Report of the Domestic Homicide Review Panel into the death of Gemma on 7 October 2013

Definition of Domestic Violence

The government definition of domestic violence and abuse was extended to include young people aged 16 and 17. Wording was also included to capture coercive control. The new definition, which was implemented from 31 March 2013, is:

> *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*
>
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
>
> *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."*

The Government definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

It has been widely understood for some time that coercive control is a core part of domestic violence. As such the extension does not represent a fundamental change in the definition. However it does highlight the importance of recognising coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control.[1]

[1] Information for local areas on the change to the Definition of Domestic Violence and Abuse - Home Office, March 2013

Contents

Executive Summary

Throughout the Executive Summary the following initials are used to maintain the confidentiality of those persons referred to within the report. The terms mother, father, aunt and uncle are used where confidentiality is not compromised:

David – Perpetrator	Gemma – the victim
Josie – an ex-partner of David	Donald – Gemma's partner immediately before her death

Kirsty – A female friend of David

1. The Review process

1.1 The purpose of a Domestic Homicide Review (DHR) is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra- and inter-agency working.

1.2 This review arose from a killing within the area of the Epping Forest District. The victim, a female aged 34, died on 6 October 2013 of stab wounds inflicted by an ex-partner. Within a few hours the perpetrator, David, proceeded to kill himself. The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004 in that the violence appeared to be perpetrated by a person with whom she had an intimate personal relationship. The members of the Review Panel express their condolences to the family and friends of those who died as a result of these distressing events.

1.3 This DHR has been conducted in accordance with statutory guidance under section 9 of the Domestic Violence, Crime and Victims Act 2004. The Review examines agency responses and the support given to the victim who was a resident of Epping Forest District prior to her death. The review considers agencies' contact and involvement with the victim and perpetrator covering the period from 1January 2008 to the victim's death on 6 October 2013. The Panel has determined that there were no ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on agency involvement in respect of this Review.

1.4 The key reason for undertaking a DHR is to facilitate lessons to be learned when a person is killed as a result of domestic violence. To enable these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of these tragedies happening in the future.

2. Circumstances of the death

2.1 At around 06:50 on Monday 7 October 2013, officers from Hertfordshire Constabulary attended an incident reported to them by a member of the public involving a male found hanging by a dog lead attached to the hoop of a basketball pole within the grounds of a leisure centre in Broxbourne.

2.2 Initial enquiries at the scene established the identity of the male as David, who was later identified as the perpetrator of Gemma's death. Found on the body at the time of discovery was a black wallet, an Oyster card and a Nationwide Bank card in the name of the victim. David was pronounced dead at 07:20 that same day by paramedics.

2.3 Once David had been identified and his last known address ascertained, police officers attended Gemma's address to inform her of David's death. After failing to obtain a reply, they made enquiries with neighbours who directed them to family members living nearby. These enquiries raised further concerns as the family were unable to make telephone or other contact with Gemma. Police officers at Gemma's address called the phone number belonging to Gemma and could hear it ringing within the property. The phone rang several times and was not answered by Gemma. As a result of concerns for her safety, officers forced entry into Gemma's property.

2.4 Once inside, the police found the body of Gemma in the bedroom. She had significant stab injuries to her neck and chest, and a kitchen knife was found on the bedroom floor. Gemma's death was certified at 11:42 on 7 October 2013.

2.5 On 6 November 2013 Essex Police informed the Chair of the Epping Forest District Community Safety Partnership (CSP) that the circumstances of Gemma's death appeared to fulfil the criteria set out in section 9(3)(a) of the Domestic Violence, Crime and Victims Act 2004 in that her death was likely to have been caused by David, with whom Gemma appeared to have been in an intimate personal relationship. On 6 November 2013, the Home Office was informed of the intention to undertake a Domestic Homicide Review (DHR). The CSP then established a Domestic Homicide Review Panel (DHR), and the first meeting of the DHR took place on 2 December 2013. Due to the late receipt of an Individual Management Review from one organisation and the requirement to appoint a new Chair part way through the review process (explained in detail in the main body of the report), it was not possible to complete the review within the normal 6 month timescale set out by the Home Office. At its meeting on 13 May 2013, the Epping Forest Community Safety Partnership agreed to extend the deadline, and the Home Office was so informed on 20 May 2014. This review was completed and presented to the

CSP on 18 November 2014 and submitted to the Home Office on 21 November 2014.

3. The Review

3.1 The Terms of Reference for the review agreed by the CSP were as follows:

(1) In conducting the Domestic Violence review into the death of Gemma, the Panel shall have regard to:-

(a) the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews as revised and applicable from 1 August 2013; and

(b) the Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance of September 2012;

(2) The Panel will operate on a presumption that Gemma was killed on or around 6 or 7 October 2013 by her then partner David, who then proceeded to commit suicide;

(3) Factual background as to the immediate relationship between Gemma and David prior to her death, and the manner of her death will be sought. Reports shall be sought from relevant practitioners and agencies involved with Gemma and David prior to their deaths, and as to any actions taken or offered in relation to them. The Review shall consider whether such practitioners or agencies had any need to increase their own levels of awareness and information gathering, were sensitive to the needs of Gemma and knowledgeable about potential indicators of domestic abuse, and were aware of actions they could take if concerns had arisen;

(4) Consideration shall be given to the role of any agencies that had not come into contact with Gemma and/or David and which might have been expected to do so;

(5) The Panel shall seek to coordinate its work with that of HM Coroner for Essex and any inquest that is underway. The Panel shall remain aware of any on-going criminal investigation and seek to ensure that relevant information can be shared without incurring significant delay in the review process;

(6) A decision shall be taken as to which members of Gemma's family or friends, and if appropriate family or friends of David, shall be asked to contribute to information gathering, and how that will be managed;

(7) In particular the Panel will try to ascertain whether Gemma had made any disclosures about David to any practitioner, agency or individual, had any contact with a domestic violence or abuse organisation or helpline, had ever been subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether drug or alcohol misuse by Gemma and/or David could be of relevance. Any background in the lifestyle of

Gemma relevant towards understanding the events leading to her death shall be considered. Records of any disclosures made shall be sought;

(8) Information about the background and convictions of David shall also be sought, and as to whether or not he had ever been subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP);

(9) The Overview Report shall be written by the Chair of the Panel who shall submit a draft to the whole Panel for their consideration prior to its submission to the Community Safety Partnership, and then to the Home Office. The report shall address the issue as to the extent (if at all) the homicide could have been anticipated and possibly prevented and, whether from the facts of this death, there are improvements that could be made in the way in which relevant agencies can work to safeguard potential victims;

(10) The Panel shall seek to complete its work in good time before 6 May 2014, this being the last date before which the Community Safety Partnership should submit the final report to the Home Office; and

(11) Individual Management Reviews undertaken by relevant practitioners and agencies will be required to cover the time spanning at least between 1 January 2008 and 7 October 2013. If practitioners or agencies consider that events outside of this time frame are significant and of relevance to the Review, then they should include that information setting out the date involved.

3.2 The Review Panel undertook a scoping exercise in order to gather information about the victim, Gemma, and the perpetrator, David. In accordance with the Terms of Reference of the Review, the DHR covered the period between 1 Jan 2008 and 7 October 2013. A total of 63 agencies and organisations were contacted, of which 21 indicated that they knew of, or held, information relevant to the review. Based upon the information received, Individual Management Reviews (IMRs) were sought initially from 5 agencies:

a) Epping Forest District Council Housing Directorate;

b) Essex Police;

c) Metropolitan Police;

d) Sun Street GP Practice, Waltham Abbey; and

e) Market Square GP Practice, Waltham Abbey

Following information received subsequently, a further IMR was sought from the Hertfordshire Constabulary, making a total of 6 IMRs.

3.3 Essex Police had had no contact at all with the perpetrator David, and the Metropolitan Police had no dealings with Gemma and David whilst they were a couple living in Waltham Abbey. Hertfordshire Constabulary had considerable

involvement with David in the Hertfordshire area, along with a female acquaintance, Kirsty, but no involvement with Gemma.

3.4 The first Chair of the Panel interviewed family and friends of both Gemma and David in order better to understand the individuals and the relationship between them. The Panel was also able to view, on a limited basis, some of the statements provided to Essex Police as part of their investigation into the death of Gemma.

3.5 Given the death of the perpetrator, there was no need for a court case to be pursued. As is the norm for unexplained deaths, there was a Coroner's Inquest into both deaths, which was held in February 2014. The outcome of that Inquest was that Gemma had been unlawfully killed and that David had committed suicide. It is not the role of a Coroner's Inquest to apportion blame, but it is pertinent to note that at the Inquest, Essex Police stated that had David not taken his own life, there was sufficient evidence to have recommended to the Crown Prosecution Service that David be charged with Gemma's murder.

4. Key issues arising from the Review

4.1 There is always a danger when deriving conclusions from a review, that hindsight is used to criticise agencies which were not privy to information at the time of, or previous to, the incident, to which the Panel subsequently has access. However, it is clear to the Panel that there were steps which could have been taken by agencies, which, whilst being unlikely to have affected the eventual outcome, might have provided an opportunity for the perpetrator, David, to have been dealt with more robustly.

4.2 In the immediate period before Gemma's death, David's drug-related behaviour was deteriorating, bringing with it irrational and violent behaviour. Gemma had decided that she would bring her relationship with David to an end, and she had informed David of that intention. However, David was reluctant to accept that position, since he was heavily reliant upon Gemma for food, shelter and money (albeit sometimes stolen from her). Following the ending by her of their relationship, Gemma allowed David to remain in her flat, because at that time he had nowhere else to go.

4.3 It appears clear that Gemma, although being aware of David's drug related behaviour, felt that she was able to control the situation and continued to decline help offered to her by various agencies, even when she had herself sought that help. It is worthy of note that her immediate family and friends were of the opinion that David did not pose a material threat to Gemma's safety and welfare. It is likely that a number of factors contributed to Gemma's refusals of assistance including the fact that Gemma had apparently been less than truthful to the authorities in respect of her claims for housing and unemployment related benefits. It is possible that she may have feared the loss of these benefits (or worse) had she enabled the relevant authorities to fully investigate her personal circumstances.

4.4 It is not clear whether Gemma was aware that David's female acquaintance, Kirsty, had also found it necessary to report David's drug-related and irrational behaviour to the police. Had she been aware, this might also have provided an opportunity for her to review her relationship with David. Hertfordshire Constabulary and Essex Police were unaware of the connections between David, Kirsty and Gemma.

4.5 Essex Police had had limited interaction with Gemma, the majority of which being prior to the period of her relationship with David. However, they were aware of Gemma's complaints about her being subjected to domestic violence, although they were unable to pursue these matters due to her refusing to engage with them and provide information. Essex Police did complete a domestic violence assessment, classing her as being at "medium risk" based upon a lack of engagement.

4.6 The Epping Forest District Council Housing Directorate also had dealings with Gemma, since she made a number of applications to be rehoused away from her Waltham Abbey flat on the grounds that she was at risk of violence from former partners. Gemma was a private tenant (albeit in a former Council owned flat) and not a tenant of the Council. Her applications were properly assessed and classified in accordance with the Council's criteria. At no time, based upon the information she provided, was she considered to be of sufficiently high priority to qualify for rehousing in Council accommodation. However, she was offered advice and financial assistance in order to help her find alternative accommodation in the private sector, and she was also offered accommodation in a specialist refuge, which, on each occasion, she refused. Gemma also declined the offer of a second Multi-Agency Risk Assessment Conference (MARAC) referral. She therefore remained at her Waltham Abbey flat. The Council did not make detailed enquiries to establish the identities of those who were threatening her, although they did refer her to the police on a number of occasions.

4.7 Both Gemma and David were known to the Metropolitan Police, although most of this contact was prior to them being in a relationship, of which the Metropolitan Police was unaware. There was one significant event in the Metropolitan Police area when David was involved in a drugs-related incident in a restaurant, which resulted in him being taken by ambulance to hospital, where he remained for 7 days before being discharged to Gemma's address in Waltham Abbey.

4.8 At the time when scoping information was sought from relevant agencies, Hertfordshire Constabulary stated that they had no information on either Gemma or David. It later came to light that they had had significant dealings with David in respect of violent and drug-related behaviour and Hertfordshire Constabulary then provided an IMR. Whilst they were aware of David's friendship with a vulnerable female, Kirsty, they were not aware of his relationship with Gemma until immediately after his death. In their IMR, Hertfordshire Constabulary recognise that there had been opportunities to have

taken a more robust enforcement approach with David, particularly in respect of:

a) an incident in October 2011 involving an alleged firearm where David was not arrested or interviewed until late November 2011. An interview only took place following David voluntarily attending a police station. Hertfordshire Constabulary have accepted that this incident was not properly dealt with and that the investigation fell below the expected standards. The officers who carried out the investigation have received words of advice from a senior manager and have been reminded of their responsibilities in relation to carrying out a thorough investigation; and

b) an incident in late August 2013 when officers attended Kirsty's address following Kirsty's complaint that David was there. On attending, officers took the view that David was under the influence of drugs. However, the officers failed to access the Police National Computer (PNC) and therefore were unaware of bail conditions which precluded him from being in that geographical area. Hertfordshire Constabulary accept that the officers should have completed a through check on the PNC. The officers have been spoken to by a senior manager and reminded of the importance of carrying out thorough checks through the PNC and other corporate systems in the future. Whilst they could have arrested David for that breach of his bail conditions, it should be noted that under the circumstances at the time, David would, in all probability, have been immediately re-bailed and therefore released.

4.9 The hospital authorities at University College Hospital London, when discharging David home following a drugs-related hospital stay and assessment, did not take any steps to satisfy themselves of the domestic arrangements in place for David, nor whether any other vulnerable person or persons resided at the address he had provided to them as his home. This address was Gemma's.

4.10 A number of key agencies which were asked to provide information to the Review Panel failed to respond fully or in some cases to respond at all. In other instances, agencies were slow to provide information, provided inaccurate or incomplete information and/or failed to ensure that responses were adequately quality-checked by senior personnel before submission. This inaction compromised the Panel's ability to fully analyse the circumstances of Gemma's death and caused delays to the completion of the Review Report.

