Restricted until publication

Safer Kingston Partnership

DOMESTIC HOMICIDE OVERVIEW REPORT

Report into the death of Agapito

To be published 14th November 2014

Report Produced by Davina James-Hanman – Independent Chair and Author

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REPORT INTO THE DEATH OF AGAPITO[1]

Name	**Age at time of the incident**	**Relationship**
Agapito	37	Victim
Sarim[2]	29 (28*on some Agency Records)*	Partner of victim and perpetrator
Grace[3]	2 years, 3 months	Daughter of victim and perpetrator

Address 1 is the home in Kingston where Agapito lived with her partner and child from around September 2010. Their address prior to this is address 2.

[1] Not her real name
[2] Not his real name
[3] Not her real name

INTRODUCTION

This Domestic Homicide Review (DHR) report examines agency responses and support given to Agapito, a resident of the Royal Borough of Kingston prior to the point of her murder on 26 September 2011.

The Royal Borough of Kingston upon Thames (RBK) is in southwest London. The main town is Kingston upon Thames and it includes Surbiton, Chessington, New Malden, Tolworth and part of Worcester Park. It is the oldest of the eight Royal Boroughs in England and has a population of around 160,400. It is a relatively wealthy area when compared with other London Boroughs and employment is above the national average. The borough is home to the highest number of South Koreans in Europe, although the Borough also has a significant Tamil and Indian population. Overall, however, RB Kingston is around 84.5% White, higher than average in London.

Kingston is consistently rated among the safest of all London boroughs by the Metropolitan Police. In 2011, the year of the murder, there were a total of 1,843 domestic violence reports made to Kingston Police of which 769 were recorded as crimes and the remaining 1,074 were logged as non-crime domestic incidents. This is lower than the London average but it should be noted that women's help-seeking patterns are affected by their socio-economic status. Middle class women are less likely to report domestic abuse to the police, choosing solicitors as their most likely first disclosure to a professional.[4]

At the time of the incident, RB Kingston had undertaken a number of local domestic violence initiatives to raise awareness. This has included awareness of services to victims, how to help a friend or colleague experiencing domestic violence and work in schools to educate children and young people. In addition to the statutory services, there are also a number of specialist services, including a One-Stop Shop which operates half a day a week, a floating support service and a sanctuary scheme designed to enable women to stay in their homes. The One Stop Shop is managed by the Metropolitan Police and as such, their involvement in this DHR has been considered as part of the Metropolitan Police's IMR. Like most local authorities, RB Kingston also provides a MARAC and an IDVA service. The Safer Kingston Partnership provides free training and guidance for local professionals in responding to domestic violence and a detailed local directory. There are also two empowerment groups for survivors although none for children.

In May 2012 there was an Ofsted inspection of safeguarding services for children and young people which referenced this DHR as follows:

'The council has not adequately addressed all the areas identified in their internal management review of a domestic violence homicide. Although an action plan was drawn up and some progress made, the findings from this inspection demonstrate insufficient progress has been made.'

A further Ofsted inspection in July 2013 also concluded that RB Kingston was rated as inadequate for child protection services.

There has been much change since as a result of an independent external review, the Ofsted Improvement Plan and this DHR.

[4] Jayne Mooney *'The Hidden Figure'* (1994); *'Domestic Violence: a handbook for Health Care professionals'* (DoH 2005)

SUMMARY OF THE CASE

Sarim entered the United Kingdom, from Pakistan, on 17 September 2003 on a student visa.

Agapito was originally from the Philippines. She entered the United Kingdom on a visa entitling her to visit her brother and was subsequently issued with a student visa.

Agapito and Sarim had originally met via the internet and began a relationship. In 2009 they had a daughter, Grace. At this time, the couple were living at address 2 in the London Borough of Merton but by September 2010 had moved to address 1 in RB Kingston, a single bedroom first floor flat in a house of multiple-occupancy.

Agapito herself, and the trial, would later reveal that the relationship was unhappy by the summer of 2011. Agapito confided – via Facebook and SMS – in a friend who had once been her boyfriend many years before. From 1 September onwards, the couple's relationship deteriorated rapidly with both Sarim and Agapito making contact with several agencies which also generated subsequent referrals. The agencies were the Metropolitan Police, the NSPCC, RBK Children's Social Care, Kingston Hospital Trust and SW London and St George's Mental Health Trust.

On 26 September 2011 Agapito made her final agency contact when she went to the One Stop Shop (OSS) in Kingston, a multi-agency domestic violence help centre.

Later that evening, police were called to address 1 by a neighbour.

Officers found Agapito in her flat lying face down with injuries to the back of her head. Beside her body was a blood stained hammer. Sarim was found sitting in the room, holding his daughter Grace.

Agapito was pronounced dead at the scene and Sarim was arrested. He said '*she cheated on me so she deserved it.*' He was subsequently charged with her murder. Grace was taken into police protection.

POST MORTEM

A Post Mortem was conducted on 28 September 2011. It was concluded that death was caused by massive trauma and blood loss due to extensive head injuries.

INQUEST

On 6 October 2011, the inquest opened and adjourned on 22 February 2012 at West London Coroner's Court.

