safety inspection. Victims can also self refer to KFRS. All victims of domestic abuse referred to them are treated as a high risk vulnerable person in terms of their fire safety intervention. This review has highlighted that KFRS will offer advice and may install smoke alarms and lockable letter boxes.

## **9 Victims and Family Perspective**

9.1 The family of the victims have described the relationship between Cydney and Derek as being in the main very loving however they were not aware of all of the domestic abuse incidents. The pregnancy was not planned; at the time of the pregnancy she was undergoing medical tests and Cydney believed she would not be able to have children. The family were aware of the domestic abuse incident that Cydney reported to the West Midlands Police whilst she was living in Coventry which led to her immediately moving with Solomon back to live with her parents in Medway. The family were not aware of the detail of all of the incidents of the violent relationship that were disclosed to the IDVA after she moved to Medway and those identified as part of the subsequent investigation into the murder.

9.2 It is the view of Cydney's family that Cydney could not take the risk of Derek harming Solomon and it was because of this concern that she left him and she had taken advice regarding divorce proceedings. According to the family it is possible that the relationship would have continued if there had not been a baby. After their separation in April 2011 Derek had regular contact with Cydney and Solomon, spending time with both of them although arguments and domestic abuse did continue.

- 9.3 The family have stated that after the separation Derek had been frequently in contact with Cydney by telephone and in April 2011 Derek had 'kicked off' and threatened to take his son. They also said that on another occasion Cydney had travelled with Solomon to see Derek in Coventry and when they met Derek he 'lost it' and was shouting and screaming at Cydney and kicked out at property. It was at this time Cydney told Derek that the separation was final. At some stage the family became aware that Derek's new girlfriend had started sending Cydney abusive texts.
- 9.4 The family including Cydney did not believe that Derek posed any significant risk to Cydney, there was a concern that he may take Solomon out of the country. Derek had agreed to the divorce however he always hoped for reconciliation. Derek maintained contact with Cydney and Solomon by telephone. There were no formal arrangements regarding access to Solomon. The relationship between Cydney and Derek did change in August 2011 when Derek commenced a new relationship with the woman who was convicted in connection with this homicide. Cydney was agreeable to Derek having access to Solomon which was evidenced by the trip to the zoo just before the murder.
- 9.5 The mother of Cydney was unaware that Derek was present for the home visit by the Health Visitor that took place in July 2011. Cydney had no definite plans for the future at the time of the homicide other than to obtain local authority accommodation in Medway. Her focus was on caring for Solomon.

## **10. Conclusion**

- 10.1 Derek and Cydney had been in a relationship for six years when he made the decision to set fire to the house where his wife and baby were living which led to their death. The full extent of the violence that Cydney had suffered was never known to any agency in the two areas they had lived in; none of Cydney's family or friends was aware either.
- 10.2 Based on all of the information that this review has been made available the panel has concluded there were sufficient indicators available to professionals to conclude that Derek did pose a risk of further assault upon his wife and their baby and more should have been done to protect them. The risk factors that the panel identified were
- The couple had separated
  - Weapons ( cans, remote controls, knives) had been used in the past
  - Derek had issues with alcohol and drug misuse
  - Derek had mental ill health issues including self harming
  - Cydney was concerned that Derek may take Solomon



- Derek was in constant contact with Cydney
- Derek continued to be abusive after the separation
- There were financial pressures

- 10.3 A number of agencies possessed some of that information but did not recognise the significance and then share it. The indicators of abuse known to agencies were that Derek had hit his wife on at least one occasion, he had hit his baby at least once, he admitted getting angrier and that the way he dealt with it was by punching items. In addition his alcohol and drug misuse coupled with his low moods and self harming were further indicators of risk. He had little support from his family with only his brother living in the same area. In addition although he sought help he did not actively engage with services other than frequent appointments with his GP.
- 10.4 There was no evidence provided to the review panel that indicated that this homicide was based on any cultural or religious beliefs. There was also no evidence of any issues concerning culture, religion, language or ethnicity in the way that the services were provided. Derek had indicated on his medical registration forms that he spoke English and did not require the services of an interpreter. None of the reports suggest that any of the services had any difficulty when communicating with him as he responded both to verbal and written communication.
- 10.5 There was evidence of agencies working in accordance with their policies and guidance and providing an appropriate, timely and effective service to both Cydney and Derek such as the West Midlands Police when they dealt with the assault and the IDVA in Medway however that good work was not followed through with effective information sharing.
- 10.6 The failure to share information in a timely and accurate manner was evident in this case by the police, GP, mental health services both psychological services and community mental health services in Coventry and then by the IDVA service in Medway.
- 10.7 The lack of information sharing in this case restricted any agency carrying out a full risk assessment of all the information available and therefore they were prevented from making complete risk reduction plans for both Cydney and Solomon. The failure to share information is a recurring theme in reviews of both domestic homicides and child protection cases that have been carried out nationally. The importance of information sharing is highlighted in most policies and guidance. Agencies continually fail to share information and continue to work with the 'rule of optimism'.
- 10.8 This review has highlighted the issue of families that move between areas and the difficulties that agencies face in tracking them. The majority of