4.11 The Panel's investigative work was also compromised by its inability to gain unfettered access to all of the witness statements provided to the police, on the basis that the statement providers had not given their consent

5. Conclusions

5.1 The Review Panel, after a careful and thorough consideration of the information presented to it, is of the view that the death of Gemma could not have been reasonably foreseen or prevented by any agency or individual. However, the

Panel does draw a number of conclusions from its Review, upon which its recommendations in Part 6 of the Review Report are based:

5.2 The Panel has concluded that:

a) it is clear from the information provided in the Hertfordshire Constabulary IMR that Kirsty, who was well known to them, should have received greater consideration as a potentially vulnerable adult and been referred to specialist agencies accordingly. Instead, it appears to the Panel that because she was well known to the Hertfordshire Constabulary and often very difficult to deal with, her complaints were perhaps not always dealt with in the most appropriate manner. This conclusion is further emphasised by Hertfordshire Constabulary's knowledge of David, his alleged drug taking and irrational behaviour, and the obvious relationship/friendship that existed between him and Kirsty;

b) Hertfordshire Constabulary missed two opportunities to deal with David more robustly, these being an incident involving the alleged use of a firearm and a later failure to access the PNC resulting in him being transported back to an area where he was in breach of his extant bail conditions;

c) regrettably, Gemma failed to recognise the risks to her arising from David's drug taking and increasingly irrational and violent behaviour. This was despite the fact that she was clearly aware of David's drug habit and had tried to assist him in dealing with it. Furthermore, the Panel has concluded that Gemma failed to fully engage with the specialist services/agencies offered, including a refusal to accept the advice and assistance offered to her. The Panel is of the view that this seriously increased the risk of her becoming a victim of serious domestic violence. In reaching this conclusion the Panel has taken into account the fact that the information Gemma provided to the relevant authorities in order to obtain a range of benefits was not true, given that she was in employment and her flat was occupied by a person (or persons) in addition to herself. The Panel is also aware that during this period, her brother was seeking early release from prison on the basis of being able to reside at her address. The Panel believes that these factors may well have influenced her decision making in providing accurate information to, and considering the various options offered to her by, agencies in a position to assist her;

d) the Panel's request for information and IMRs from some agencies was not afforded the importance and priority required. Furthermore, the Panel has concluded that when information is requested by a DHR panel, that information should be compiled by someone with appropriate skills, and the final document should be 'signed off' by an officer of suitable seniority;

e) the Panel's investigative activities were seriously compromised by the unwillingness of some agencies and organisations to engage (in any way) with the Review Panel and respond to requests for information;

f) the Panel's investigative activities were potentially compromised by its inability to be able to access witness statements provided to Essex Police as part of their investigation into Gemma's death, without the consent of the statement providers; and

g) there should be improved communication between police Senior Investigating Officers (SIO) and DHR Chairs to ensure that all available information is shared, thus enabling Coroners to be fully aware of an on-going Domestic Homicide Review and any assistance that the Panel Chair may be able to provide to the Coroner.

6. Recommendations arising from this Review

Recommendations from Individual Agencies

The recommendations which follow are taken from the Individual Management Reviews received from the relevant agencies.

Epping Forest District Council Housing Service:

6.1 That, in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence and that advice and assistance has been refused by that person, then such cases should be referred back to the Multi Agency Risk Assessment Conference (MARAC) and if appropriate the named officer within the Essex Police Domestic Violence Team.

6.2 The Panel has been made aware that the Housing Service has subsequently concluded that this recommendation does not accord with good practice and has amended its recommendation to the following:

That, in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence and that advice and assistance has been refused by that person, the such cases be referred back to the Essex Police Central Referral Unit.

Market Square Surgery, Waltham Abbey:

6.3 That patients' computerised records be enabled to display a prominent icon ('flag') on the front page to enable a GP or health professional accessing the record to be immediately aware of domestic violence issues; and

6.4 That the practice be able to access specialist domestic violence agencies more easily.

Hertfordshire Constabulary:

6.5 That a reminder is published force wide for the requirement to refer vulnerable adults who fall outside that of criminal neglect to Health and Community Services.

Recommendations from the Review Panel

The recommendations which follow are those of the Review Panel and upon which the Action Plan set out in Appendix B is formulated.

6.6 That the recommendations of the individual agencies be noted and agreed with the following additional comments/recommendations:

Essex Police:

6.6.1 That when undertaking a Domestic Violence Assessment, additional weight should be given to alleged victims who are considered to be uncooperative, whereby additional detailed enquiries are made where persons refuse to engage over an extended period of time;

Metropolitan Police:

6.6.2 To ensure that all officers are aware of the need to fully report into the police MERLIN systems all relevant incidents attended to that involve any vulnerable adult, to ensure that records in respect of individuals with whom the police have interacted are complete in all respects and shared with relevant health and support agencies.Hertfordshire Constabulary:

.6.6.3 That Hertfordshire Constabulary should formally remind all staff, via email and internal newsletters, of the importance of carrying out PNC and other information checks when dealing with all individuals, including when they are already (well) known to the police, to ensure that all staff react appropriately. This requirement/reminder should also be reinforced as part of the initial training of officers.

Home Office, Justice Ministry and Department of Health:

6.6.4 That the Home Office remind all agencies likely to be contacted in respect of domestic homicide matters of the roles and responsibilities of a Domestic Homicide Review Panel and those agencies be required to respond in good time to requests for initial scoping information and Individual Management Reviews;

6.6.5 That, further to the recommendation in paragraph 6.6.4 above, the Home Office remind those same agencies of the importance of the completion of initial scoping information and Individual Management Reviews being undertaken by suitably qualified and competent staff and that before submission the information is reviewed and authorised by an officer of appropriate seniority;

6.6.6 That the Department of Health seeks the views of hospital authorities on the practicality of making enquiries of patients about their home/domestic circumstances before discharging patients with known drug and violent tendencies, and to inform relevant agencies accordingly;

6.6.7 That the Department of Health informs GP practices of the benefits of computerised patient records displaying a ‘flag’ or icon on the front page of the patient record enabling incidences of domestic violence to be clearly visible to a GP or other health professional;

6.6.8 That the Department of Health recommend GP practices take steps to ensure that all relevant staff are fully aware of specialist domestic violence agencies and services which are available in their respective areas;

6.6.9 That the Ministry of Justice and/or Home Office consider reminding police forces of the importance and benefit of police Senior Investigating Officers (SIOs), maintaining close contact with the Chair of a Domestic Homicide Review Panel when investigating a death believed to be the result of domestic violence, with a particular requirement to ensure that Her Majesty's Coroners are aware of the establishment of a DHR; and

6.6.10 The Ministry of Justice/Home Office review the rules pertaining to the release of statements made to the police as part of homicide investigations to Domestic Homicide Review Panels.

The Action Plan which sets out the steps to be taken to implement the above recommendations can be found as Appendix B in the main report.

Main Report

Introduction

In order to ensure anonymity, the following initials have been used to identify those persons referred to in the report. Mother, father, uncle and aunt have the normal meaning associated with them.

David – Perpetrator	Gemma – the victim
Josie – an ex-partner of David	Donald – Gemma's partner immediately before her death

Kirsty – A female friend of David

1. **The Review Process**

1.1 The purpose of a Domestic Homicide Review (DHR) is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2 This review arose from a killing within the area of the Epping Forest District . The victim died on 6 October 2013 of stab wounds inflicted by an ex-partner. Within a few hours the perpetrator then proceeded to kill himself. The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004 in that the violence appeared to be perpetrated by a person with whom she had an intimate personal relationship. The members of the Review Panel express their condolences to the family and friends of those who died as a result of these distressing events.

1.3 This DHR has been conducted in accordance with statutory guidance[2] under Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Review examines agency responses and the support given to the victim who was a resident of Epping Forest District prior to her death. The review considered agencies' contact and involvement with the victim and perpetrator covering the

2 *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Revised – applicable to all notifications made from and including 1 August 2013*. Home Office 2013

period from 1 January 2008 to the victim's death on 6 October 2013. The Panel has determined that there were no ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on agency involvement in respect of this Review.

1.4 The key reason for undertaking a DHR is to facilitate lessons to be learned when a person is killed as a result of domestic violence. To enable these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of these tragedies happening in the future.

1.5 The current Chair of the Panel would like to take this opportunity to thank the former Chair, Judge Anthony Bradbury, all of the Panel members and their respective agencies and all other agencies who participated in the review process for their contribution to the formulation of this report.

Panel membership

1.6 The membership of the Review Panel was as follows:

Name	**Position/Organisation**
Panel Members	
His Honour Judge Anthony Bradbury	Independent Member and initial Panel Chair (until 10 April 2014)
Councillor Gary Waller	Chair of Epping Forest District Community Safety Partnership, Epping Forest District Council's Portfolio Holder, Safer, Greener and Transport and Panel Chair following the resignation of Judge Bradbury (from 29 April 2014)
John Gilbert	Director of Environment and Street Scene, Epping Forest District Council (until 31 May 2014). Panel Member and also Report Author (from 1 June 2014)
Colleen O'Boyle	Director of Governance and Solicitor to the Council, Epping Forest District Council
Jim Nolan	Assistant Director Neighbourhoods, Epping Forest District Council
Chief Inspector Denise Morrissey	Essex Police

Name	Position/Organisation
Detective Sergeant Angie Barton	Critical Incident Advisory Team, Metropolitan Police
Detective Chief Inspector Elizabeth Hanlon	Hertfordshire Constabulary (Panel Member from 15 September 2014) Hertfordshire Constabulary was initially thought not to be involved. However, once their involvement was better understood, they were invited to attend Panel meetings but were not invited to sit as full members. Hertfordshire Constabulary did request full membership, but the initial Panel Chair did not consider that appropriate. Following the resignation of the initial Chair, the DHR Panel formed the view, at its meeting on 15 September 2014, that it was appropriate for Hertfordshire Constabulary to become a full member of the Panel.
Jayne Gentry	Safer Places - Harlow
Val Billings	Essex Safeguarding Adults Board, Essex County Council
Sheona Siewertsen	Lead for Safeguarding Adults, West Essex Clinical Commissioning Group (CCG)
Caroline Wiggins	Community Safety Manager, Epping Forest District Council
Alan Hall	Director of Communities, Epping Forest District Council (from 1/4/2014 initially with observer status only)
Non Panel Members	
Claire Baccarini	Administrator, Epping Forest District Council
Chief Inspector Tom Simons	Essex Police – took over previous role of CI Denise Morrissey and although not a formal member of the Panel, was requested to comment upon the final report.

Appointment of replacement Chair

1.7 It became necessary towards the conclusion of the review to appoint a new Chair, following the resignation of the original Chair, Judge Anthony Bradbury. The Judge had been put forward to the Members of the Review Panel for

consideration as the Chair of the Review Panel by the Chairman of the Epping Forest District Community Safety Partnership (CSP), Councillor Gary Waller. Judge Bradbury had been an independent member of a previous DHR Panel that had investigated an earlier domestic homicide, and it was considered that his experience as a former Deputy High Court Judge, alongside this previous involvement, made him a particularly suitable nomination. His appointment was unanimously agreed by the DHR Panel members.

1.8 Excellent progress was made with the review and the production of a draft Review Panel Report by the DHR Panel, under his Chairmanship. He took the lead in drafting the Panel's Report, up to the point where he had produced a first draft for consideration by this Panel. However, in early April 2014, a number of issues arose which resulted in the Judge resigning as the Chair of the Review Panel. In essence these were:

a) corrections and minor textual amendments made to his initial draft report by Council Panel members led to a perception by Mr Bradbury that they were seeking to amend the initial draft before it was sent to all Panel members. Whilst the Panel believes that this was intended to be helpful to Panel members by making minor corrections such as referring to Panel members by the correct titles of their posts and ensuring compliance with Home Office guidelines, with hindsight the Panel and relevant Council officers accept that this should not have happened;

b) the Community Safety Manager being concerned about the nature of some criticism of a participating agency, thought it would be helpful to discuss those criticisms informally with Panel members from two other participating agencies, once again before wider circulation. As above, whilst this was intended to be helpful, it is the Panel's view that this should not have taken place without the consent of the Chair, and should have been a matter for discussion by all Panel members at a subsequent meeting. Judge Bradbury subsequently received an apology from the Community Safety Manager and the Chairman of the Community Safety Partnership; and

c) the Judge's concerns regarding the balance of the Review Panel membership and the role of the Council's Community Safety Manager on the Panel. Throughout its work the Panel has been supported by both the Community Safety Manager and a dedicated administrator. The Community Safety Manager, while also undertaking some administrative tasks, was a full member of the Review Panel, although this was not initially made clear to Judge Bradbury. He took the view that this further unbalanced the Panel, which he considered already to have too many officers from Epping Forest District Council. It should be noted that Mr Bradbury had not, prior to his resignation, raised this as an issue.

1.9 The combination of a), b) and c) above, but in particular issue c), led to Judge Bradbury drawing the conclusion that his Chairmanship had been undermined

and that he therefore had no alternative other than to resign. Despite attempts to persuade him otherwise, he stood down as Chairman with effect from 10 April 2014.

1.10 The resignation of the Chair at such a late stage in the review process left the Review Panel in a very difficult position in that the report was essentially complete, albeit in its initial draft form, and before the Panel had had an opportunity to discuss it. The Panel was faced with three options:

a) appoint a new and fully independent Chair and start the Review process afresh;

b) endeavour to appoint a new and fully independent Chair, whose role would be to see the DHR process through to its conclusion; or

c) consider whether the appointment of a Chair could be made from within the existing Panel members, who would be aware of all the circumstances around the issues discussed by the Panel up to that point and who, as a result, although not wholly independent, would be in a position to oversee the completion of the review within a reasonable time frame.

1.11 The Panel members discussed these three alternatives, giving particular attention to the need to:

a) maintain the probity and impartiality of the Panel and its report;

b) avoid, as far as possible, any criticism or concerns arising from the participating agencies, the family and friends of the victim, the former Chair of the Review Panel and/or the Home Office DHR Quality Assurance Unit; and

c) be able to complete and publish the Review Report as soon as practicable.

1.12 At its meeting on 29 April 2014 the Panel unanimously concluded that Option c) in paragraph 1.10 above was the most appropriate and pragmatic option. The Panel agreed to make an appointment from within the existing DHR Panel membership in order to see the process from the draft report stage through to its conclusion. Whilst there were a number of Panel members who could have undertaken the role, it was considered that the best option was to appoint the Chair of the Community Safety Partnership and Panel member, Councillor Gary Waller, to the position of Chair of the Review Panel. It was further agreed that John Gilbert, who was shortly to retire from his position as Director of Environment and Street Scene with Epping Forest District Council, should remain as a Panel member and be appointed to the role of Report Author.

1.13 The Review Panel is of the view that whilst the appointments of a new Chair and Report Author at such a late stage were regrettable, this approach represented the most effective way of completing the review process as soon as possible, so that the recommendations made could be shared quickly. The Panel was also satisfied that Councillor Waller's roles within Epping Forest

District Council and The Community Safety Partnership did not in any way affect his ability to act independently in the role of Panel Chair.

Timescale

1.14 This Review began on 6 November 2013, when the Home Office was advised by Councillor Gary Waller, Chair of Epping Forest District Community Safety Partnership (EFCSP) that a DHR would be conducted. The Review was concluded on 19 November 2014. There were no criminal proceedings associated with this case as the perpetrator committed suicide.

1.15 The Home Office guidelines for the undertaking of a DHR recommends that it should be completed and submitted to the Home Office within six months of the date when it is notified that a DHR is to be carried out. In view of the late submission of an IMR by one of the agencies and the resignation of the initial Chair late in the process, it became clear to the Review Panel that the timescale could not be achieved. The Panel therefore sought an extension from the Epping Forest Community Safety Partnership (EFCSP) at its meeting on 13 May 2014, when an extension was agreed. The Chair of the Review Panel informed the Home Office of this agreed extension on 20 May 2014.

Confidentiality

1.16 The findings of this Review remained confidential during the review process. Information was available only to participating officers/professionals and their line managers until the report was approved for publication by the Home Office Quality Assurance Group. The Home Office Quality Assurance Group letter of approval is attached at Appendix D and any suggested amendments referred to in that letter have been considered and included within this final report where considered appropriate.

1.17 Information discussed by the agencies' representatives within the DHR Panel meetings is strictly confidential and Panel Members were made aware that information must not be disclosed to third parties without the agreement of Panel members.