Subsequent to Sarim's conviction on 03 December 2012, a decision was made on 18 December that the inquest would not be resumed.

COURT DATES

In June 2012, the case went to trial but was stopped for legal reasons and a new trial ordered.

On 3 December 2012, Sarim appeared at court for murder. He admitted killing Agapito but denied murder on the grounds of diminished responsibility and loss of control, claiming he was suffering from severe depression. The jury did not accept this defence and on 13 December he was found guilty of murder and sentenced to life with a minimum tariff of 12 years.

DECISION TO HOLD A REVIEW

When Kingston Community safety Partnership (CSP) was notified of the murder, records were immediately secured and in consultation with partners, a decision was made to instigate a DHR and the Home Office duly notified.

Following careful consideration, the LSCB agreed that this case did not meet the threshold for a Serious Case Review. However it was agreed with the LSCB that, where not already covered by the Review, any issues pertaining specifically to the child or safeguarding should be integrated into the work of the DHR Review Panel. In order to accommodate this, the report includes information pertaining to the immediate aftermath in respect of responses to Grace.

SCOPE OF THE REVIEW

Initial searches of agency records found no evidence of agency contact related to domestic violence except in the three weeks prior to the murder. To ensure that nothing was missed, the scope was set from September 2003 when Sarim first entered the UK to the point of the murder. In addition, services in neighbouring Boroughs were contacted to check that nothing of significance was held in their agency records.

TERMS OF REFERENCE

The terms of reference for the review are set out below.

The DHR Panel will consider:

1. Each agency's involvement with the following family members between 1 September 2003 and the murder of Agapito on 26 September 2011 (all resident at address 1):

(a) Agapito
(b) Sarim
(c) Grace

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

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

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

(a) Professional standards
(b) Domestic Violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Agapito, her partner or their child, concerning domestic violence or other significant harm from 1st October 2008. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
(c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
(d) The quality of the risk assessments undertaken by each agency in respect of Agapito and Sarim.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

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

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

TERMS OF REFERENCE FOR THE CHILD'S ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

10. In relation to this Review the child is not identified as a victim as specified in paragraph 3.3. 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the child affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

11. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in Kingston and also any other agencies and local authorities. It should also highlight any good practice that can be built on.

12. Specifically the areas of this Review relevant to the child involved are as follows:

(a) Whether RBK Learning and Children's Services took appropriate action to protect and support the child from the time the homicide was reported and in the immediate seven days afterwards.
(b) Whether the agencies had in place policies and procedures for safeguarding and promoting the welfare of children in relation to domestic violence and whether there were any failings in the policies and procedures themselves, in the implementation of policies and procedures, in management oversight or in compliance with policy and procedures.
(c) How well the needs of, and potential risks to, the child involved were identified by all agencies and how well were the child and the parents engaged in this process. In particular the Review will explore whether the impact of domestic violence on the child was recognised and appropriate action taken to respond to her needs in the light of what was known by any agencies about domestic violence that was occurring in the household.
(d) Whether each agency has systematic processes in place to ensure compliance with statutory responsibilities to safeguard children in the context of domestic violence including appropriately targeted training.
(e) Whether practitioners in all agencies were aware of the needs of the child involved, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child's welfare.

1. THE REVIEW PROCESS

The Kingston Homicide Review Panel was initially convened on 26 October 2011 with all agencies that potentially had contact with the victim, perpetrator and their child prior to the murder.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder (see appendix A) and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to make their services more accessible.

Enquiries were made with a number of agencies and those that had contact with Agapito, Sarim or Grace were asked to complete an IMR. These agencies were:

- Metropolitan Police[5]
- NHS Kingston and other health agencies.[6]
- NSPCC
- Royal Borough of Kingston upon Thames Children's Social Care
- South West London & St George's Mental Health Trust
- UK Borders Agency - Hounslow Richmond & Kingston Local Immigration Team
- Victim Support

The DHR was then suspended, awaiting the outcome of the criminal trial.

Each agency's IMR covers the following:

- A chronology of interaction with the victim and/or their family;
- What was done or agreed
- Whether internal procedures and policies were followed
- Whether staff had received sufficient training to enact their roles
- Analysis of the above using the terms of reference
- Lessons learned
- Recommendations

Each IMR was scrutinised at a Panel meeting and in some instances, additional recommendations were made which have been included in the action plan at appendix B.

TIMESCALES

This review began on 26 October 2011 and was concluded in March 2014. Eight meetings of the DHR Panel took place.

It was hoped that members of the family would be involved in the Review so proceedings were suspended to await the outcome of the trial. Unfortunately, despite repeated contacts, no family member or friends chose to participate.

[5] The Metropolitan Police are the formal employers of the Manager of the One Stop Shop. To ensure her particular perspective was heard, the Chair interviewed her separately.

[6] This comprised seven separate IMRs from the following: Kingston Hospital Trust; St George's Hospital Trust; St George's Hospital Trust – Midwifery; Kingston GP; Hospital GP; Your HealthCare (Kingston); Merton & Sutton NHS

The DHR was suspended for over a year to take account of the criminal trial. Unfortunately, the unusually long time taken to complete the trial meant that the Chair was unavailable for several months during the DHR process.