agencies and in some cases departments within agencies have their own databases which restricts the information available to professionals. Also when an individual moves, records are not automatically transferred and there is often a delay in the records arriving in the new area. This is a national issue which would only be fully resolved by some form of national database that all agencies could access in order to identify families and their history of involvement with agencies. In addition some of the agencies and individuals were of the view that because they had separated then the risk to Cydney was reduced. When in fact separation, especially in cases involving child contact arrangements coupled with the distance between them may have actually increased the risk. There is no national policy for the police service regarding notification of victims of domestic abuse who move to another police area other than when a victim is subject to MARAC.

- 10.9 Deaths by arson are relatively rare; in England and Wales in 2010/11 twenty victims were killed by burning out of a total of six hundred and thirty six victims of all homicides. The actual use of fire in domestic abuse is also rare although the threat is more common. Of the two hundred and four domestic abuse referrals the fire service in Kent and Medway received in a year one hundred and eighteen included arson as a threat. There was no information or intelligence held by any agency or any individual that Derek was likely to carry out an arson attack and therefore understandably arson was not specifically included in any of the advice provided by agencies to Cydney.
- 10.10 This review may have an impact on the work of other services not directly involved in this process and as a consequence a copy of the report will be sent to other groups for their consideration. See Appendix E for details.

## **11. Recommendations**

- 11.1 This review should be circulated as widely possible within organisations to enable practitioners and supervisors to reflect on their practice and ensure that the learning from this piece of work is absorbed into their work. In particular, the issues of accurate recording and appropriate sharing of information to enable full risk assessments of both victims and offenders to take place. A copy of this review has been sent to the relevant safeguarding boards in Coventry and Medway (See Appendix E)
- 11.2 All agencies should use this report when reviewing/monitoring their work in connection with domestic abuse and the contents should be considered when any review of policy/guidance takes place. In addition the learning from this report should be incorporated into any existing or new training programmes.

11.3 As a consequence of this review some agencies have made single agency recommendations to improve practice, linked to action plans and have been put into place; these are welcomed by the panel. The recommendations from this review can be found in Appendix F.

## **Appendix A – Terms of Reference**

### Terms of Reference for Domestic Homicide Review Two (DHR2) into the circumstances of the death of female (aged 20 years).

On 10/9/11 a female died in a fire at her parents' house in Medway, also her son aged 15 months and her father died, the female's mother and brother were also injured. Her estranged husband, his current girlfriend and a friend have all been charged in connection with this incident. The female and her husband had previously lived in Coventry before she and her baby left him in April 2011.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004 it has been agreed by the Kent and Medway DHR Core Panel that the criteria for a DHR have been met. The panel agreed this on 6/10/11 and this decision has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent and Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

The purpose of the review is to:

- **Establish what lessons are to be learned regarding the way in which professionals and organisations work individually and together to safeguard victims.**
- **Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result;**
- **Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working;**
- **Prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.**

This review will focus on the identification of possible and actual domestic abuse by agencies and their response to it in accordance with their own and multi agency procedures in existence at the time. In particular the review should examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practise. The review will examine how the incidents were recorded and what information was shared with other agencies.

The review will be carried out by the provision of Individual Management Reports (IMRs) by the agencies involved with the victims and the alleged offender. The reports should be prepared by an appropriately skilled individual who has not been involved with any individuals in the case. These reports should include a chronology and if relevant a genogram and analysis of the service provided. The report should highlight both good and poor practise and make recommendations

for both the individual agency and where relevant for multi agency working. The report should include issues such as resourcing/workload/supervision/support and training/experience of the professionals involved. The IMRs will then be considered by the Domestic Homicide Review Panel and an Overview Report will be compiled. The Overview Report will be anonymised and will usually be published.

The review will be focused on the female the offender and their son, information is not required on the other victims or alleged offenders unless there is some relevant link to Domestic Abuse.