Epping Forest Community Safety Partnership (CSP)

1.18 After the death of Gemma, Essex Police on 14 October 2013 notified Councillor Gary Waller, as a Member of Epping Forest District Council and Chair of the CSP, that Gemma's death had occurred within the Council's area. After discussions with Essex Police and the Essex Domestic Violence Co-ordinator, Councillor Waller determined that the death should be treated as a Domestic Homicide and on 6 November 2013 the Home Office was notified that a Domestic Homicide Review Panel (DHR) would be established.

Panel Chair(s)

His Honour Judge Anthony Bradbury:

1.19 Anthony Bradbury qualified and practiced as a solicitor. In 1981 he was appointed as a District Judge, and later a Recorder of the Crown Court. In 1992 he was appointed a Circuit Judge, and in 1997 a Deputy High Court Judge. He

retired in 2008. He lives within the district of Epping Forest but otherwise has had no direct connection with any of the individuals named in the Report, the agencies represented on the Panel, or with those who have made contributions to the work of the Panel. He was an independent member on a previous DHR Panel review undertaken by the Epping Forest CSP, submitted to the Home Office in September 2013. As referenced earlier in this report, he resigned the Chairmanship on 16 April 2014.

Councillor Gary Waller:

1.20 Gary Waller is the Chairman of the Epping Forest District Community Safety Partnership. He was the Member of Parliament for Brighouse & Spenborough from 1979 to 1983 and then for Keighley from 1983 to 1997. Between 1992 and 1997 he was Chairman of the House of Commons Information Select Committee, overseeing the work of the House of Commons Library and Parliamentary ICT services. Gary Waller was elected to Epping Forest District Council in 2011 and has been the Safer, Greener & Transport Portfolio Holder since May 2012.

Report Author

1.21 It had been originally intended that the initial Chair would author the Review Report. Following the resignation of the initial Chair, the Panel agreed that Mr J Gilbert, the former Director of Environment and Street Scene for Epping Forest District Council should be retained as a Panel Member following his retirement on 31 May 2015, and that he should also be tasked with the authorship of the Review Panel report.

The Coroner's Inquest

1.22 The Inquest took place on 3 April 2014 and found that Gemma was unlawfully killed. The Coroner also concluded that her former partner, David, took his own life. Essex Police, in giving evidence at the Inquest stated that, had David not taken his own life, there was sufficient evidence to recommend to the Crown Prosecution Service that he be charged him with the murder of Gemma. The Review Panel was provided with the transcript of the Inquest.

Circumstances leading to the Review

1.23 At around 06:50 on Monday 7 October 2013, officers from Hertfordshire Constabulary attended an incident reported to them by a member of the public following the discovery of a male found hanging by a dog lead attached to a basketball pole and hoop, within the grounds of a leisure centre in Broxbourne.

Initial enquiries at the scene established the identity of the male as David, who was later identified as the perpetrator of Gemma's death. Found on the body at the time of discovery was a black wallet, an Oyster card and a Nationwide Bank card in the name of the victim. David was pronounced dead at 07:20 that same day by paramedics.

1.24 Once David had been identified and his last known address ascertained, police officers attended Gemma's address to inform her of David's death. After failing

to obtain a reply, they made enquiries with neighbours who directed them to family members living nearby. These enquiries raised further concerns as the family were unable to make telephone or other contact with Gemma. Officers at Gemma's address called the phone number belonging to Gemma and could hear it ringing from within the property. The phone rang several times without response. As a result of concerns for her safety, police officers forced entry into Gemma's property.

1.25 Once inside, the police found the body of Gemma in the bedroom. She had significant stab injuries to her neck and chest, and a kitchen knife was found on the bedroom floor. Gemma's death was certified at 11:42 on 7 October 2013.

Scope of the Review

1.26 On 2 December 2013 the Panel considered draft Terms of Reference prepared by the initial Chair and, after revision, adopted the following Terms of Reference:

(1) In conducting the Domestic Violence review into the death of Gemma, the Panel shall have regard to:

(a) the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews as revised and applicable from 1 August 2013; and

(b) the Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance of September 2012.

(2) The Panel will operate on a presumption that Gemma was murdered on or around 6 or 7 October 2013 by her then partner David, who then proceeded to kill himself;

(3) The factual background as to the immediate relationship between Gemma and David prior to her death, and the manner of her death will be sought. Reports shall be sought from relevant practitioners and agencies prior to their deaths, and as to any actions taken or offered in relation to them. The Review shall consider whether such practitioners or agencies had any need to increase their own levels of awareness and information gathering, were sensitive to the needs of Gemma and knowledgeable about potential indicators of domestic abuse, and were aware of actions they could take if concerns had arisen;

(4) Consideration shall be given to the role of any agencies that had not come into contact with Gemma and/or David and which might have been expected to do so;

(5) The Panel shall seek to coordinate its work with that of HM Coroner for Essex and any inquest that is underway. The Panel shall remain aware of any on-going criminal investigation and seek to ensure that relevant information can be shared without incurring significant delay in the review process;

(6) A decision shall be taken as to which members of Gemma's family or friends, and if appropriate family or friends of David, shall be asked to contribute to information gathering, and how that will be managed;

(7) In particular the Panel will try to ascertain whether Gemma had made any disclosures about David to any practitioner, agency or individual, had any contact with a domestic violence or abuse organisation or helpline, had ever been subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether drug or alcohol misuse by Gemma and/or David could be of relevance. Any background in the lifestyle of Gemma relevant towards understanding the events leading to her death shall be considered. Records of any disclosures made shall be sought;

(8) Information about the background and convictions of David shall also be sought, and as to whether or not he had ever been subject to Multi-Agency Public Protection Arrangements (MAPPA), or Domestic Violence Perpetrator Programme (DVPP);

(9) The Overview Report shall be written by the Chair of the Panel[3] who shall submit a draft to the whole Panel for their consideration prior to its submission to the Community Safety Partnership and then to the Home Office. The report shall address the issue as to the extent (if at all) the homicide could have been anticipated and possibly prevented, and whether from the facts of this death, there are improvements that could be made in the way in which relevant agencies can work to safeguard potential victims;

(10) The Panel shall seek to complete its work in good time before 6 May 2014[4] being the last date before which the Community Safety Partnership should submit the final report to the Home Office; and

(11) Individual Management Reviews undertaken by relevant practitioners and agencies will be required to cover the time spanning at least between 1 January 2008 and 7 October 2013. If practitioners or agencies consider that events outside of this time frame are significant and of relevance to the Review, then they should include that information setting out the date involved.

1.27 The Panel was aware that the Terms of Reference could be further changed in the light of information received by it, but no information was received to warrant any change. No other review relating to the death of Gemma or any other person has been conducted or combined within this or another report. The Inquest into both deaths took place on 3 April 2014 and the transcript of the Inquest includes reference to the fact that the DHR process was underway and that Essex Police had submitted an IMR for the Panel's consideration.

[3] See paragraph 1.21 regarding the change of report author following the resignation of the initial Chair

[4] Deadline for completion subsequently extended by the Community Safety Partnership.

Review Methodology

1.28 This Review has followed the statutory guidance issued for the conduct of DHRs. A total of 63 agencies were contacted to check for any involvement with the parties concerned in this Review. There were 42 nil returns, a total of 21 agencies responded with some level of involvement with the victim and/or the perpetrator.

1.29 Agencies were asked to give chronological accounts of their contact with Gemma and David. The DHR covered in detail the period from 1 January 2008 through to 7 October 2013; however some agencies also provided additional historical context where appropriate.

Appendix A details all the organisations that were requested to co-operate with this Review.

1.30 Following receipt of the information the Review Panel considered whether an Individual Management Review (IMR) was required. A total of 6 IMRs were requested from the following agencies:

a) Epping Forest District Council Housing Service;

b) Essex Police;

c) Metropolitan Police;

d) Sun Street Surgery - Gemma's GP Practice (closed in July 2009);

e) Market Square Surgery - Gemma's GP Practice (Dec 2010 – Oct 2013); and

f) Hertfordshire Constabulary

1.31 The IMRs numbered a) to e) above were requested in December 2013 following the initial scoping exercise. From the information shared with the initial Chair by Essex Police, it was ascertained that the involvement of Hertfordshire Constabulary with David was considerably more extensive than originally indicated in their initial response to the scoping exercise. This led the Panel to investigate Hertfordshire Constabulary's involvement with David in more detail, and in particular, his involvement with a Waltham Cross resident Kirsty. On 22 January 2014 Hertfordshire Constabulary provided new information about their knowledge of David and Kirsty and consequently the initial Chair requested an IMR from Hertfordshire Constabulary. A draft IMR was provided on 17 February 2014 and a further amended IMR was provided on 28 February 2014.

1.32 Gemma had attended three GP Surgeries within the period covered in the Terms of Reference. Two IMRs were requested, one from the Market Square Surgery where Gemma was registered at the time of her death and secondly from the Sun Street Surgery where she had been registered until July 2009. Gemma had been registered for a short period (5 months) with a GP practice in Howard Close, Waltham Abbey. However the Hertfordshire Clinical Commissioning Group did not engage with the review and an IMR was not sought. The Sun Street Surgery IMR was completed by the West Essex

Clinical Commissioning Group based upon records since the surgery is no longer providing services.

1. 33 All IMRs were assessed by the Panel to ensure that content was appropriate and fit for purpose. IMR authors were, where relevant, requested to provide further information or to clarify matters raised. Additional documents referred to included:

a) Serious Crime Directorate of Kent and Essex Police Current Situation Report - the report set out the available forensic evidence and summaries of statements made by 41 police and civilian potential witnesses, and family members updated to 12 November 2013. This report was provided to the Chair, Community Safety Manager and Panel Administrator but was not circulated to the full Panel;

b) Statements from Gemma's family and friends which were included in the current situation report and where the police had permission from the person giving the statement for it to be shared with the Panel;

c) Transcript of the Coroner's Inquest into the deaths; and

d) PROTECT Report – DASH Risk Assessment from the Essex Police incident 30th March 2013.

1.34 On 19 December 2013 the initial Chair, Community Safety Manager and Panel Administrator met with Gemma's mother and aunt. A Police Family Liaison Officer (FLO) accompanied them. Both Gemma's mother and aunt were most helpful in providing family background details about Gemma and in responding to questions about Gemma's relationship with David. The initial Chair had hoped to meet with David's uncle, the relative with whom David appeared to have the most contact. However, despite repeated attempts to engage with him both by letter and through the police, no response to this request was forthcoming.

1.35 Interviews were conducted by the initial Chair with the Essex Police Senior Investigating Officer. This led to him also interviewing Detective Chief Inspector Hanlon of the Hertfordshire Constabulary. DCI Hanlon and Hertfordshire Constabulary IMR author also attended a DHR Panel meeting to set out and discuss the position of Hertfordshire Constabulary. The initial Chair also sought guidance from the Home Office as to when statements supplied by police could be circulated to the DHR Panel, notwithstanding a lack of consent from the statement providers, but no clarification has been provided. With regard to the statement of David's uncle, discretion has been exercised in referring to elements of his statement in this Report.

1.36 On completion of this report attempts were made to contact the families of those concerned to enable them to see the report and comment upon it ahead of its submission to the Home Office and its publication. No response has been received from any related family member.

2. The Facts

Gemma

2.1 At the time of her death Gemma was 34 years old and living in Waltham Abbey. It is understood that the relationship between her and David had started two years previously; however by October 2013 the relationship had broken down and, although they were living in the same property, they were leading separate lives.

Background information on Gemma prior to her involvement with David

2.2 Gemma was born in London in July 1979. Her mother had five children of whom Gemma was the eldest. Gemma had three brothers and one sister, who, in October 2013, were aged 26, 23, 16 and 24 years respectively. Gemma was never married and had no children.

2.3 Gemma was brought up in Stratford (East London), Chigwell and Waltham Abbey. Her mother, with other members of the extended family, still lives in Waltham Abbey. Gemma left school, and home, at the age of 16 and worked for a firm of City solicitors undertaking secretarial work. Of this time her mother remarked that Gemma became exposed to what she describes as 'bad boys', these being young men that for some reason or another had become involved with the police or found themselves requiring Gemma's employer's legal services. Her mother suggested that Gemma found herself attracted to such men and that this seemed to set the trend for her future boyfriends. Her mother described her subsequent involvement in *"*erotic dancing*"* at London clubs and her links with other girls. She stated that Gemma had more recently worked for women working in the adult sex industry and that she became close to many of the girls through dealing with their telephone calls, and keeping and organising their diaries and appointments. This might include the booking of rooms as well as arranging flights and accommodation for the girls who might be away on photo and film shoots. Her mother said that she liked to be the boss and took control of situations. It is believed that at the time of her death Gemma was engaged in this occupation. Away from work her mother also said that Gemma had helped her during difficult times, both emotionally and financially. Her mother stated that Gemma loved her friends and family.

2.4 From descriptions given by her mother, Gemma was not short of money, having the means to buy expensive clothes and jewellery, and with substantial sums of money kept in her home.

2.5 At the time of her death Gemma was living in a one bedroom flat within a block of nine flats in Waltham Abbey, Essex. The block is owned (as freeholder) by Epping Forest District Council. Some flats were sold on very long leases, and others remained in Council ownership and let by the Council to tenants. Gemma was the private tenant of a long lessee of the Council and had lived at the address from at least 2008.

2.6 Gemma had applied for and was in receipt of housing benefit from Epping Forest District Council. She had never stated at any time that anyone else was

in occupation of the flat with her. She never disclosed an occupation to the Council and was therefore in receipt of full housing benefit on the basis of her unemployment and inability to work, supported by some medical evidence, largely of her depressive state. The information she supplied to the Council about her personal situation as part of her benefits claim does not accord with the description of her lifestyle given by her mother and friends.

2.7 From 2008 onwards she made repeated applications to the Council to be housed in Council accommodation, although she was specific as to where she wished to live and turned down an offer of an interest free loan in order to take a private let. In 2012 Gemma contacted the Housing Options Team again, reporting a domestic abuse incident involving a previous partner who was serving a term of imprisonment for attempted murder and other violent offences and who was due to be released in or around April 2012. Unfortunately, after thorough investigations involving three police forces, the Panel has been unable to identify any details of the ex-partner or records of the incidents disclosed to both the Council's Housing Teams and Gemma's GP.

2.8 The Council was not able to re-house her. She never attained sufficient housing priority to qualify for an offer but, in a series of contacts between her and Council officers, she was provided with information as to how she might find alternative accommodation in the private sector herself. The Council also had correspondence with Gemma's constituency Member of Parliament who was aware of Gemma's alleged situation. The Council was able to demonstrate that Gemma had been signposted on a number of occasions to both local and national support agencies for domestic abuse.

2.9 Essex Police has notes of over 15 incidents relating to Gemma, including some arrests but where no charges were later brought. Those matters are not relevant to this review. However, long before meeting David she had previously made complaints of domestic violence upon her by two of her brothers in separate incidents, and by other males. These events were in 2010 and 2011, and in both cases police DV/1assessments (a process used to assess potential cases of domestic violence which also includes a DASH risk assessment) were completed, one being given a standard risk assessment and the other a medium risk assessment. In both cases Gemma chose not to supply full information to the police.