However, the extended time period to conclude this Review did not prevent agencies from implementing emerging lessons learned as is evidenced in the information below.

PARALLEL INVESTIGATIONS

As indicated in the terms of reference above, the Local Safeguarding Children Board (LSCB) decided not to hold a Serious Case Review. As such, issues relating to the child were fully considered throughout the DHR process with the LSCB Chair being a member of the DHR Panel and the LSCB has agreed to consider the report and its recommendations when it can be disseminated. However, there was also an Ofsted inspection in May 2012 which referenced this DHR as follows:

'The council has not adequately addressed all the areas identified in their internal management review of a domestic violence homicide. Although an action plan was drawn up and some progress made, the findings from this inspection demonstrate insufficient progress has been made.'

Overall, RB Kingston was rated as inadequate for child protection services in the May 2012 inspection.

A further Ofsted inspection in July 2013 also concluded that RB Kingston should be rated as inadequate for child protection services. It should be noted that this second Ofsted inspection did not mention the DHR but did contain a number of areas that were identified for improvement relating both directly and indirectly to domestic violence. For example:

'ensure a more timely response, better communication and cohesive joint working relationships with the police when children are suffering, or at risk of suffering harm, in particular from domestic abuse, child sexual exploitation and missing from home'[7]

There was also a criminal trial and an inquest.

CONTRIBUTORS TO THE REVIEW

DHR panel members were as follows:

- Assistant Chief Officer - Kingston & Richmond Local Delivery Unit, Kingston Probation
- Designated Nurse for Safeguarding and Looked after Children, Kingston Clinical Commissioning Group
- Detective Inspector, Specialist Crime Review Group, Metropolitan Police Service
- Detective Sergeant - Kingston Community Safety Unit, Metropolitan Police Service
- Divisional Manager – South West London Victim Support
- Divisional Manager, Royal Borough of Kingston Housing
- Domestic Violence Coordinator, Safer Kingston Partnership
- Head of Children's Social Care Royal Borough of Kingston
- Immigration Enforcement Team Leader UKBA (now the Home Office)
- Director of Public Health, Royal Borough of Kingston
- LSCB Chair, Kingston LSCB
- Relationship Manager, Safer Kingston Partnership

[7] Ofsted Inspection of RB Kingston services for the protection of children 2013

- Service Manager Hestia Housing and Support
- Service Manager, Adult Safeguarding, Royal Borough of Kingston

All of the above agencies were represented by senior staff who were all independent of the case. IMR authors attended those Panel meetings where their IMR was discussed.

In addition to Panel members and those consulted with for IMRs, several individuals also approached the Review to provide information. To protect their privacy, only job titles have been used. These were:

- BBC journalist
- Surrey Comet journalist
- Chief Executive of RB Kingston local authority
- Former Acting Head at RB Kingston Children's Social Care
- Former Social Work manager at RB Kingston Children's Social Care

Two further individuals were approached by the Chair to seek clarification:

- CPS Prosecutor in the trial of Sarim
- Manager of the One Stop Shop

DISSEMINATION

DHR Panel members have all received a confidential copy of this report.

CONFIDENTIALITY

The findings of this review are confidential and all parties have been anonymised. However, it should be noted that media interest in this case means it is unlikely to remain anonymous. For ease of reading, the victim and perpetrator have been allocated alternative names.

Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

INDEPENDENCE

This report was written on behalf of the DHR panel by the Independent Chair of the Review, Davina James-Hanman.

Davina James-Hanman is the Director of AVA (Against Violence & Abuse) which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK. From 2000-08, she had responsibility for developing and implementing the London Domestic Violence Strategy for the Mayor of London.

She has worked in the field of violence against women for almost 30 years in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and two book chapters and formerly acted as the Dept. of Health policy lead on domestic violence as well as being an Associate Tutor at the national police college. Davina has also authored a wide variety of resources for survivors.

She was also formerly a Lay Inspector for HMCPSI, acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence (2007/08) and Chairs the Accreditation Panel for Respect. From

2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. In recent months, her focus has been on improving commissioning, increasing survivor involvement in service design and development and in delivering the accredited training for DHR Chairs. Davina is also a Trustee of Women in Prison.

None of the IMR authors had any contact with the victim or perpetrator or had line management responsibility for those that did. Each IMR was signed off by a senior manager within the organisation. All Panel members were also similarly independent.

EQUALITY AND DIVERSITY ISSUES

All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have relevance to this DHR. These were:

Age: Agapito was 37 and Sarim was aged 29 at the time of the murder. Sarim told professionals that this was his first serious relationship.

Disability: Sarim experienced mental health issues which if they had persisted for more than 12 months, are considered to be a disability under the Equality Act 2010. However, his earlier bouts of depression reported to his GP (which fell outside the scope of the DHR) never triggered a referral for a formal mental health assessment. The first time Sarim had a formal assessment was following his attempted suicide. On balance, therefore, the Panel felt that it was unclear whether Sarim's mental health issues should be deemed a disability. Nevertheless, the Panel did reflect on whether it affected the services Sarim received and concluded that it did not.

Marital status: Agapito was not married to Sarim. Evidence from the British Crime Survey suggests that co-habiting women are more at risk of domestic violence than married women although the highest risk group is separated women.