The relevant period for the review is from 1/1/2007 – 11/9/2011 however, any other information prior to this period should be included if it is felt that it may be relevant such as previous incidents of violence, alcohol or substance misuse and mental health issues.

Any disability, cultural and faith matters (including possible issues around Honour Based Violence) should also be considered by the authors and included if relevant. If not relevant a statement to that effect that it has been considered should be included.

Specific issues that must be addressed in the IMR are:-

- **Which agencies in Kent, Medway and Coventry were aware of the abusive relationship and what action had they taken to protect the female?**
- **What information was shared with other agencies?**
- **What action was taken in response to the mental health issues raised by the offender?**
- **Was information shared across all areas i.e. Coventry, Kent and Medway?**
- **Is arson/threat of arson considered as part of safety planning?**

## **Appendix B - Details of Agencies that supplied IMR reports and their authors and Details of Review Panel Members**

Arden Cluster NHS Warwickshire and NHS Coventry – Leanne Dagger – Deputy Designated Nurse Child Protection

Coventry and Warwickshire NHS Partnership Trust – Penny Greenaway – Lead Nurse for Safeguarding Children and Adults at Risk

Coventry Children’s Social Care Services – Terry Cranston – Integrated Service Manager and Helen Watson – Head of Children Centre

Kent Fire and Rescue Service – Alexa Kersting-Woods – Community Service Delivery and Performance Manager

Kent Police – David Stevens – Review Officer

Medway Citizens Advice Bureau (IDVA Service) – Dan McDonald – Chief Executive Officer

Medway Council Housing and Corporate Services – Deborah Upton – Assistant Director Housing and Corporate Services

NHS Kent and Medway (Medway Locality) – Cathy Ross – Designated Nurse for Safeguarding Children and Adults

West Midland Police – Leanne Dudley – Detective Constable Public Protection Headquarters (Review)

Medway Children’s Social Care did not have any contact with this family and so have not conducted an IMR. Because of Cydney’s age Medway Education Services were contacted and requested to check their records to see if they had any relevant information. No relevant information was discovered and so they have not conducted an IMR.

### **Review Panel Members**

Greg Barry – Independent Chair

Andrew Coombe – Kent and Medway PCT Cluster – Associate Director of Safeguarding

Mark Dalton – Independent Chair of Coventry Safeguarding Children Board’s Serious Case Review Sub-Committee

Tim England – Medway Council – Head of Safer Communities

Alison Gilmour – Kent and Medway Domestic Violence Coordinator

Penny Greenaway – Coventry and Warwickshire NHS Partnership Trust – Lead Nurse for Safeguarding Children and Adults at Risk

Matthew Gough – Medway Council – Head of Strategic Housing

Simon Hill – West Midlands Police – Detective Sergeant

Alexa Kersting-Woods – Kent Fire and Rescue Service – Community Service Delivery and Performance Manager

Dan McDonald – Medway Citizens Advice Bureau (IDVA Service) – Chief Executive Officer

Carol McKeough – Kent County Council Family and Social Care Directorate (Adults) – Safeguarding Adults Policy and Standards Manager

Maxine Nicholls – Coventry and Warwickshire NHS Partnership Trust Named Professional for Safeguarding Adults

Maurice O'Reilly – Kent Probation Trust – Director North Kent

Shafick Peerbux – Kent County Council – Business and Partnership Development Manager

Jayne Phelps – Coventry and Warwickshire NHS Partnership Trust – Designated Nurse Safeguarding Children and Young People

Andy Pritchard – Kent Police – Detective Chief Inspector

Alison Quigley – Coventry City Council – Harm Reduction and Strategic Victim Support Officer

Cathy Ross – NHS Kent and Medway (Medway Locality) – Designated Nurse for Safeguarding Children and Adults

Jivan Sembi – Coventry City Council Children's Services – Head of Safeguarding

Kat Sibley – West Midlands Police – Acting Detective Sergeant

Claire Wilkes – Medway Council Children's Services – Operational Safeguarding Lead

**Appendix C – Chronology (REDACTED).**



## Appendix D - Glossary and explanation of risk assessment/screening tools

BMA	British Medical Association
CAADA	Coordinated Action Against Domestic Abuse
CAB	Citizens Advice Bureau
CAIU	Child Abuse Investigation Unit
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHS	Community Mental Health Services
CMHT	Community Mental Health Team
CMHW	Community Mental Health Worker
CPS	Crown Prosecution Service
CSC	Children's Social Care
CSS	Children's Social Services
DASH- RIC	Domestic Abuse Stalking and Harassment – Risk Identification Check List – Risk assessment tool
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review/Report
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conference
PCT	Primary Care Trust
RCGP	Royal College of General Practitioners
SPE	Single Point of Entry – Adult Mental Health Services Coventry