2.10 The incident in 2010 related to an ex-partner refusing to leave her flat. When police attended, they established the male had since left and concluded that the incident amounted to a verbal argument. The incident in 2011 related to Gemma ringing the non-emergency number 101 and reporting that she had been receiving threats from an ex-partner, this being a different male to the one noted above in 2010. Police officers attended the incident but Gemma refused to provide any details and would not complete a DV/1. In the event the police officers who attended completed a DV/1 assessment on behalf of Gemma in which the risk was assessed as 'medium' and she was contacted by a member of the Domestic Abuse Safeguarding Team (DAST) who provided contact details. When Gemma reported this incident she had given details of a previous

incident in the Metropolitan Police area where she had received threats. The DAST Officer was tasked with requesting further information concerning the Metropolitan Police incident and a subsequent entry states that no suspect was identified and no one was arrested. DAST Officers completed a form that resulted in a flag being placed against the address within the STORM Police Command and Control System. This would alert officers to the potential of firearms and/or violence and contained details of the previously disclosed incidents.

2.11 Police records from 2012 also confirm correspondence recorded within PROTECT between Gemma, Essex Police and Broxbourne Housing suggesting that in 2012 Gemma was concerned about the imminent release from prison of a former boyfriend, not previously referred to above, who she feared might cause her trouble. The Panel was unable to locate any reports to the Essex Police, Hertfordshire Constabulary or Metropolitan Police concerning this former boyfriend.

2.12 Gemma's General Practice at the time of her death was the Market Square Surgery, Waltham Abbey. From the IMR produced by the Surgery, records have disclosed numerous surgery visits where she complained of depression. In 2011 and 2012 her anxiety related to a previous partner and his impending release from prison. There are references to that former partner up to May 2012. However, the IMR does not provide any details of the partner in question. Gemma was referred to the practice counsellor but failed to attend the appointment. She was signposted to local specialist domestic abuse services and provided with on-going advice and support by her GP. It was also noted in the IMR that her GP discussed with her the possibility of getting a restraining order if contact with the ex-partner was unwanted.

2.13 There are no references in these records to anyone who might have been David and throughout 2012 Gemma advised her GP practice that she was living alone.

<u>Background information on David prior to his involvement with Gemma</u>

2.14 David was born in Jamaica and he was 35 years old at the time of his death. In 1995 David was living in Jamaica at his grandmother's address, though his father was then living in London. His parents are divorced. Each parent had previous marriages and David had two younger sisters and other step siblings. At some time during the period 1997 to 1998 David moved from Jamaica to London and remained living in the London area thereafter. David's uncle believed David had already started to use crack cocaine in Jamaica and that his father sent for him to come to the United Kingdom to get David away from that lifestyle. His mother now lives in the Bahamas

2.15 David had a number of relationships between 2000 and 2013. He was married once and had one child in that marriage. Subsequent to that marriage he had five other children with three different partners. Before meeting Gemma, David had been in a relationship with Josie, with whom he had lived for more than six years. David and Josie had one child, a boy, who was born in 2007.

2.16 David's uncle noted in his statement to Essex Police that he was aware that David took drugs including crack cocaine during his relationship with Josie and that the use of drugs made David on occasion wild with rage and prone to acts of aggression, either to property, or on one occasion to Josie herself, whom he had seen with bruising to her face. David had told his uncle that he would seek help to try to resolve his drug addiction but there is no evidence that he was ever able to maintain any treatment offered to him.

2.17 Based upon limited medical evidence about David from various hospitals through the scoping exercise, supplemented by replies to questions posed by the Chair or Community Safety Manager, it appears that David attended North Middlesex University Hospital in Edmonton with throat problems in 2007, 2009 and 2010 and Barnet and Chase Farm Hospital in 2009 when he was diagnosed as having acute tonsillitis. On 27 February 2012 he was taken, according to East of England Ambulance Service records, from a Waltham Cross, Hertfordshire address, to the Queen Elizabeth Hospital, Welwyn Garden City, following an "overdose of medication". The medical report supplied, dated 28 February 2012 comes from the Lister Hospital, Stevenage and relates to an overdose of 30 tablets that he said he took because of fears of eviction from an address in Waltham Cross. If that address was then his home, he could not have been living with Gemma for the two years prior to her death, but rather for about 18 months. He told the Lister Hospital team that he had no known medical problems, did not take alcohol, and had last taken cannabis a year previously. Nothing is recorded as to cocaine. As to his mental state at interview, the medical report states: *"There was no abnormal behaviour reported. No psychotic symptoms evident or thought disorder present. Well oriented, good attention and concentration."* The Mental Health Team Plan was *"Discharge home in care of partner. To inform GP."* The partner is not named but the likelihood is that it was Josie. It could not have been Gemma if he had truthfully told the Team that he had a child by his then present partner.

2.18 A copy of that report was sent to the Barton House Health Centre General Practice in London N16. David had been registered with that practice since 2005 but the practice has no record of an attendance by him since then. They did receive the report from the Lister Hospital in Stevenage and filed it with the patient records. Their address for David in 2005 was that he lived on the Woodberry Down Estate in Hackney.

2.19 The Metropolitan Police searched crime records from 1995 for references to David. In the period from January 2000 to February 2005 there were six recorded complaints against David for domestic violence against the same unnamed woman. There was also one recorded incident where David was himself the alleged victim of abuse. In each case the complainant withdrew their allegations or declined further assistance to the police so that criminal proceedings were never commenced.

2.20 On 25 August 2008 David is listed as a witness to an alleged indecent assault of his girlfriend's 4 year old daughter. The Panel believe the girlfriend to be Josie. On 18 January 2012 an allegation of child cruelty was made against him

and Josie on the basis that they had left her two children aged 2 and 7 years alone in a locked car (the children being, at least initially, asleep). Both accepted a police caution. On 5 August 2012 police noted an incident involving David and Josie relating to David demanding to see his child. (The 2 year old was David's son.)

2.21 The Metropolitan Police also had records relating to:

a) searches of David following allegations of drug dealing;

b) an allegation of threats to shoot another man; and

c) an event on 22 March 2011 when David ran into the home of an unknown female alleging that he was being chased. There was concern that he suffered from a mental health problem. A girlfriend confirmed that he suffered from depression and had an appointment for assessment. The date would suggest that the girlfriend at this time was Josie. Police took no further action.

2.22 Hertfordshire Constabulary had details of an incident on 26 October 2011 (subsequently reported to the Metropolitan Police on 27 October 2011) when David is alleged, at Cheshunt swimming pool, to have made threats to shoot his ex-partner Josie's new partner. No prosecution followed even though the complainant alleged that the threats were made at a time when David appeared to be carrying a gun. The complainant was not interviewed by Hertfordshire Constabulary until 9 November, and David was not interviewed until 29 November when he voluntarily attended a Hertfordshire Constabulary police station following a note left by police officers at his address on 18 November. The police had attended that address on 18 November with the intention of arresting David but in his absence took no further steps to see him until he attended the police station 11 days later. David was not then arrested and in interview he denied making threats to kill. A Detective Sergeant subsequently decided there was insufficient evidence to proceed on the basis that the alleged incident was one person's word against that of another. The Hertfordshire Constabulary IMR Report writer is critical of the handing of this allegation. It is helpful to note that the IMR author stated:

"There is no entry on the crime record to suggest that David's address was searched. Bearing in mind the seriousness of the complaint made against David and the fact that the threats were alleged to have been reinforced with the use of a firearm, David should have been arrested. This would have allowed the police to carry out a search for the weapon. Although by this time it was unlikely that a firearm would have been found, had it been, it would have provided evidence against David who would have received a lengthy prison term. This was a missed opportunity."

Background Information on the Relationship between Gemma and David

2.23 Both Gemma's mother and David's uncle, in their statements to police, have stated that the relationship between Gemma and David went back about two years before their deaths. If correct, that would be to Autumn 2011, but the relationship may have been of slightly shorter duration. In the meeting with the initial Chair of this Panel, Gemma's mother and aunt thought that the relationship might have started in about December 2011

2.24 David's uncle stated that Gemma and David met through a friend of Gemma's who lived close to David and his partner at that time, Josie. The inference is that Gemma met David at her friend's home. David's uncle further stated that they formed a relationship and that Josie, who had been trying to end their relationship for some time, finally left David once she had found David and Gemma together.

2.25 David's uncle further stated that David, owing rent money on the flat where he lived, moved in with Gemma at her flat in Waltham Abbey. He believed that their relationship was initially a good one and that Gemma was fond of David. That view is supported by Gemma's mother who had no initial complaints or concerns about the relationship. Indeed she never suspected David of being violent towards or threatening violence towards her daughter. David would call her "Mum*"* and she was entirely content about that. She did however say that David was *"*a naughty boy who did naughty things to naughty boys*".* Gemma's aunt was also untroubled about the relationship and she did not consider that there were any dangers for Gemma.

2.26 Gemma's mother did however say in the meeting that she witnessed an argument between Gemma and David in a car during Christmas 2012, as a result of David going off with one of his ex-partners, and that Gemma had said it was *"*driving her nuts*".* On other occasions Gemma would ring her mother during the night and complain that *"he is doing my brain in".* Her mother felt that the relationship began to become strained around 7 months before Gemma's death (i.e. about April/May 2013). She recalled witnessing an argument between Gemma and David after which David had said that he would never hurt Gemma in a million years.

2.27 Gemma's mother made no reference to any of the events involving David and Hertfordshire Constabulary during the period 2011- 2013. She was seen by the initial Chair in December, this being before Hertfordshire Constabulary made their later disclosures, so was not directly asked about those events.

2.28 David's uncle stated that Gemma knew that David was trying to stop taking crack cocaine, and that she took him to a clinic in Edmonton. That clinic has now been traced by the Panel and is known as 'Compass Enfield'. It is an integrated drug and alcohol service for adults. They were asked for information and sent a report stating that David attended the clinic, with Gemma, in February 2013, where initial assessments took place. A further appointment was arranged for later that month, but David failed to attend and did not respond to telephone calls. Since David had not provided an address,

Compass Enfield was unable to make contact with him and it closed its file in April 2013.

2.29 In his statement to police made on 20 October 2013, after the death of Gemma, David's uncle said: "*About six months ago I became aware that the relationship had started to break down. Gemma started to get fed up with David's drug taking, he was always stealing from her, she was frequently lending him money that was not paid back. David stole her jewellery and money from the flat and it got to the point towards the end of the relationship where Gemma was considering moving out into hotel accommodation*."

2.30 David's uncle described in his statement to the police a number of occasions where he witnessed David's increasingly erratic and violent behaviour that appeared to be linked to his drug habit. He recalled how David always said he would seek assistance with his drug addiction after his violent incidents but after he had calmed down, he would forget about his problem and try to hide it from everyone.

2.31 His uncle disclosed that, when David was living with Josie, he had seen Josie with bruising to her face. David had admitted to him that he had hit Josie, but when questioned, David seemed almost quite proud that he had not hit Josie for a couple of months. David's uncle did not discuss Josie's injuries as he found it difficult to raise the subject with her.

2.32 Both David's uncle and Gemma's mother described how the relationship between the two was volatile and Gemma's mother noted in her statement: *"The relationship with David was volatile and had its moments, there were arguments and I would sometimes get called to the flat by Gemma to assist in getting David to leave, not that she couldn't deal with him herself, but she found him frustrating as he wouldn't listen to her. I would talk to him, his uncle would talk to him over the phone and get to him to calm down and eventually leave."*

2.33 In the conversation with the initial Chair both his mother and aunt said that they had never seen David in a drug-induced state. Neither was aware of David's drug-related incident in late April 2013.

2.34 On 30 March 2013 Gemma made a 999 call to Essex Police reporting domestic abuse at her Waltham Abbey address. She told the emergency operator that her partner David was going 'crazy'. Police officers attended the incident but found the premises empty. However, they did note blood on the stairwell and confirmed with neighbours that the couple had left in a vehicle. A check of the local hospitals was made but no one fitting their description had been admitted. Gemma was located and she returned home where she was interviewed by police officers. Gemma was uninjured and refused to disclose where David had been taken, and asserted she was not a victim of crime. She also refused to provide details for a DV/1 assessment and signed a police officer's pocket book to that effect.

2.35 However, a DV/1 assessment was completed by the officers and signed off by a supervisor; this was risk assessed as 'Medium' due to a lack of information.

Details of the incident were placed on the PROTECT database and Gemma was contacted by a member of the DAST team. It was noted that Gemma appeared hostile and she stated that everything was okay and refused to disclose the identity of her current partner.

2.36 The copy of the Domestic Incident Log, circulated to the Review Panel, confirmed most of the above chronology. It gave a Waltham Cross address for David where he had previously lived with Josie. Gemma was subsequently telephoned by police on 5 April 2013. She would not give the name of her partner and the DV/1 assessment form records that she said she didn't feel she needed any help or advice from police.

2.37 The East of England Ambulance Service has a record of a 999 call made from Gemma's address at 04:56 on 31 March 2013 from a male losing blood. Their record sets out: *"Adult male triaged in control room. Patient not seen by ambulance staff."* No other medical information has been supplied to the Panel about that event. If David did go to hospital it has not been possible to establish which hospital.

2.38 Gemma's mother and aunt became aware of the 30 March incident on the following day. They understood from Gemma that she was trying to stop David from going after someone. Gemma had said that he was in a frenzied state but she did not feel under threat herself.

2.39 The Panel has been advised that David attended the Accident and Emergency Department at North Middlesex University Hospital on 30 April 2013. The hospital record indicates that David was brought to the hospital by ambulance on that day at 20:33. It was noted that he had been at a restaurant where he tried to enter the kitchen of the restaurant. He was removed from the kitchen by the staff and the police contacted. Prior to this he had (allegedly) smoked £20 worth of crack cocaine. He was admitted to the ward with drug-induced chest pain. The diagnosis at the time was cocaine induced rhabdomyolysis (renal impairment) and NSTEMI (cardiac anomaly). He was on the ward for 7 days and was seen and treated by the renal, cardiac and medical teams. It appears that on 6 May 2013 there was an abnormality with an ECG and it was subsequently requested by the Heart Hospital (UCLH) that David be transferred there by ambulance under blue lights. David was discharged into the care of the Heart Hospital. There is no mention of counselling within hospital records, although he was advised to cease or cut down on his drug use.

2.40 Enquiries to the London Ambulance Service as to whether they took David to hospital remain unanswered. With difficulty, and following the assistance of the Hertfordshire Constabulary, the Metropolitan Police DHR Panel member has discovered that the Metropolitan Police had requested that an ambulance take David to hospital but the officers concerned did not record their actions in a formal report. The Metropolitan Police Panel member has now been able to determine that at 18:28 on 30 April 2013 a female at a kiosk rang the police to say that a male had jumped behind a counter and picked up a knife. No further details were provided. The first call was at 18.28 and at 18.35 the police arrived

and spoke to the male who had earlier caused trouble on a bus. The police called for an ambulance as they believed the male had taken drugs, that he had mental health issues and was acting in an unusual manner. By 19.15 they had called several times again for an ambulance and reported that the male was vomiting. At 19:30 an ambulance from another part of London was sent to the location, arriving at 19:46.