Pregnancy: Agapito was not pregnant at the time of her murder although the Panel did note that the elevated risk of domestic violence during pregnancy actually increases following birth. At the time of the murder, Grace was two years old.

Religion and belief: Sarim was Muslim who applied his religion selectively. He told mental health professionals of his outrage as a Muslim at the (mistaken) knowledge that Agapito was having an affair with a married man but seems not to have considered that he had a child outside of wedlock with a Roman Catholic.

Ethnicity: Agapito was from the Philippines and Sarim was from Pakistan. Evidence suggests that differing cultural expectations of both relationships and gender roles may have been a factor in their relationship. For example, Sarim told professionals that his parents had severed ties with him as they did not approve of his relationship with Agapito. For both of them, their nationality also played a role as both had insecure immigration status. For Agapito, this did affect the ante-natal services she received regarding her choice of hospital and timeliness therefore of ante-natal services being provided..

Sex: The panel recognised Agapito's sex could be relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[8]. Latest published figures show that just over half of female victims of homicide aged 16 or over had been killed by

[8] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover.

INVOLVEMENT OF FAMILY AND FRIENDS

Repeated efforts were made to involve family members and friends. In addition to introductory letters, emails, texts and phone calls were made. No response was received.

2. CHRONOLOGY

A complete chronology of agency involvement was provided to the Panel. At appendix A, there is a complete record of all agency contacts that had relevance to the murder. Most contacts not relevant to the murder, such as routine medical appointments which occurred prior to any known domestic violence, have been removed. In some instances they remain as they demonstrate the recording of information that was to later be significant or because they reveal something about the state of the relationship between Agapito and Sarim.

A lack of records in the chronology from any participating agency should, therefore, only be read as a lack of relevant contact rather than no contact.

Below are edited highlights of the most significant events relating to the murder. Events are further explored for each agency in the sections which follow.

2003 - 2008

17/09/2003: UK Border Agency

Sarim arrived in the UK on a student visa.

04/05/2007: UK Border Agency

Agapito was issued with a visitor visa to visit her brother (valid until 04/11/2007).

31/10/2007: UK Border Agency

Sarim's visa expired. No further applications are received.

17/12/2007: UK Border Agency

Agapito is issued with student visa to study at XXX College (valid until 30/04/2009). Agapito arrives in the UK on 28/12/2007.

28/03/2009: UK Border Agency

Agapito applied for further leave as student. This is rejected on 17/05/2009 due to an incomplete form.

12/06/2009: UK Border Agency

Agapito made a further student application. This was rejected on 14/08/2009 due to an out of date application form.

01/09/2009: UK Border Agency

Agapito made a further visa application as a student. This application was still outstanding at point of murder.

2009 – AUGUST 2011

27/06/2009: Grace is born. Routine postnatal care follows.

16/09/2010: UK Border Agency

Agapito advised UK Border Agency of a change of address to address 1.

2011: THE FINAL WEEKS

01/09/2011: Kingston Hospital Trust

Sarim attended the A&E Department at Kingston Hospital after taking an overdose of paracetamol although blood tests showed an insufficient amount had been consumed to require treatment. Sarim told staff that he had taken the overdose on discovering that Agapito was cheating on him.

He had discovered this by accessing her emails and messaging service. He talked about translating messages on Yahoo, finding out that his girlfriend and her ex-boyfriend were meeting. He mentioned how they had talked about the situation but still she went to meet her ex boyfriend, switching her phone off. He then felt *'he couldn't cope'*.

Staff assessed it as an impulsive overdose and discharged him with a referral to the Crisis Home Treatment Team (CHTT) to contact him the following day. CHTT phoned Sarim and arranged to meet on 04/09/2011.

It should be noted that the subsequent investigation and trial did not discover any evidence that Agapito was having an affair. Prior to her death, Agapito had made contact with a former Filipino boyfriend via Facebook. He had been her boyfriend many years before. At the time of contact being renewed, he was himself married with a family and lived in Wales. Contact was solely by email except for one visit when the former boyfriend travelled from Wales to London and back in the same day. At trial, the defence produced an email sent around noon on the day of the murder. This seemed to indicate that there was an affair but later investigation found that the email had been sent by Sarim.

04/09/2011: NSPCC and South West London and St Georges Mental Health Trust

At 07.20 am, Agapito contacts the NSPCC help-line via email. She expresses concerns that her partner may try to abduct their 26 month old daughter. She also wrote about '*fighting'* with her partner in front of Grace. She was seeking information about protecting her daughter so that her partner could not take her away. A reply is emailed to Agapito at 11.13 am informing her that a referral was being made to RBK Children's Social Care recommending an initial assessment be carried out. This would be to determine the level of risk to her daughter and identify possible areas of support.

At 11.09 am, Sarim contacts the NSPCC help-line by email. The trial established that Sarim was at some point accessing Agapito's emails. The exact date is not known but it is probable that Sarim contacting the NSPCC a few hours after Agapito was no coincidence, particularly since he had told mental health staff three days earlier that he had accessed Agapito's on-line accounts. In Sarim's email, he writes about how he met Agapito, about their relationship, and birth of their daughter. He is seeking advice because he thinks Agapito is now seeing her ex-partner and is concerned that she will take their daughter away. He also discloses his recent overdose.