### DASH –RIC

The **Domestic Abuse Stalking Honour Based Violence Risk Identification Checklist** is a risk assessment tool used by the police and other agencies to assess the risk to a victim of domestic abuse it does not assess risk to children. The tool utilises the following questions:-

1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)
2. Are you very frightened?
3. What are you afraid of? Is it further injury or violence?
4. Do you feel isolated from family/friends i.e. does (name of abuser(s) ..... ) try to stop you from seeing friends/family/doctor or others?
5. Are you feeling depressed or having suicidal thoughts?

6. Have you separated or tried to separate from (name of abuser(s)....) within the past year?
7. Is there conflict over child contact?
8. Does (.....) constantly text, call, contact, follow, stalk or harass you?
9. Are you pregnant or have you recently had a baby (within the last 18 months)?
10. Is the abuse happening more often?
11. Is the abuse getting worse?
12. Does (.....) try to control everything you do and/or are they excessively jealous?
13. Has (.....) ever used weapons or objects to hurt you?
14. Has (.....) ever threatened to kill you or someone else and you believed them?
15. Has (.....) ever attempted to strangle/choke/suffocate/drown you?
16. Does (.....) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else?
17. Is there any other person who has threatened you or who you are afraid of?
18. Do you know if (.....) has hurt anyone else?
19. Has (.....) ever mistreated an animal or the family pet?
20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues?
21. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?
22. Has (.....) ever threatened or attempted suicide?
23. Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children?

24. Do you know if (.....) has ever been in trouble with the police or has a criminal history?

The professional carrying out the assessment will also consider any other information and add up the yes responses and if the total is fourteen or above then the case should automatically lead to a MARAC referral. A professional can also use their judgment to make a referral to the MARAC if the total is less than fourteen.

## **Appendix E - Circulation list for this review**

This report has been circulated to the following groups for their consideration:-

1. Medway Safeguarding Children Board
2. Coventry Safeguarding Children Board
3. Kent and Medway Adult Safeguarding Board
4. Coventry Safeguarding Adults Board

## Appendix F – Recommendations

As a consequence of this review some agencies have made single agency recommendations to improve practice, linked to action plans and have been put into place; these are welcomed by the panel. The following recommendations were made by this review:-

- All agencies in Coventry to reassure themselves that staff are accurately recording and sharing information in cases of domestic abuse and in particular where children are resident so that others accessing records can identify the issues and risks as well as seeking specialist advice where appropriate.
- The Clinical Commissioning Group in Coventry responsible for GPs to review and update their guidance to GPs regarding treatment and referrals of perpetrators of domestic abuse and the need to consider the protection of victim's families by appropriate sharing of information. In addition the review should take into account the guidance issued by the RCGP and CAADA in May 2012. Correction: Since April 2013, Primary Care Services are commissioned by NHS England and not Clinical Commissioning Groups. At the time of the DHR, Coventry Primary Care Trust (PCT) was responsible for commissioning primary care from independent GP practice.
- The CCG in Coventry responsible for GPs to recommend that GPs review their guidance for all staff regarding their response to patients who threaten to harm themselves or others. The guidance should be that only appropriately trained medical staff should deal with such matters and other agencies such as the police should be involved in the response when necessary. The individual should be seen and the risks assessed and recorded as well as protection plans for anyone identified as being in danger. Note: Since April 2013, Primary Care Services are commissioned by NHS England and not Clinical Commissioning Groups. At the time of the DHR, Coventry PCT also recommended to GPs that they review their guidance not CCG as stated.
- The Coventry and Warwickshire NHS Partnership Trust to review and update their guidance to psychological services and adult mental health teams regarding treatment and referrals for patients who they are treating that are perpetrators of domestic abuse. In particular the need to consider the protection of victim's families by appropriate sharing of information with other agencies.

- The West Midlands Police to reassure themselves that staff are aware of the requirement to carry out risk assessments in domestic abuse cases in accordance with their policy.
- West Midlands Police consider reviewing the joint domestic abuse screening process to ensure there are no back logs and that information is recorded accurately by all partners of all decisions made.
- The CAB and Housing Department in Medway to review their policy and guidance regarding sharing of information with each other and other agencies to ensure that full risk assessments take place.
- The Home Office working with other government departments considers developing policy regarding when agencies become aware a victim of domestic abuse has moved from their area to another area and how they should share that information with agencies in the new area.