2.41 Police were with David for one hour and twenty minutes. During this period no details were taken of David and a MERLIN Report (a Metropolitan Police database that stores information in children and adults at risk who have become known to the Police for any reason) was not completed. MERLIN was introduced in April 2013 and is not just an intelligence report, but also an 'adult coming to notice' report.

2.42 University College London Hospital (UCLH) has a record stating that David had a one night in-patient stay on 6 May 2013. Their records state that the medical reason for David's in-patient stay was chest pain potentially caused by cocaine use. A cardiac angiogram was performed and post-procedure David was discharged from the hospital, advised to stop using cocaine and to see his GP if he had any problems. The registered address of David was given as Waltham Abbey, Essex. If there was any consideration as to whether David's dugs abuse posed a danger to others, then that consideration is not recorded.

2.43 Whilst Hertfordshire Constabulary have no records that connect David in any way with Gemma, they dealt with David once in 2011 and on numerous occasions during the summer of 2013.

2.44 On 22 July 2013, Kirsty, a female well known to Hertfordshire Constabulary because of her regular contacts and complaints to the police, telephoned to say that a man, David, had taken a knife from her address three or four days previously. David had previously lived nearby with his former partner Josie. Kirsty also complained that David had smoked something at her address causing his behaviour to become erratic. Because of the events that are described in the following paragraph, police were unable to visit Kirsty until the following day, when she was not present. A number of attempts were made by Hertfordshire Constabulary to arrange an interview date with her, but due to frequent changes to the arrangements made by Kirsty, she was not interviewed until 26 July, by which time David had been arrested for the offences described in the next paragraph.

2.45 Later on 22 July 2013 officers of Hertfordshire Constabulary attended a kebab shop in Waltham Cross following a telephoned complaint that a man (later identified as David) had stolen a knife from the shop and was holding it against a girl. Kirsty also contacted the Hertfordshire Constabulary control room advising them that a male had his arms round a girl who was screaming. Kirsty described the male but stated untruthfully that she did not know his surname. The girl was not co-operative with police when they attended at the kebab shop, but police were then told that David had followed a man into an off licence and had struck that man with a piece of metal. Police, on seeing David, were of the

view that he was “high” on something and in a later interview David admitted smoking crack cocaine. David was arrested and taken to Hoddesdon Police Station and there charged with Assault Occasioning Actual Bodily Harm (the assault on the man), theft of a knife and possessing an offensive weapon. He was released on bail to appear at court in September 2013. A condition of bail was that he was not to go to a specified street in Waltham Cross, Hertfordshire. He gave his address as being in Waltham Abbey, but it appears that Hertfordshire Constabulary made no enquiry as to who else might live at that address and nor did they liaise with Essex Police regarding this address. It was Gemma’s address.

2.46 On 29 August 2013 Hertfordshire Constabulary were again called to Kirsty’s address. David was there. Police officers considered him to be under the influence of drugs. A drugs search did not result in drugs being found and the police officers took David by car to Waltham Cross High Street where they dropped him off. If the police had made appropriate enquiries of the PNC they would have found that David was in breach of extant bail conditions by being in the street referred to in paragraph 2.48, where Kirsty also resided, and the Panel notes that this breach should have resulted in David’s arrest.

2.47 On 31 August 2013 Kirsty again contacted police to say that David was at her address and frightening her. Police made a number of attempts to interview Kirsty, but just as in the incident set out above, Kirsty frequently changed arrangements. By the time Kirsty offered a date for the interview, officers were not able to attend because of their being required at a serious traffic incident. Again it was not recognised that David, in attending Kirsty’s address, was in breach of extant bail conditions. He could have been arrested for breach of that bail condition.

2.48 On 18 September 2013, for the events in the evening of 22 July 2013, David pleaded guilty at North and East Hertfordshire Magistrates’ Court to a lesser charge than occasioning Actual Bodily Harm, namely Common Assault, and to theft of a knife. Despite enquiry by the Panel Administrator, it is not known whether the magistrates were made aware of David’s alleged drugs condition on the night of his arrest, although the Hertfordshire Constabulary are satisfied that this information was provided to the CPS. No custodial sentence was imposed, but David received a fine of £338. David had made no payment to the Court prior to his death.

2.49 On 4 and 5 October 2013 Kirsty again complained to Hertfordshire Constabulary that David was bothering her. David was not then on bail and so not in breach of any bail condition. There was no offence on either occasion for which David could have been arrested, and indeed police were more concerned about Kirsty’s condition than they were with David. Kirsty again contacted the police control room asking for a Sergeant to contact her after she had slammed her door in the faces of the officers who had attended and refused to let them enter. Kirsty terminated a further call from a Sergeant in the control room. The control room returned her call advising her an officer would contact her in the

morning. On 6 October, Kirsty was again contacted and the police incident log states:

"*Kirsty is not making a formal complaint, neither was she making a complaint against David. She was not happy with the way she was spoken to"*.

Despite this complaint, the Hertfordshire Constabulary IMR states that in their view, despite the issues which existed between Kirsty and the force, they always treated her with a *"level of respect and dignity."*

2.50 It is in relation to Kirsty that the Hertfordshire Constabulary IMR makes a recommendation that:

"*A reminder is published force wide for the requirement to refer vulnerable adults who fall outside that of criminal neglect to Health and Community Services".*

The following day, David killed Gemma. It appears that Hertfordshire Constabulary did not consider whether anyone other than Kirsty was at risk through David's consistent abuse of drugs.

2.51 On the weekend prior to her death Gemma was spending time in a London hotel, with Donald, a former boyfriend. In a statement to Essex Police, a female friend of Gemma stated that prior to leaving the hotel on 6 October 2013, Gemma had received a telephone call from David, and that Gemma later sent a text to her informing her that she had told David of this new relationship. In Donald's view, Gemma was not in danger and he received another text from Gemma later that same day.

2.52 Another of Gemma's female friends, in a statement to Essex Police, stated that she had received a text from Gemma, and a different female friend had received a telephone call when Gemma had indicated that she was trying to sort matters out. No-one else subsequently saw Gemma alive, and her body was discovered in her flat the following day.

Gemma's Property

2.53 Her mother disclosed in her conversation with the initial Chair that Gemma had given David money, that she had a number of different bank accounts and would let David borrow bank cards. Her mother and aunt both believed that David had stolen from Gemma, including a watch and the wedding ring of Gemma's grandmother. Her mother said that if Gemma had discovered the loss of the ring she would have been extremely upset. They had discovered, after Gemma's death, that a lot of her jewellery was missing and there was no money found in her flat. They said that Gemma usually kept a lot of money in her flat though she had started taking money to her aunt's home for safekeeping from about May/June 2013. This was also confirmed to be the case by Gemma's female friends. After Gemma's death, her mother and aunt found some photographs of other men associated with her, including Donald, her final boyfriend. These photographs had the faces burnt out, and had then been replaced back in their original location.

Legal process

2.54 The Inquest took place during the period of the Panel's investigations and concluded that Gemma had been unlawfully killed and that David had subsequently taken his own life.

3. Key Events Analysis

3.1 Appendix C details the key events leading up to the death of Gemma in diagrammatic form.

3.2 The DHR process provided an opportunity to gather and analyse information from a number of different sources. There is always a danger in undertaking such an analysis that conclusions will be drawn with the benefit of hindsight and with the benefit of information not available to people and/or agencies at the time. It appears clear from the evidence that, in the immediate period before Gemma's death, David's drug related behaviour was deteriorating and that Gemma was endeavouring to bring the relationship to an end.

3.3 It is also clear that Gemma felt able to manage the situation herself. Signs that this was the case included not following through with calls to the police, not providing any evidence to support her original concerns and not following through on advice provided to her by relevant agencies in respect of her securing alternative housing.

3.4 Whilst the Metropolitan Police, Hertfordshire Constabulary and Essex Police had themselves various contacts with Gemma, Kirsty and David, it is clear that they were not aware and could not necessarily have known of the involvement of the other police forces with the three individuals. However, with respect to Hertfordshire Constabulary, they accept that opportunities were missed in following through incidents involving David, that might have led to more extensive enquiries and/or obtaining information on David's given address and behaviour in the Essex Police area.

3.5 When David was discharged from UCLH following a drugs-related incident and treatment, no steps were taken by the hospital staff to satisfy themselves that the address to which he was being discharged was satisfactory or whether there were any existing occupants who should be forewarned of the reason for his recent period in hospital. The Panel recognises that such actions may be difficult for hospital staff but nevertheless is of the view that it is an important issue.

3.6 Due to the concerns Gemma had regarding the imminent release from prison of former partners, she made contact with Essex Police and sought rehousing from Epping Forest District Council on a number of occasions. However, although the Council was unable to assist directly with rehousing, it did offer financial and other advice to Gemma to enable her to find alternative accommodation. Gemma failed to take up these offers of assistance and remained at her Waltham Abbey address.

3.7 Gemma's family and friends did not appear to consider David to be a risk to Gemma even though some were clearly aware of his drug habit and

occasionally irrational behaviour. It is therefore perhaps not wholly surprising that Gemma herself, whilst being aware of David's drug habit and behaviour, also did not consider him to be a direct threat to her wellbeing.

3.8 It is not clear whether Gemma was aware of Kirsty in Waltham Cross and that Kirsty had also found it necessary to report David's erratic behaviour to the police. Had Gemma been aware, this might have provided her with an opportunity to review her situation. It is possible that, had the relevant agencies followed through fully on enquiries, the connection between David, Gemma and Kirsty might have become apparent and appropriate advice given or action taken.

3.9 Gemma had made David aware of her rekindling of a former relationship with Donald. Gemma was aware that David was seeing other women and therefore clearly saw her relationship with him as being over. However, she allowed him to stay on at her Waltham Abbey flat because he had nowhere else to go at that time. Information from her mother and a female friend, strongly suggests that whilst David was aware of Gemma's decision, he was unable or unwilling to accept the position and continued to press the relationship since he saw Gemma as his provider of shelter and money.

4. Lessons Learnt

Essex Police

4.1 The Essex Police IMR clearly sets out the various contacts between them, Gemma and David over an extended period of time. Their contact with David is limited to one arrest for a breach of bail conditions. Whilst their contact with Gemma was more extensive, including events prior to her relationship with David, it is clear that she frequently failed to follow through with complaints made to them, or failed to provide information to Essex Police regarding the behaviour of David.

4.2 Essex Police have made amendments to their domestic violence protocols following previous incidents and they have concluded that following their detailed review of this homicide, no further recommendations for changes in procedure are required.

4.3 However, the Panel did note that Essex Police assessed Gemma's risk as "medium", based upon the fact that, although at risk, she failed to co-operate with police enquiries and to provide further information regarding her relationship with David. Whilst there is no evidence to suggest that this overall assessment was in error, the Panel is concerned that a pattern of regular calls to the police, followed by regular non co-operation, could indicate an underlying risk to the person making the calls. For this reason, the Panel is of the view that in such cases, the assessment outcome should properly reflect that failure to co-operate or provide further information and suggests that should this become the norm in their dealings with an individual, this should trigger deeper enquiries into possible issues of concern.

Epping Forest District Council Housing Service (EFDCHS)

4.4 The EFDCHS IMR clearly sets out the contact with Gemma between July 2008, this being the first MARAC referral, and her death in October 2013. As indicated earlier in the report Gemma was offered a range of assistance, albeit falling short of her request to be moved into Council accommodation. In all instances she declined the assistance being offered which ranged from the provision of accommodation in a refuge to the provision of financial assistance in finding alternative accommodation in the private sector. In November 2010 she also declined the offer of a further referral to a MARAC.

4.5 The IMR recommends that in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence, and that advice and assistance has been refused by that person, then such cases should be referred back to the MARAC. Whilst the Panel understands this recommendation, it does not reflect how the MARAC process operates. However, the Council's Homelessness Prevention Team has subsequently confirmed that the correct referral channel in such circumstances is to the Essex Police Central Referral Unit (CRU) and they have changed their procedures accordingly.

4.6 Furthermore, the Housing Service appears not to have made any enquiries of Gemma as to the identities of the men she alleged threatened or abused her.

Metropolitan Police

4.7 The Metropolitan Police had no involvement in the murder enquiry. They were requested to complete an IMR on the basis that both Gemma and David had various connections with the Metropolitan Police area and therefore the police may have held information relating to either or both of them.

4.8 Both Gemma and David were known to the Metropolitan Police, but this information was not related in any way to the relationship between them. In particular, David was involved in a number of incidents involving his then partner(s) and their associated children. He was also implicated in drug-related matters. The Metropolitan Police were never involved in any matters relating to Gemma and David as a couple.

4.9 However, there was an event in April 2013 when the Metropolitan Police were involved with David during what was a drug-induced incident. This resulted in David being taken by ambulance and admitted to hospital for treatment. Although not directly related to the eventual death of Gemma, it is worth recording that, subsequent to the receipt of the IMR, the Metropolitan Police have accepted that the manner in which this incident was recorded, in that the MERLIN police record was not generated with the event, fell below the standards required, and steps have been taken by the Metropolitan Police to make officers aware of the system and to remind them of their responsibilities in this regard.

4.10 Irrespective of the actions set out in paragraph 4.9 above, the Metropolitan Police have not identified any issues directly relating to this Review and have

therefore not made any recommendations. The Panel agrees with that overall assessment.

Sun Street Surgery, Waltham Abbey

4.11 Gemma was a patient at this surgery until it closed in July 2009. There are records in respect of Gemma reporting to the surgery that she was in a violent relationship. She was offered counselling but did not attend appointments. Gemma was also treated for depression. Given the context of the time period leading up to the closure of the surgery in mid 2009, there was no DASH risk assessment, but there is nothing to suggest that Gemma's health and related needs were not properly assessed or managed by the surgery.

4.12 Given that the surgery closed in mid 2009, there are no lessons to be learned.

Market Square Surgery, Waltham Abbey

4.13 Gemma was registered with this surgery from 13 December 2010 until her death. Gemma expressed her concerns to her GP regarding violent relationships and the imminent release of a former (violent) partner from prison. Gemma was repeatedly offered counselling, which she either refused or, when appointments were made, failed to attend. Gemma's last appointment was in June 2013 when she was diagnosed as being in "a depressed mood". No reference was made to domestic violence at that last appointment.

4.14 Reports of domestic violence are all read by a GP before being entered into the patient record. However, they do not display as "flagged' within the computerised system, as some other issues do. Therefore, upon initial screening of the electronic record, issues of domestic violence are not prominently displayed.

4.15 The practice is of the view that it did all it could in treating and advising Gemma and that her death could not have been foreseen. The Practice has however identified a need for the electronic record to display an icon that flags up issues of potential domestic violence. The Practice Manager is exploring ways in which that might be achieved. The Panel is of the view that this is a potential issue for all GP practices.

4.16 The Practice has also identified a benefit in having access to specialist domestic violence services as soon as someone discloses this as a potential issue. However, the Panel is surprised by this comment, since services were available (and remain available) whereby GP practices can gain access to advice in relation to domestic violence and related matters.