Later that afternoon, the CHTT call Sarim as he had not attended his appointment. Sarim said that he had been expecting directions to be sent to him and was now unable to attend. He declined an appointment for the following day as he was hoping to meet with his lawyer but said that he would contact CHTT to re-arrange.

05/09/2011: NSPCC

NSPCC referred Agapito and Grace to RBK Children's Social Care recommending that an initial assessment be completed due to Agapito reporting relationship conflicts and fear for her daughter being abducted. Referral is made by both phone and fax.

NSPCC responds to Sarim's email encouraging him to prioritise his daughter's needs, and to see his GP in relation to the overdose and how he is feeling. Contact details were provided for Families Need Fathers and community legal advice.

05/09/2011: South West London and St Georges Mental Health Trust

Sarim calls the CHTT to rearrange his missed appointment and agrees to meet outside McDonalds on 07/09/2011

05/09/2011: RBK Children's Social Care

Following the referral from NSPCC, checks were made of internal records to establish whether the family were known. They were not. A decision was made to respond with information and advice. This decision is not implemented for three days and is not recorded on ICS (the case management system) until 12/09 2011.

07/09/2011: South West London and St Georges Mental Health Trust

Sarim met with CHTT. He spoke about his relationship, his belief that Agapito was having an affair and that she will leave and get married when the boyfriend has got divorced. He said he was embarrassed about his overdose but he wants to save the relationship. However, he also said that he would move to Ireland soon with his daughter and help with his uncle's business. He said he was planning to see his lawyer today and to discuss options of sole custody. He did not feel that he required further input and agreed to be discharged from the service effective immediately. He was assessed as of no current risk to himself or others although issues of parental responsibility and sole custody were not raised or discussed and the threat of abducting a child was not specifically followed up.. Advice was given regarding Relate or counselling through his GP and information about Crisis Line.

08/09/2011: Children's Social Care

An email is sent to Agapito by RBK Children Social Care Safeguarding duty social worker (Team 2). Information is provided about three possible local domestic violence contact points and a list of solicitors to approach for legal advice regarding Grace being abducted. An email reply from Agapito is received the following day expressing thanks for the information provided and stating that the matter had been sorted out. Both of these emails are sent from individual accounts and are not recorded centrally.

23/09/2011: RBK Children's Social Care

Agapito e-mailed the individual email account of the duty social worker (Team 2). This was passed over to the team leader (Team 3) for a response. The Duty Social Worker telephoned her, offering information and advice as requested. Agapito disclosed that an argument had taken place the previous evening (22/09/11) as she had confided in an ex-boyfriend and Sarim had found out. Sarim had shown a pornographic video to Grace and kept saying *'this is what your mummy's doing, she is a prostitute, whore, dirty woman'*. He let

Grace play with cigarettes and told her that in the future she will learn how to smoke. She also disclosed Sarim's recent attempted overdose. Agapito was worried because she works while Sarim stays home with Grace. Advice was given to contact the Domestic Violence Coordinator[9]. Permission was obtained for RBK Children's Social Care to contact the GP and Agapito was encouraged to make contact again if needed.

23/09/2011: Victim Support

On the advice of the Social Worker, Agapito made contact with Victim Support by phone. Practice is that a full risk assessment is done face to face so a meeting was arranged for 29/09/2011 in Victim Support's office. A brief but incomplete risk assessment was done on the phone using the SPECCS[10] checklist. As Agapito had said that she had been referred by RBK Children's Social Care, a referral was not made to them. A text was sent to Agapito confirming the appointment.

23/09/2011: NSPCC

A second email is received by the NSPCC help-line. In it, Sarim describes difficulties in his relationship with Agapito writing that she was '*always trying her level best to get me angry...Last night I got angry cause wherever she goes now she takes my daughter...*'. He described a recent argument when he took his daughter to see his brother which Agapito did not like. He was seeking advice about controlling his emotions. Records are not searched to establish the previous contacts.

A reply the same day urges again for Sarim to prioritise his daughter and to seek help from provided agency details.

24/09/2011: NSPCC

A third email is received from Sarim at 11.37 on Saturday morning. He wrote that the situation with Agapito had '*gotten worse'*. He stated that they had argued and he became angry and broke her mobile phone. Agapito had left the house with their daughter and a man who lived downstairs. He does not know where they have gone. He further claimed (inaccurately) that Agapito did not let him have any contact with their daughter. He mentioned in the email that he was aware that Agapito had previously contacted the NSPCC. This triggered a search of the records which located the referral to RBK Children's Social Care and the original email from Agapito but this was not made clear in the second referral to RBK Children's Social Care which was prepared to be sent on Monday morning.

A reply to the email informs Sarim that the NSPCC will be making a referral to RBK Children's Social Care recommending that an initial assessment be carried out to determine level of risk to his daughter and discuss support for him and his partner. It also suggests that if his partner and daughter do not return, he could contact the police to report them missing.

At 16.02 a fourth email is received from Sarim saying that his partner and daughter still had not returned and seeking advice as to whether he should contact the police now or should he wait. The NSPCC respond at 17.21 acknowledging his distress and informing him that he did not have to wait 24 hours before reporting a missing child. The reply went on to say *'It sounds like you and Agapito need some breathing space from one another and certainly your daughter would benefit from not witnessing any further arguments and confrontations.*' The reply concluded by saying that they would include this additional information in the referral they were making to RBK Children's Social Care.

24/09/2011: Metropolitan Police Service

[9] Now called the Independent Domestic Violence Adviser
[10] An earlier risk assessment model used by the Metropolitan Police, subsequently replaced with DASH.

Agapito attended Kingston police station to report the incident that occurred two days earlier which had resulted in criminal damage to her mobile phone. A SPECCS risk assessment is completed. Sarim is arrested the same day for criminal damage and the police make a referral to Children's Social Care as follows:

> *'On 24/09/11 and 25/09/11 Agapito attended the police station and outlined that on Thursday 22/09/11 at around 19.30 p.m. Sarim returned home displaying strange behaviour. He could have been on drugs or under the influence of alcohol acting in an aggressive manner, shouting and swearing at her. He put the computer on, played a sex video and picked up a few rings and threw them at her. These hit her in the chest but there were no injuries. He allowed Grace to play with the cigarette packet indicating that she will be smoking. She let him calm down and went to bed. He stayed in the room. On Saturday 24/09/11, while getting Grace ready, she left the phone charging and when she picked it up it had been smashed. Sarim admitted that he smashed it. She was shocked, picked up the phone and left the house. Sarim was interviewed by the Police. He stated that on 27/08/11 he managed to get into Agapito 's emails and found out she had been communicating with her ex-partner. He claimed that the pair had apparently fallen in love again. Agapito was supposed to have gone to Legoland but lied and had taken the week off. She was openly talking and texting the ex-partner, playing with his emotions. He denied showing Grace pornography but admitted calling Agapito names. He admitted damaging the phone. The police contacted Agapito , discussed bail conditions and concluded that it was difficult as Sarim looked after Grace while she works. In consultation with Agapito, bail conditions were not imposed.*[11] *Sarim was told that any further incidents would be construed as witness intimidation.'*

Sarim is bailed in order to assess disposal decision.

26/09/2011: Your Healthcare (Kingston)

Police notification (Merlin) received by the Safeguarding Team detailing domestic abuse between 22 September and 24 September. The information is shared with the Health Visiting team at Churchill Medical Centre.

26/09/2011: Metropolitan Police Service

Agapito attends the One Stop Shop (OSS). She speaks with a casework adviser.

Agapito disclosed that Sarim had made threats to kill her within the last few weeks and his attempted suicide. Agapito was offered access to the other services that the OSS provided. She declined housing assistance but spoke to both the police officer and a solicitor. The solicitor advised her that there was insufficient evidence to apply for a Non Molestation Order due to the bail conditions currently in place.

Morning of 26/09/2011: RBK Children's Social Care

RBK Children's Social Care receives a further referral from the NSPCC concerning the emails received from Sarim over the past three days. This is not dealt with until after the murder.

26/09/2011: Metropolitan Police Service

Later that evening police were called to address 1. The call had been made by another occupant of the building, who had heard a disturbance emanating from Agapito and Sarim's flat.

[11] This is not entirely accurate as Sarim was told he would have to live at his brothers but could still visit Agapito daily to provide childcare for Grace. This was at Agapito's request.

Officers arrived at 9.21pm and were met outside the building by the owner of the property. The officers found Agapito in her flat lying face down with injuries to the back of her head. Beside her body was a blood stained hammer. Sarim was found sitting in the room, holding his daughter Grace.

Agapito was pronounced dead at the scene, and Sarim was arrested for her murder. When arrested he said '*she cheated on me so she deserved it.*' He was subsequently charged with her murder. Grace was taken into police protection.

26/09/2011: UK Border Agency

Police call command at control at UK Border Agency to report the death. An Immigration Officer is deployed to the police station.

27/09/2011: RB Kingston CSC record the referrals on their case management system.

3. INDIVIDUAL AGENCY RESPONSES

A full chronology of all agency contacts is provided at appendix A. In the accounts which follow, agency involvement has been summarised to focus on those contacts relevant to the DHR.

ST GEORGE'S HOSPITAL TRUST; ST GEORGE'S HOSPITAL TRUST – MIDWIFERY; KINGSTON & LAMBETH GP; YOUR HEALTHCARE CIC (KINGSTON) AND MERTON & SUTTON NHS

Summary of involvement

These IMRs have all been dealt with together as none of the staff were aware of domestic violence and indeed, it is highly likely that at the time of their contacts with Sarim and Agapito (mostly up to and including the birth of their daughter), that there was no domestic violence.[12] Contact was largely as a consequence of Agapito's pregnancy and subsequent birth of Grace. There were delays for Agapito is accessing ante-natal care due to her insecure immigration status. As a consequence, on reviewing procedures, several areas were identified for improvement and these are reflected within the accompanying action plan. The organisations are to be commended for their willingness to learn lessons even when not directly related to this specific domestic homicide.