4.17 The Panel also notes that subsequent to their involvement in the DHR, the Practice now has a worker from Safer Places working with them as part of the "Daisy GP Service". The Daisy GP Service operates as part of the wider Daisy Mesh service, which is provided by Safer Places in West Essex. Daisy Mesh is a network of specialist domestic abuse practitioners who work within Accident & Emergency and Maternity Services at Princess Alexandra Hospital, Harlow and with GP practices. The Daisy GP service provides training to GP practice staff to raise their awareness and confidence in questioning their patients about

abuse and how then to refer to Daisy and work with the service to support their patients' safety and wellbeing. As part of the Daisy Mesh, the Daisy GP practitioner will follow up and liaise with practices where a victim has disclosed abuse to hospital staff to ensure that victims do not slip through the net and GPs are as well informed as possible. When a victim discloses to a health professional within primary care, they can put the victim in touch with Daisy at once by making a call and passing the phone to the patient who can then arrange a meeting with Daisy. Daisy will then meet with the client, undertake a needs and risk assessment, put immediate safety plans in place if required, refer to MARAC and liaise with the GP practice, ensuring they are fully aware and able to play their part in supporting their patient. As well as being better able to support patients who are victims of domestic abuse, GPs are also better able to manage the treatment of perpetrators who are often also registered with them.

Hertfordshire Constabulary

4.18 Hertfordshire Constabulary, when originally approached, responded that they held little relevant information pertaining to Gemma and David. On this basis the Panel concluded that a formal IMR would not be required. However, it later became clear that David had indeed had significant contact with Hertfordshire Constabulary and they were therefore requested to reconsider their original response to the scoping exercise, at which point they disclosed 6 incidents of threatening behaviour by David dating from mid July 2011. Based upon this information, the initial Panel Chair concluded that a formal IMR should be sought from Hertfordshire Constabulary.

4.19 When Hertfordshire Constabulary were asked to explain this change in position, they responded that the initial scoping exercise had been undertaken by a civilian employee rather than by an officer in the Police Community Safety Unit. This resulted in the initial record search being inadequate. Hertfordshire Constabulary have recognised this oversight and have stated that relevant officers have been made aware of the importance of accuracy and additional training has been provided.

4.20 Hertfordshire Constabulary have also recognised a number of shortcomings in their dealings with David and to a lesser extent with Kirsty. They accepted in their IMR that a number of opportunities were missed to deal more appropriately with David, especially in respect of the firearms incident and their failure at a later incident to check the PNC. Whilst it is most unlikely that alternative actions would have in any way have prevented the death of Gemma, Hertfordshire Constabulary have recognised that their officers' actions fell below the expected standard

North Middlesex and University College Hospitals

4.21 Based upon the information received from the scoping exercise, neither hospital was requested to submit a formal IMR. However, the information received regarding David's treatment at these hospitals raises some issues. The Panel comments upon this within its conclusions and recommendations.

London Ambulance Service

4.22 The London Ambulance Service failed to respond to any requests for information. The Panel comments upon this within its conclusions and recommendations.

5. Conclusions

5.1 The Review Panel, after a careful and thorough consideration of the information presented to it, is of the view that the death of Gemma could not have been reasonably foreseen or prevented by any agency or individual. However, the Panel does draw a number of conclusions from its review, upon which its recommendations in Part 6 of the Review Report are based:

5.2 The Panel has concluded that:

a) it is clear from the information provided in the Hertfordshire Constabulary IMR that Kirsty, who was well known to them, should have received greater consideration as a potentially vulnerable adult and been referred to specialist agencies accordingly. Instead, it appears to the Panel that because she was well known to Hertfordshire Constabulary and sometimes very difficult to deal with, her complaints were perhaps not always dealt with in the most appropriate manner. This conclusion is further emphasised by Hertfordshire Constabulary's knowledge of David, his alleged drug taking and irrational behaviour, and the obvious relationship/friendship that existed between him and Kirsty;

b) Hertfordshire Constabulary missed two opportunities to deal with David more robustly, these being an incident involving the alleged use of a firearm and a later failure to access the PNC resulting in him being transported back to an area where he was in breach of his then extant bail conditions;

c) regrettably, Gemma failed to recognise the risks to her arising from David's drug taking and increasingly irrational and violent behaviour. This was despite the fact that she was clearly aware of David's drug habit and had tried to assist him in dealing with it. Furthermore, the Panel has concluded that Gemma failed to engage fully with the specialist services/agencies offered and available to her, including a refusal to accept the advice and assistance offered to her. The Panel is of the view that this seriously increased the risk of her becoming a victim of serious domestic violence. In reaching this conclusion, the Panel has taken into account the fact that the information Gemma provided to the relevant authorities in order to obtain a range of benefits was not true, given that she was in employment and her flat was occupied by a person (or persons) in addition to herself. The Panel is also aware that during this period her brother was seeking early release from prison on the basis of being able to reside at her address. The Panel believes that these factors may well have influenced her decision making in providing

accurate information to, and considering the various options offered to her by, agencies in a position to assist her;

d) the Panel's request for information and IMRs from some agencies was not afforded the importance and priority required. Furthermore, the Panel has concluded that when information is requested by a DHR Panel, that information should be compiled by someone with appropriate skills and the final document should be 'signed off' by an officer of appropriate seniority;

e) the Panel's investigative activities were seriously compromised by the refusal of some agencies and organisations to engage in any way with the Review Panel and respond to requests for information;

f) the Panel's investigative activities were potentially compromised by its inability to be able to access witness statements provided to Essex Police as part of their investigation into Gemma's death, without the consent of the statement provider; and

g) there should be improved communication between police Senior Investigating Officers (SIO) and DHR Chairs to ensure that all available information is shared, thus enabling Coroners to be fully aware of an on-going Domestic Homicide Review and any assistance that the Panel Chair may be able to provide to the Coroner.

6. Recommendations arising from this Review

Recommendations from Individual Agencies

The recommendations that follow are taken from the Individual Management Reviews received from the relevant agencies.

Epping Forest District Council Housing Service:

6.1 That, in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence and that advice and assistance has been refused by that person, then such cases should be referred back to the Multi-Agency Risk Assessment Conference (MARAC) and if appropriate the named officer within the Essex Police Domestic Violence Team.

6.2 The Panel has been made aware that the Housing Service has subsequently concluded that this recommendation does not accord with good practice and has amended its recommendation to the following:

That, in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence and that advice and assistance has been refused by that person, that such cases be referred back to the Essex Police Central Referral Unit.

Market Square Surgery, Waltham Abbey:

6.3 That patients' computerised records be enabled to display a prominent icon ('flag') on the front page to enable a GP or health professional accessing the record to be immediately aware of domestic violence issues; and

6.4 That the practice to be able more easily to access specialist domestic violence agencies.

Hertfordshire Constabulary:

6.5 That a reminder is published force wide for the requirement to refer vulnerable adults who fall outside that of criminal neglect to Health and Community Services.

Recommendations from the Review Panel

The recommendations that follow are those of the Review Panel and upon which the Action Plan set out in Appendix B is formulated.

6.6 The recommendations of the individual agencies should be noted and agreed, with the following additional comments/recommendations:

Essex Police:

6.6.1 That when undertaking a Domestic Violence Assessment, additional weight should be given to alleged victims who are considered to be uncooperative, whereby additional detailed enquiries are made where persons refuse to engage over an extended period of time.

Metropolitan Police:

6.6.2 To ensure that all officers are aware of the need to fully report into the police MERLIN systems all relevant incidents attended to that involve any vulnerable adult, to ensure that records in respect of individuals with whom the police have interacted are complete in all respects and shared with relevant health and support agencies.

Hertfordshire Constabulary:

6.6.3 That Hertfordshire Constabulary should formally remind all staff, via email and internal newsletters, of the importance of carrying out PNC and other information checks when dealing with all individuals, including cases where they are already (well) known to the police, to ensure that all staff react appropriately. This requirement/reminder should also be reinforced as part of the initial training of officers.

Home Office, Justice Ministry and Department of Health:

6.6.4 That the Home Office remind all agencies likely to be contacted in respect of domestic homicide matters of the roles and responsibilities of a Domestic Homicide Review Panel, and those agencies be required to respond in good time to requests for initial scoping information and Individual Management Reviews.

6.6.5 That, further to the recommendation in paragraph 6.6.4 above, the Home Office remind those same agencies of the importance of completing initial scoping information and Individual Management Reviews, being undertaken by suitably qualified and competent staff, and that before submission the information is reviewed and authorised by an officer of appropriate seniority.

6.6.6 That the Department of Health seeks the views of hospital authorities on the practicability of making enquiries of patients of their home/domestic circumstances before discharging patients with known drug and violent tendencies, and to inform relevant agencies accordingly.

6.6.7 That the Department of Health informs GP practices of the benefits of computerised patient records displaying a 'flag' or icon on the front page of the patient record enabling incidences of domestic violence to be clearly visible to a GP or other health professional.

6.6.8 That the Department of Health recommend GP practices to take steps to ensure that all relevant staff are fully aware of specialist domestic violence agencies and services which are available in their respective areas.

6.6.9 That the Ministry of Justice and/or Home Office consider reminding police forces of the importance and benefit of police Senior Investigating Officers (SIOs) maintaining close contact with the Chair of a Domestic Homicide Review Panel when investigating a death believed to be the result of domestic violence, with a particular requirement to ensure that Her Majesty's Coroners are aware of the establishment of a DHR; and

6.6.10 The Ministry of Justice/Home Office review the rules pertaining to the release of statements made to the police as part of homicide investigations to Domestic Homicide Review Panels..

Appendix A – Participation in the Review

1. The following agencies and organisations were sent scoping requests to determine whether they held information relevant to the Review Panel's enquiries:

Adults Health & Wellbeing Essex County Council

Anglian Community Enterprise - Community Interest Company (ACE CIC)

Barnet & Chase Farm, Hospital NHS Trust

Barton House Group Practice, Stoke Newington

Basildon Borough Council

Basildon & Thurrock University Hospital NHS Foundation Trust

Basildon Women's Aid

Braintree District Council

Brentwood District Council

Broxbourne Borough Council

CAFCASS (Children and Family Court Advisory and Support Service)

Castle Point District Council

Central Essex Community Services

Chelmsford City Council

Chelmsford Prison Service

City & Hackney Clinical Commissioning Group

Colchester Borough Council

Colchester Hospital University NHS Foundation Trust

Community Drug & Alcohol Service

Compass Enfield (Integrated drug and alcohol treatment service)

Crown Prosecution Service

Director of Children's Safeguarding Specialist Services Essex County Council

Director of Health and Community Services

East of England Ambulance Service NHS Trust

East & North Herts Clinical Commissioning Group

Epping Forest District Council

Essex & Hertfordshire Victim Support

Essex County Council Public Health

Essex Police

Essex Probation Trust

Hackney Council

Harlow District Council

Hertfordshire & South Midlands Area Team NHS England

Hertfordshire Probation Trust

Hertfordshire Constabulary

Hertfordshire Partnership Foundation Trust

IDVA Service - Victim Support Essex

London Probation Service

Maldon District Council

Met Police Critical Incidents Advisory Team

Mid Essex Hospital Services NHS Trust

NHS Basildon and Brentwood Clinical Commissioning Group

NHS England Area Team covering Herts

NHS North Essex

NHS South Essex

NHS Herts

North East London Foundation Trust (NELFT)

North Essex Partnership NHS Foundation Trust

North Middlesex Hospital

Open Road Essex

Princess Alexandra Hospital

Refuge (Richmond)

Rochford District Council

Schools, Children and Families Essex County Council

South Essex Rape and Incest Crisis Centre (SERICC)

Southend on Sea Borough Council

South Essex Partnership Trust

Tendring District Council

Thurrock Council

University College Hospital London

Uttlesford District Council

Westminster Drug Project - Essex Inside Out

West Essex Clinical Commissioning Group

Whipps Cross Hospital

2. Agencies were asked to give chronological accounts of their contact with the victim or the perpetrator prior to the victim's death. Where there was no involvement, or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family;
- What was done or agreed;
- Whether internal procedures were followed; and
- Conclusions and recommendations from the agency's point of view.

3. The accounts of involvement with the victim and perpetrator cover different periods of time prior to the victim's death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

4. In total, 42 agencies responded with a 'nil return' having had no contact with either the victim or the perpetrator.

5. The following agencies responded with information indicating some level of involvement with the victim or the perpetrator:

Adults Health & Wellbeing - Essex County Council

Information supplied:

Records relating to Gemma, albeit with slightly different spelling, but with the same date of birth; contact made to general County Council contact numbers made between 1990-1998, all logged as general requests for information. No other records on the SWIFT system and no recorded involvements.

Date information supplied:

November 2013

Last contact with this agency:

1998

Relevance:

No relevance Records outside the scope of the Review

Barnet & Chase Farm Hospital

Information supplied:

David attended the A & E Dept. of the Hospital regarding an Ear, Nose and Throat (ENT) related issue and attended a further Out Patients' appointment.

Date information supplied:

13 November 2013

Last contact with this agency:

October 2009

Relevance:

Information is not relevant to the Review.

Barton House Group GP Practice

Information supplied:

David was a registered patient of this practice and the practice provided a summary of his record entries.

Date information supplied:

14 November 2103

Last contact with this agency:

It appears from David's records that he last attended the practice in August 2005. Records after this period are notifications from Chase Farm Hospital where he received treatment for tonsillitis and Lister Hospital where he was seen in February 2012 after a deliberate overdose.

Relevance:

David had very little engagement with his GP Practice and they would not have been able to follow up any of the notifications sent by the two hospitals as they were not aware of where David was living on each occasion.

Broxbourne Borough Council

Information supplied:

Details of a Housing and Council Tax benefits claim for Gemma dating back to 2004 in respect of a property at Waltham Cross. Within the claim Gemma indicated she was fleeing domestic abuse from an ex-partner. Additional information was requested by the Council, and despite several reminders, this information was not received and the case was closed in May 2004.

With regard to David the Council advised in 2011 they commenced court proceedings against David and his partner at the time, Josie, with regard to non-payment of council tax. In September 2011 the case was referred to the Council's bailiffs for investigation and recovery. During the period from September 2011 to May 2013 the Council's bailiffs made numerous enquiries and visits to the address in Waltham Cross but were never able to identify effects belonging to the debtors. In July 2013 the Council was made aware that David had been traced to Gemma's Waltham Abbey address. David was contacted on 23 July 2013 advising him of the outstanding council tax debt and indicating that further action would be taken within 14 days if no payment was received. On the 12 September 2013 the Council referred the case back to their bailiffs with details of the new address.

Date information supplied:

7 November 2013

Last contact with this agency:

September 2013

Relevance:

Gemma made a number of allegations of domestic abuse ranging from 1998 through to 2013 concerning domestic abuse linked to ex-partners. The claim to Broxbourne Borough Council is one of the earliest claims the Panel have identified. However, these allegations fell outside the timescales of the Review.

With regard to David, the information may help to confirm when he left his previous partner, Josie, and began living with Gemma. The Panel are not aware whether the bailiffs had contacted him at Gemma's address.

Children & Family Court Advisory & Support Service (CAFCASS)

Information supplied:

David was known to CAFCASS as a respondent in a section 8 private law application, received on 23 June 2010.

Date information supplied:

29 October 2013

Last contact with this agency:

11 August 210

Relevance:

Identified that David was involved with Family Court proceedings. However, the Panel did not request further information, as there is no provision under the Family Procedure Rules for automatic disclosure of information to DHRs and this permission would have to be sought from the Court. The initial Panel Chair considered that these proceedings were not relevant to the DHR.