UK BORDER AGENCY[13]

Summary of involvement

Both the victim and suspect were known to the UK Border Agency, having entered the UK legally with visas, Sarim in 2003 and Agapito in 2007. Sarim extended his stay in the UK until 31st December 2007 and since that date until his arrest on 27th September 2011 went undetected by the UK Border Agency as an overstayer in the UK. Agapito's leave to enter the UK expired on 30th April 2009 but she sought to extend her leave to remain in the UK as a student and was in regular contact with the UK Border Agency until the time of her death.

Sarim was granted two visit visas by the British High Commission in Islamabad, but did not use them to travel to the UK. He was issued a student visa by the same High Commission on 13 August 2003 and used it to enter the UK on 17 September 2003. He subsequently made three in time, valid applications for further leave to remain in the UK as a student and his leave to remain was extended until 31 December 2007. Each

[12] This assumption is based on Agapito's willingness to report apparently 'low level' domestic violence in 2011.
[13] Since restructured into two entities: UK Visas and Immigration and the Immigration Enforcement.

application was supported by a college on the Register of Education and Training Providers and was granted without issue.

Sarim did not come to the attention of UK Border Agency after his last application for further leave to remain in the UK was granted on 9th December 2006. Since his leave to remain in the UK expired on 31st December 2007 and he made no further applications for further leave to remain, he was an overstayer in breach of UK immigration law. It must be presumed that since he had no valid leave to remain in the UK, he did not travel out of the UK after 31 December 2007 since he could not have re-entered the UK legally (without obtaining a new visa, which he did not do). UKBA are currently implementing systems which will identify overstayers.

Agapito first entered the UK with a visit visa issued in Manila in April 2007. She was subsequently issued a student visa in Manila valid from 17 December 2007 until 30 April 2009. She last arrived in the UK on 28 December 2007.

On 28 March 2009 she submitted an application for further leave to remain in the UK as a student but this application was rejected due to the form being incomplete.

A second application was submitted on 12 June 2009 but this application was rejected due to an out of date application form.

A third application for leave to remain was submitted on 1 September 2009. This application was accepted as valid but was not concluded quickly because at the time of application Agapito's intended place of study was suspended from the sponsor register.

On 16 February 2010 Agapito submitted evidence of enrolment at another college, this time one which was on the register, Derby, but her application remained un-concluded. She obtained a photocopy of her passport in person at UK Border Agency's offices in Croydon on 15 February 2011. The reason for requesting this copy is not recorded.

Agapito wrote to the UK Border Agency on 7th March 2011 asking about progress on her application, but did not receive a reply. This was followed on 23 June 2011 by a letter from Edward Davey MP requesting a progress report. He received a reply from UK Border Agency stating that her application *'is complex and requires further investigation some of which may be outside UKBA'*.

On 4 August 2011 Agapito wrote to the UK Border Agency again regarding her outstanding application. The letter was linked to her UK Border Agency file and sent to storage on 26 September 2011 without a reply being sent.

Agapito entered the UK legally and held leave to enter the UK until 30th April 2009. Her in time application to extend her leave to remain in the UK was rejected and after this rejection on 15 May 2009 she did not have permission to stay in the UK. However, since further applications were submitted within a month of the two application rejections, she was not treated as an overstayer by the UK Border Agency.

At the time of her death Agapito had had an application for leave to remain outstanding with the UK Border Agency for two years. This time frame is excessive but was due to the status of the colleges involved in the applications rather than unwarranted administrative delay by the UK Border Agency.

There is no evidence of any suggestion made by Agapito to the UK Border Agency that she was a victim of domestic violence and there is no evidence that any outside agency made any contact with the UK Border Agency apart from Edward Davey MP.

Grace was born in the UK on 27 June 2009. At the time of her birth her parents Agapito and Sarim did not have indefinite leave to remain in the UK and Grace therefore requires leave to remain in the UK. UK Border

Agency systems do not indicate that Agapito informed the UK Border Agency that she had a child born in the UK. Indeed the application form signed by Agapito on 28th August 2009 required her to list *her 'any dependant(s) who are applying at the same time as the applicant'*; this section of the application form was left blank.

Grace was therefore at the time of her mother's death, a person who required leave to remain in the UK, but whose presence in the UK was not known to the UK Border Agency.

Author's note: Since the murder, Grace has been relocated abroad.

KINGSTON HOSPITAL NHS TRUST

Kingston Hospital only had contact with Sarim over one episode with Kingston Hospital NHS Trust; the Accident & Emergency (A&E) attendance on 01/09/2011 17.24, following an alleged overdose.

The presentation was of an alleged ingestion of a maximum 20 paracetamol tablets two hours prior to attending the department. Following discussion with the department's consultant a blood test was carried out following local protocol four hours after the alleged ingestion to check for paracetamol levels in the blood. This would ascertain whether any treatment would be required. The blood results showed that paracetamol was present in the blood, confirming that he was truthful about taking the tablets, but the level (76mg/litre) was below the threshold for treatment (100mg/litre).