Compass Enfield - Fully integrated drug and alcohol treatment service

Information supplied:

Chronology of David's involvement with service.

Date information supplied:

12 December 2013

Last contact with this agency:

7 February 2103

Relevance:

David and Gemma attended an appointment with a Compass worker following assessment by the Independent Assessment Team on 30 January 2013.

Following the initial meeting, further appointments were arranged which David failed to attend. David also failed to respond to phone calls, and as he had registered as no fixed abode the file was closed on 4 April 2013.

East of England Ambulance Service NHS Trust

Information supplied:

Initial response to scoping exercise confirming Ambulance Service response to Gemma's death

Date information supplied:

31 October 2013

Last contact with this agency:

Attendance at the scene of Gemma's death on 7 October 2013 was the Ambulance Service's only contact with the victim. With regard to the perpetrator, the Ambulance Service was called to David's previous property in Waltham Cross on 27 February 2012 when he took a deliberate overdose of medications. David was transported to Queen Elizabeth Hospital, Welwyn Garden City. Ambulance services were called to the victim's property in Waltham Abbey on 31 March 2013 when Gemma reported to the police David was going 'crazy' however, no ambulances were sent and the chronology states the male was triaged via Control room clinical triage.

Relevance:

Not relevant to the events that led to the death of Gemma.

East & North Hertfordshire Clinical Commissioning Group

Information supplied:

Initially a nil return as they had no recorded activity for either Gemma or David in Hertfordshire. However they were able to advise the Panel that in the period David was living in Waltham Cross his two emergency admissions were linked to Gemma's address in Waltham Abbey. Both hospitals involved were outside

of Hertfordshire, at the North Middlesex and University College London. David was not registered with any GP practice in Hertfordshire.

Date information supplied:

1 November 2013

Last contact with this agency:

Not applicable

Relevance:

The information provided allowed the Panel to contact the two hospitals, North Middlesex and University College London, to investigate further.

Epping Forest District Council: Benefits

Information supplied:

Chronology of Housing Benefit Claims.

Date information supplied:

12 November 2013

Last contact with this agency:

In October 2008 a letter was received from Gemma's GP supporting her request for her Housing Benefit to be paid straight to her landlord.

Relevance:

At no point during her claim with Epping Forest District Council did Gemma declare that any other person was residing at her Waltham Abbey address.

Epping Forest District Council: Housing

Information supplied:

Chronology

IMR

IMR Supplementary Report on dealing with complaints

Safer Places Report

Date information supplied:

7 November 2013	Chronology
13 January 2013	IMR
21 January 2013	Safer Places Report
22 January 2014	Supplementary IMR

Last contact with this agency:

6 July 2013

Relevance:

The information supplied by the Housing Service details Gemma's attempts to be rehoused in Epping Forest District. It also included a number of domestic abuse allegations by various partners over the period July 2008 through to July 2014 and what support and information was provided to Gemma. It also highlights that Gemma's description of her lifestyle was at odds with the information provided by her family and friends.

There was clear evidence that Gemma was offered advice about special domestic abuse services and counselling on a number of occasions as well as assistance with joining the Housing Register and seeking alternative accommodation in the private sector. In November 2012 in response to a stage 2 complaint where Gemma disclosed abuse, Gemma was urged to notify the police and to contact the Homelessness Prevention Team. Due to the risks disclosed in the complaint, a Housing Officer was asked to contact Gemma and arrange an appointment.

This was held in November 2010 and the housing advice and assistance provided to Gemma included concerns from the Council about her remaining in the Waltham Abbey or nearby areas for her own personal safety. Gemma was asked to consider a referral to Safer Places, a local specialist domestic abuse service. She was provided with an explanation as to how the Housing Allocations Scheme works and an opportunity to consider the Council's own rental loan scheme. It was also explained to Gemma that a priority move could not be considered in her case as she was not a Council tenant. Gemma was also offered assistance to fast tracking housing benefit and finally, an offer of a fresh MARAC was declined. Unfortunately Gemma was not satisfied with the options or the Council's assistance and left before the Homelessness Prevention Officer could ask for her signed authority to be completed under homelessness prevention procedures.

The Panel also asked for further information on how the Homelessness Team engage and work with Safer Places and they were provided with a breakdown of the working arrangements between the respective agencies.

Essex Police

Information supplied:

Response to initial scoping exercise, providing chronology of Essex Police's involvement with Gemma and David.

IMR dated 6 January 2014

Full report of the critical incident including:

Details of the procedures used by Essex in responding to domestic abuse incidents

Details of the incident during 2013 involving Gemma & David

Incidents with ex-partners

Current Situation Report

Statements from friends and family

Dates information supplied:

30 November 2013	Chronology received
7 January 2014	IMR received
11 December 2013	Current Situation Report
11 December 2013	Statements from friends and family.

Last contact with this agency:

30 March 2013

Relevance:

Within the reporting period Essex Police attended four reports of domestic abuse where Gemma was the reported victim. Only one of those involved David as the perpetrator; the others involved previous partners. Gemma refused to provide clear information to the police officers about the events on all four cases.

In 2009 Gemma did disclose in custody she had been the subject of an abusive relationship in 2008 which had now ended. The information was recorded within the custody record, and Gemma was examined by two health care professionals.

The Panel identified within the Current Situation Report a reference to David from the statement of a neighbour who lived close to his previous address in Waltham Cross. This information included serious allegations against David which had not been previously disclosed by Hertfordshire Constabulary and subsequently an IMR was requested from them.

The Panel was also able to identify, after further investigation, that David and Gemma had voluntarily attended Compass Enfield, a drug and alcohol treatment service, initially for a referral, and that David failed to attend further appointments.

The information provided demonstrated the limited contact between Essex Police, Gemma and David and no additional areas for recommendations were identified.

Hertfordshire County Council - Children's Safeguarding Specialist Services

Information supplied:

Details of a safeguarding incident.

Date information supplied:

20 November 2013

Last contact with this agency:

January 2012

Relevance:

Gemma was not known to this service. David was briefly known to Safeguarding and Specialist Services following a referral from the police, when he and his ex-partner Josie, left their child and his stepdaughter in a car unattended. Another vehicle collided with the car and police were called. An assessment was conducted and it was concluded there were no risks or safeguarding concerns to the children and the case was closed.

Herfordshire County Council: Health & Community (Adults Services)

Information supplied:

Notification that David was recorded on their systems as a relative of a school child.

Date information supplied:

5 November 2013

Last contact with this agency:

Not applicable

Relevance:

Not relevant to the purposes of the Review.

Hertfordshire Constabulary

Information supplied:

Response to initial scoping exercise, providing chronology of Hertfordshire Constabulary's involvement with Gemma and David

After the review of information supplied by Essex Police in their victim statement, Hertfordshire Constabulary were sent a request for further information.

IMR (no date)

Supplementary questions requested by the Review Panel Chair.

Date information supplied:

5 November 2013	Scoping Exercise
22 January 2014	Request for further information
17 February 2014	IMR
28 February 2014	Supplementary Questions response

Last contact with this agency:

5 October 2014

Relevance:

The initial scoping exercise in November 2013 listed three incidents relating to David and no information pertaining to Gemma. On the basis of this initial response, the Panel decided not to request an IMR from Hertfordshire Constabulary or invite them to become a member of the DHR Panel.

After reviewing statements provided to the Panel by Essex Police, the initial Panel Chair requested further information from Hertfordshire Constabulary relating to incidents concerning David, including an alleged incident with a police taser and a number of incidents relating to David visiting Kirsty's address in Waltham Cross. The response received from Hertfordshire Constabulary detailed six further incidents between the period 22 July 2013 and 9 October 2013 that had not been previously disclosed to the Panel. On the basis of the information disclosed, an IMR was requested.

The IMR was received on 17 February 2014 and included an additional incident that occurred on 22 July 2013, but which had not been previously disclosed to the Panel. This incident involved a female and described David running into a fast food restaurant in Waltham Cross, assaulting a male and grabbing a knife, and then running into the street dragging a female along the street in a headlock. Kirsty was present at the incident, but she refused to engage with the police officers who attended. The officers were of the view that David was high on drugs during this incident; he admitted to having smoked 'crack cocaine' earlier but had not been drinking.

On receipt of the IMR from Hertfordshire Constabulary, the initial Chair prepared a list of supplementary questions for the Constabulary. The Chair sought clarification as to what address David give on the three occasions Hertfordshire Constabulary either arrested him, searched him or when he was charged and bailed in September 2013. On each of these occasions David gave his address as being that of the victim Gemma, in Waltham Abbey. The

initial Chair requested confirmation as to whether the police witnessed the assault on 22 July 2013 as detailed above. It was confirmed that the officers who attended the incident did not witness the assault and when they approached the female whom they assumed was involved, she refused to provide any information relating to the incident.

The initial Chair asked if the police had considered whether this female was David's girlfriend and if so whether this incident should have been treated as a domestic incident. The Panel was advised that the female would not engage with the police and there was therefore nothing to suggest this was a domestic incident. The supplementary questions drew attention to the breach of bail conditions and the lack of appropriate PNC checks. The Panel also noted that, when police attended Kirsty's address on 4 October 2013, there was a further failure to carry out PNC checks or to enter his details on the log. This may have been due to the officers attending recognising him from previous incidents.

Hertfordshire Constabulary stated that since they believed David had never been in an intimate relationship with Kirsty and nor were they related, the incidents referred to in the IMR did not fall within the definition of domestic abuse. However, they did accept that David could have been dealt with more robustly on at least two occasions.

Hertfordshire Constabulary identified one recommendation within their IMR, referring to the need to ensure that when vulnerable adults are identified, they are referred through to Social Services.

Hertfordshire Probation

Information supplied:

The Panel originally received a nil response from Hertfordshire Probation but went back to them following the receipt of further information that they may have prepared a social enquiry report on behalf of the Magistrates Court prior to David's conviction for common assault on 18 September 2013. Hertfordshire Probation confirmed that no reports had been prepared.

Date Information supplied:

29 January 2014

Last contact with this agency:

No contact

Relevance:

The Panel was endeavouring to identify whether Magistrates were aware of David's drug use when he appeared before them regarding an alleged assault.

Market Square Surgery

Information supplied:

Chronology

IMR

Date Information supplied:

13 November 2013 Chronology

21 January 2014 IMR

Last contact with this agency:

13 June 2013

Relevance:

Gemma disclosed to her GP on a number of occasions that she was a victim of domestic abuse but she did not name her perpetrator, and it was unclear to the GP practice whether she was the victim of the same perpetrator over a number of years or if there was more than one boyfriend/partner who abused her. At the time of the disclosures the GP checked that Gemma was already in contact with a domestic abuse support worker and she was offered counselling to help with problems associated with her housing condition; however this was declined by Gemma.

In May 2012 Gemma advised the GP she had been offered group counselling by the domestic abuse support services that she was engaging with, although she had requested a referral for one to one counselling, which was facilitated by the GP. A restraining order was also discussed during this appointment. The Panel have been able to find no evidence that Gemma was engaging with a domestic abuse service locally. In June 2013 Gemma failed to attend the counsellor appointment provided by the practice.

The GP practice provided evidence of good record keeping and demonstrated that discussions took place about referring Gemma to specialist domestic abuse services and consideration was given to obtaining a restraining order. Police involvement was recorded and on-going support and advice was provided by the practice.

Metropolitan Police

Information supplied:

Response to initial scoping exercise, providing chronology of Metropolitan Police's involvement with Gemma and David

IMR

Drug testing on arrest Trigger Offences

Incident in restaurant in Metropolitan Police area

Date information supplied:

15 November 2013	Chronology of involvement
14 January 2013	IMR
25 March 2013	Drug Testing on Arrest Trigger Offences
30 April 2013	Incident in London Restaurant

Last contact with this agency:

30 April 2013

Relevance:

The Metropolitan Police had no records of domestic incidents between Gemma and David. There were two reports found for Gemma involving another partner, eight reports for David relating to other previous partners and one concerning a rape allegation. The two incidents relating to Gemma were both with the same partner and in the period 1997-1998. On both occasions Gemma failed to provide a statement and no further action was taken.

David was the subject of eight domestic related incidents involving two previous partners; seven of the incidents were between the period of 2000 and 2005. MARAC referrals were not made for any of these as they occurred before the formation of MARACs. The last two incidents involved David's ex-partner Josie,

one related to the incident where the children were left in the car whilst they went shopping and the other incident was a non-crime incident where they had argued over access to their child.

At the Panel meeting in February 2013 it was disclosed there was a further unreported incident involving David which had occurred on 30 April 2013. A female member of the public made an emergency call to the Police to report an unknown male (David) had jumped in behind a kiosk at the cafe location shouting “murder, murder” and grabbed a knife.

Police officers arrived promptly and an ambulance was called. The CAD noted ‘Male taken drugs, possible mental health issues’. The ambulance was requested at 18:41 but did not arrive until 19:46. David was taken to North Middlesex Hospital. There was no record of David recorded within this CAD and it was information provided by the Herts Constabulary which assisted the Panel member from the Metropolitan Police to uncover this incident.

In 2013 the Metropolitan Police introduced a system whereby any adult coming to their notice who was vulnerable or suffering from any emotional trauma or mental health should have an ‘Adult Coming to Notice’ (ACN) MERLIN report generated. This would ensure the details are shared with partner agencies and where necessary, appropriate action taken to support the person according to their particular needs. The new system rolled out in April 2013 but the officers who dealt with this incident at the time were not aware that MERLIN should have been completed. However, they do so now and the learning has been shared with the Borough Command Unit.

North Essex Partnership NHS Foundation Trust

Information supplied:

Chronology of their involvement with Gemma.

Date information supplied:

7 November 2013

Last contact with this agency:

6 November 2008

Relevance:

The trust had very little involvement with Gemma and none with the perpetrator David. In 2008 they received a letter from Gemma’s GP advising that counselling was needed as Gemma was stressed, that she was in a violent relationship and had moved from her home to stay with her mother. Counselling appointments were offered which Gemma did not attend; she was also written to. On 6 November 2008 Gemma was discharged back to her GP due to non-attendance.

North Middlesex University Hospital NHS Trust

Information supplied:

Chronology of their involvement with David

Date information supplied:

12 November 2013

Last contact with this agency:

30 April 2013

Relevance:

The Trust had involvement on three occasions from November 2007 through to April 2013. The first three occasions David attended Accident and Emergency to report either throat problems or flu like illnesses. In April 2013 David attended Accident and Emergency after an overdose of cocaine and becoming paranoid; David was admitted and remained in hospital for seven days.

Princess Alexandra NHS Trust

Information supplied:

Chronology of their involvement with Gemma.

Date information supplied:

5 November 2013

Last contact with this agency:

January 2005

Relevance:

The Hospital had no contact with David and the information supplied regarding Gemma was not relevant to the Review.

University College London Hospital

Information supplied:

David had a one night inpatient stay at the hospital in May 2013

Date information supplied:

13 November 2013

Last contact with this agency:

November 2013

Relevance:

Information regarding their interaction with the perpetrator.

West Essex Clinical Commissioning Group

Information supplied:

The GP practice Gemma had attended until July 2009 had closed and a Safeguarding Adults Nurse Specialist at West Essex Clinical Commissioning Group (CCG) was nominated to be the author of the IMR. The IMR was completed and approved by West Essex CCG Medical Director.

Date Information received:

14 January 2014

Last contact with this agency:

Not applicable

Relevance:

A review of the patient records confirms the GP practice safely and effectively managed Gemma's health needs. There was clear evidence that Gemma was offered advice about special domestic abuse services and counselling. Gemma was given the opportunity to make an informed choice and she agreed to a referral for counselling but declined to engage with specialist domestic abuse

services. There was clear evidence of a timely response by the GP as the referral was made the next day.

APPENDIX B – Action Plan

Ref	Recommendation	Local / National / Regional	Action	Lead agency)ies)	Key milestones to action recommendation	Target date	Completion date & outcome
6.2	That in the future, where the Council has provided housing advice and assistance to any person experiencing or being threatened with domestic violence and that advice and assistance has been refused by that person, such cases be referred back to the Essex Police Central Referral Unit.	Local	Ensure that agreed revised processes are in place and relevant officers aware of them and actioning them.	Epping Forest District Council Housing Service	Action now integrated within work practices	Completed	January 2014 Action completed.
6.3 and 6.6.7	That patients' computerised records be enabled to display a prominent icon ('flag') on the front page to enable a GP or health professional accessing the record to be immediately aware of domestic violence issues.	Local Regional National	(1) Practice management to engage with software providers to determine the practicability of either changing existing front page icons or adding new. (2) West Essex CCG to provide support to practices in their discussions / negotiations with software providers. (3) The Department of Health communicates with GP practices informing them of the benefits of a "DV icon" clearly being visible as part of any patient electronic record.	(1) GP Practices in the Epping Forest District Council area. (2) West Essex Clinical Commissioning Group. (3) Department of Health.	(1)(2) On the Systmone IT system there are already two methods of addressing this by either adding a Patient Status Marker or adding a reminder to the patient record. Systmone is one of the IT systems used by GP practices in West Essex. Other IT systems have icons or alerts/prompts (pop up messages that disappear or are clicked off) and reminders that can be added to the patient home screen. (3)	Completed	October 2014 The facility to identify known victims of domestic abuse is already available to GP practices.
6.4 and 6.6.8	GP practices to be able to more easily access specialist domestic violence agencies.	Local	(1) All relevant practice staff to be aware and regularly updated on the various domestic violence related services which are available in	(1) GP Practices in the Epping Forest District Council area.	(1)(2) Literature on Domestic Abuse sent out to all GP Practices in West Essex on 10.07.2013. Any relevant updates are routinely emailed	Completed	October 2014 Action completed.

APPENDIX B – Action Plan

Ref	Recommendation	Local / National / Regional	Action	Lead agency)ies)	Key milestones to action recommendation	Target date	Completion date & outcome
			their catchment areas.		to GP Practice Managers.		
		Regional	(2) West Essex CCG to provide support to practices in the West Essex area to enable them to be in receipt of up to date service information.	(2) West Essex Clinical Commissioning Group.	(2) The West Essex Clinical Commissioning Group Adult Safeguarding team works closely with the Epping and Harlow Safer Partnerships and routinely shares the Domestic Abuse Directory with GP Practices through the Practice Managers. The Directory is also available on the WECCG intranet to which every GP Practice has easy access.		
		National	(3) The Department of Health communicates with GP practices reminding them of the importance of them being fully aware and up to date with locally available DV related agencies and services.	(3) Department of Health			
6.5	That a reminder is published force wide for the requirement to refer vulnerable adults who fall outside that of criminal neglect to Health and Community Services.	Local (Hertfordshire Constabulary)	Hertfordshire Constabulary to issue a reminder to all relevant officers of the need to consider whether a person deemed to be vulnerable should be referred to the relevant agency or agencies.	Hertfordshire Constabulary	An e-mail has been sent out to all staff within Hertfordshire Constabulary from the Safeguarding Adults from Abuse unit within Hertfordshire reminding all staff of the importance of referring adults deemed to be vulnerable to the relevant services via the referral form on the intranet or by making a referral directly to the Health and Community Services.	Completed	Completed September 2014. Training is on-going throughout the year and is given to all new recruits upon joining.

APPENDIX B – Action Plan

Ref	Recommendation	Local / National / Regional	Action	Lead agency)ies)	Key milestones to action recommendation	Target date	Completion date & outcome
					Training has also been given to staff regarding the importance of referring potentially vulnerable adults.		
6.6.1	That when undertaking a Domestic Violence Assessment, consideration is given to applying additional weight to victims who appear to be uncooperative. Where practicable, additional detailed enquiries are made where persons refuse to engage over an extended period of time.	Local (Essex Police)	The Essex Police to review their existing DV assessment criteria, such that additional consideration is given to vulnerable persons who make a complaint or complaints but refuse to provide supporting information.	Essex Police	**(Domestic Abuse Action Plan for Essex 2014/15)** As part of the above Action Plan Essex Police will review force policy to ensure that the response grading in domestic abuse cases takes account of threat, risk and harm. The Domestic Abuse Intelligence Team will be reviewed in this context.	January 2015	
6.6.2	To ensure that all officers are aware of the need to fully to report into the police MERLIN systems all relevant incidents attended to that involve any vulnerable adult, to ensure that records in respect of individuals with whom the police have interacted are complete in all respects and shared with relevant health and support agencies..	Local (Metropolitan Police)	To ensure that all officers are aware of the need to fully report into the police MERLIN systems all relevant incidents attended to that involve any vulnerable adult**,** to ensure that records in respect of these individuals with whom the police have interacted are complete in all respects and shared with relevant health and support agencies	Metropolitan Police	MERLIN was a new system and it was determined that the officers involved were not aware of its requirements. Those officers have been spoken to by a senior officer and the Enfield Borough Commander has been made aware.	Completed	March 2014
6.6.3	That the Hertfordshire Constabulary should formally remind all staff, via email and internal newsletters, of the importance of carrying out PNC and other information checks when dealing with all individuals, including when they are well known to the police, to ensure that all staff react	Local (Hertfordshire Constabulary)	Hertfordshire Constabulary to use relevant media and other means to inform and remind all staff of the importance of PNC and other information checks when dealing with incidents. This message to be reinforced in respect of dealing with	Hertfordshire Constabulary	An email has already gone out to all staff regarding the importance of carrying out a PNC check on all occasions. This reminder also incorporated the significance of checking all other available intelligence systems. An	Completed	October 2014. Action complete.

APPENDIX B – Action Plan

Ref	Recommendation	Local / National / Regional	Action	Lead agency)ies)	Key milestones to action recommendation	Target date	Completion date & outcome
	appropriately. This requirement / reminder should also be reinforced as part of the initial training of officers.		persons already known to officers.		update has also been placed on the force intranet as a reminder to all staff.		
6.6.4	That all agencies likely to be contacted in respect of domestic homicide matters be reminded of the roles and responsibilities of a Domestic Homicide Review Panel and be required to respond in good time to requests for scoping information and Individual Management Reviews.	National	The Home Office to formally write to all agencies likely to be contacted by Review Panels undertaking a Domestic Homicide Review, reminding them of the importance of the review process and their need to take requests for scoping information and management reviews seriously and respond as promptly as circumstances permit.	Home Office			
6.6.5	That all relevant agencies be reminded of the importance of completing scoping information and Individual Management Reviews being undertaken by suitably qualified and competent staff and that before submission the information is reviewed and authorised by an officer of appropriate seniority.	National	The Home Office, as part of any communication referred to in 6.7.3, also to remind agencies that scoping information and the contents of IMRs should be assessed and approved by an appropriate senior officer within their organisation before submission to the review panel.	Home Office			
6.6.6	That the Department of Health seeks the views of hospital authorities on the practicability of making enquiries of patients of their home/domestic circumstances before discharging patients with known drug and violent tendencies, and to inform relevant agencies accordingly.	National	The Department of Health to determine the practicability of information being sought from patients who are being discharged following drug or violence related medical intervention, and to make relevant agencies aware if they have concerns regarding the possible risk to persons at the	Department of Health			

APPENDIX B – Action Plan

Ref	Recommendation	Local / National / Regional	Action	Lead agency)ies)	Key milestones to action recommendation	Target date	Completion date & outcome
			patients' declared discharge address.				
6.6.9	That the Ministry of Justice and/or Home Office consider reminding police forces of the importance and benefit of police Senior Investigating Officers (SIOs), maintaining close contact with the Chair of a Domestic Homicide Review Panel when investigating a death believed to be the result of domestic violence, with a particular requirement to ensure that Her Majesty's Coroners are aware of the establishment of a DHR.	National	Government to consider whether all police forces should be requested to ensure that when investigating events which have triggered the establishment of a DHR Panel, the SIO should maintain close liaison with the Chair of that DHR Panel and also ensure that HM Coroners are fully aware of the DHR process.	Ministry of Justice and/or Home Office			
6.6.10	The Ministry of Justice/Home Office review the rules pertaining to the release of statements made to the police as part of homicide investigations to Domestic Homicide Review Panels.	National	The Home Office to review whether all statements provided to the police as part of their investigations into a domestic homicide can be made available to a Review Panel, rather than only those where the consent of the person providing the statement has been given.	Ministry of Justice and/or Home Office			

APPENDIX C – Timeline of events leading to Gemma's death

Date / date Range	David	David and Gemma	Gemma
1997/98	Moved from Jamaica to the UK		Metropolitan Police reported 2 domestic incidents involving the same partner. Gemma failed to follow through or provide further information.
2000 to 2008	Metropolitan Police recorded 6 incidents of domestic violence against the same victim: (1) January 2000 – incident in vehicle (2) September 2000 – assault (3) July 2001 – victim chased along street (4) September 2001 – assault at home (5) April 2004 – fight captured on CCTV (6) February 2005 – damage to victim's property In July 2003, there was an accusation of rape and indecent assault, but the case was discontinued.		Between 2003 and 2007 Essex Police report 2 complaints of domestic violence against her 2 brothers. Moved to Waltham Abbey in 2008
2010			In April 2010 Gemma reported domestic violence involving an ex-partner who was refusing to leave her flat. Essex Police attended and the male left voluntarily. No offences recorded but relevant records updated
2011	In the period to March, the Metropolitan Police record 4 incidences related to drugs and a threat to shoot someone	Late 2011 is the possible start of the relationship between Gemma and David.	In February 2011, Essex Police contacted by Gemma regarding threats from an ex-partner. Police attended but Gemma would not provide details and signed the officer's notebook to that effect. Police completed relevant paperwork (incl. DV/1) and Gemma's risk was assessed as "medium". Gemma was contacted by the DAST but she stated that she was OK and refused to provide any details.
January 2012	Metropolitan Police caution David and his then partner (Josie) for child cruelty.		
February 2012	David treated at the Lister Hospital (Stevenage) for a drugs overdose.		
December 2012		Gemma's mother witnesses an argument between David and Gemma.	
February 2013		David attends Compass Enfield, with Gemma, for drug abuse treatment/counselling.	
March 2013		David's uncle states that by this time the relationship between David and Gemma was deteriorating.	

APPENDIX C – Timeline of events leading to Gemma's death

Date / date Range	David	David and Gemma	Gemma
		The East of England Ambulance Service attend a "999" call from Gemma's Waltham Abbey address regarding a male "losing blood"	
April 2013	Metropolitan Police attend an incident involving David and accompany him to the North Middlesex Hospital (NMH). He remains on a ward for around a week due to drug related breathing and other difficulties.		
May 2013	David transferred from the NMH to University College Hospital (UCLH) where he stays for 1 night. On 7 May 2013 UCLH discharges David to Gemma's Waltham Abbey address.		Gemma's mother states that Gemma has rekindled a relationship with a former partner (Donald) and that Gemma had told David of this new relationship.
July 2013	On 22 July 2013 Kirsty complains to the Hertfordshire Constabulary that David had stolen a knife and was high on drugs. Hertfordshire police officers attend an incident at a kebab shop involving David threatening a female with a knife.		
August 2013	Over the period 29 to 31 August 2013 Hertfordshire Constabulary attend Kirsty's address where David is seemingly under the influence of drugs. David was taken by police to Waltham Cross.		
September 2013	On 18 September 2013 David attended Magistrates' Court when he was fined for Aggravated Bodily Harm and theft of a knife. He received a financial penalty.		
October 2013	Over the period 4 to 5 October 2013 Kirsty complains to the Hertfordshire Constabulary that David was "bothering" her. No action was taken.		Over the period 5 to 6 October 2013 Gemma and Donald spend the night together in a hotel. David was aware of this. Donald states that he did not consider David to be a risk or threat to Gemma. On 6 October Gemma exchanged calls and texts with female friends stating that she was trying to sort out matters with David. Her last contact with those friends was at 21.42 on the 6th.
October 2013		Over the period 6 to 7 October 2013 Gemma was killed by David in her Waltham Abbey flat. David then proceeded to a local sports centre where he took his own life. Gemma's body was discovered later that day in her flat by Hertfordshire Police officers who were investigating David's death.	

APPENDIX D – Home Office Quality Assurance Unit letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T **020 7035 4848**
F **020 7035 4745**
www.homeoffice.gov.uk

Caroline Wiggins
Community Safety Manager
Epping Forest District Council

27 February 2015

Dear Ms Wiggins,

Thank you for submitting the Domestic Homicide Review overview report for Epping Forest to the Home Office Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. This was a very clear and well-structured report which, subject to the feedback detailed below being incorporated, the Panel judges to be adequate

The aspects of the report that were judged to have been done well were:

- The report was thorough, and gave an honest narrative of a complex case;
- There was clear evidence provided of quick lessons to be learned;
- The recommendations contained in the report are clear and will benefit learning by agencies in the future.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider incorporating before you publish the final report:

- You should ensure that the use of pseudonyms is used consistently and accurately throughout the report;
- The report could usefully clarify the mechanisms used by agencies to establish the risk to the victim;
- You may wish to revisit the tone of the report in regard to engagement with other statutory agencies i.e. at paragraph 4.12 of the executive summary and 1.27 and 2.54 of the overview report;
- You may wish to clarify the independence of the DHR chair in the text.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely,
Christian Papaleontiou, Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable People Unit

GLOSSARY

Abbreviation	Description
ABH	Assault occasioning Actual Bodily Harm
CDAT	Community Drugs and Alcohol Team
CPS	Crown Prosecution Service
CSP	Epping Forest District Community Safety Partnership
DAHCU	Domestic Abuse, Hate Crime Unit (now DAST)
DAIT	Domestic Abuse Intelligence Team
DALO	Domestic Abuse Liaison Officer
DASH	Domestic Abuse, Stalking and Honour based violence risk identification checklist
DAST	Domestic Abuse Safeguarding Team
DHR	Domestic Homicide Review
DV/1	Domestic Abuse incident report
ECC	Essex County Council
FLO	Family Liaison Officer
GBH	Assault occasioning Grievous Bodily Harm
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MERLIN	Missing persons and other Linked indices (Metropolitan Police system)
PNC	Police National Computer
PND	Police National Database
PROTECT	Database of information on victims and suspects involved in domestic and child abuse cases
SIO	Senior Investigating Officer (Police)
SPECCSSS	Risk assessment process (Separation, Pregnancy, Escalation, Cultural diversity, Controlling, Stalking, Sexual assault, Suicide)
STORM	Essex Police control and command system
TOR	Terms of Reference
VPR	Vulnerable Persons Report