Following assessment and investigation he was deemed physically fit by A&E professionals. A psychiatric referral was made and Sarim was seen by the Psychiatric Night Duty Doctor who carried out an assessment. The assessment looked into physical and mental health along with social history. The assessment initially looked at the history of the presenting complaint. The reasons behind the attempted overdose were discussed focusing on him finding out his girlfriend had been contacting an ex-boyfriend. He apparently told several friends of the situation and one friend went to see him. After finding out that he had taken an overdose, he took Sarim to A&E. The concluding impression was of a young man presenting with an impulsive (first) overdose with no intention of killing himself, secondary to allegedly discovering his long-term girlfriend, with whom he has a child, had restarted a relationship with her ex-boyfriend. The plan was to discharge him home as Grace's godmother would be staying there overnight with him as well as Agapito and Grace. The Crisis Home Treatment Team would contact him 02/09/2011 and Sarim was given the telephone number of the Crisis Line.

In A&E the team followed guidelines in relation to Sarim's overdose of paracetamol, and following blood tests being taken, the results showed that no medical treatment was required.

The team then referred Sarim to the psychiatric night duty doctor, following department protocol, who carried out an assessment before making his final impression and plan. A very clear, concise report was produced by the night duty doctor which was then filed in Sarim's A&E records.

The plan took into account the safety and welfare of the child and his partner, ensuring that there would be a protective adult staying in the household overnight following discharge home prior to the home treatment team making contact the following morning.

Sarim was given the telephone number of the Crisis Line and an appropriate plan was made for the Home Care Team to contact him the following morning (02/09/2011).

There is no history of attendance/knowledge at Kingston Hospital in relation to domestic violence for either Sarim or Agapito.

SOUTH WEST LONDON & ST GEORGE'S MENTAL HEALTH TRUST

Contact began on Thursday 1st September 2011 and ended six days later. The first contact was at Kingston Accident and Emergency Department where Sarim was assessed by the Liaison Psychiatry Service for the Mental Health Trust.

This assessment followed Sarim reporting that he had taken an overdose of 15-20 tablets of paracetemol that evening. Sarim was accompanied by two male friends but he was seen alone. Sarim stated that he had discovered that his partner of over three years Agapito, with who he had a two year old daughter, had been in contact with her former partner. He said that he discovered this through her internet contacts and when he spoke to her about this he became tearful and upset and told her that he wanted the relationship to continue.

On the morning of the 1st September 2011, Sarim alleged that Agapito left the family home to meet with the former partner.

He said that he had sent a text to Agapito saying that '*I will always love you. I can't cope. Take care of Grace.'* When he did not receive a reply he reports that he *'wanted to cry for help'* and that he was *'not thinking straight'.* He went home and took 15-20 paracetamol tablets from a bottle and threw the remainder away.

As he was doing this, he reports that he thought about the consequences for his daughter Grace and that he had no intention to kill himself. He telephoned a friend who then took him to A&E. Sarim reported that his daughter was being cared for by her godmother and that Agapito had returned home at 21.00

Sarim reported that this was his first relationship and his family disapproved of his relationship with her. He said that his parents subsequently severed their ties with him and that he drifted away from his brother, although they are still in some contact. He is close to girlfriend's family who say that they cannot believe her behaviour.

Since Sarim informed his family about the alleged situation of Agapito having a relationship with her former partner, they have said that they will support him.

Sarim reported that he was due to receive British nationality later in the year (*Author's note: Later information would prove this was not true*), was trained in Hotel Management but has been unemployed since 2009.

He reported that he felt used by Agapito and that he wanted to *'take his daughter away from her'*. He also said that he was meeting with a lawyer the following day and that his father had said he would support with paying the cost.

The assessment indicated that there was no suicidal ideation and that he was orientated and did not have any delusions or hallucinations. His risk to himself and others was reported as low and that he was aware that he was adjusting to the alleged news about Agapito. The overdose was assessed as an impulsive act in the light of the alleged discovery of his girlfriend contacting her former partner.

The immediate plan was for Sarim to be discharged home and the Godmother would be staying overnight with him, Agapito and Grace.

He would be referred to and followed up by the Crisis and Home Treatment Team (CHTT) and he was in agreement with this plan. This contact was made the following day when CHTT telephoned Sarim and agreed to meet with him at Tolworth Hospital as he would prefer not to be seen at home. Contact was arranged for the Sunday at 14.00. Sarim did not attend this appointment so was called later the same day. Sarim explained that he had thought he would be sent directions and on receiving none, assumed the meeting was

not going ahead. Sarim said he would telephone the next day to arrange another appointment which duly occurred. The new appointment is arranged for Wednesday at 10.00 outside McDonalds restaurant.

On the Wednesday, two members of the CHTT meet with Sarim. He discussed the alleged breakdown of his relationship and questioned why Agapito does not *'love him or care about him*.'

He informed the practitioners that in his view Agapito intended to leave the family home and marry her ex-boyfriend once he gets a divorce. He said that he was embarrassed that he is a Muslim and she is leaving him for somebody who is already married.

The practitioners advised Sarim that as he said that he wanted to save the relationship he could seek a referral to Relate or counselling though his GP. He said that he did not need counselling and that he planned to move to Ireland with his daughter Grace and work in his uncle's business. He said that he was meeting with his lawyer later that day to discuss the options for sole custody of Grace.

Sarim was assessed as not being a risk to himself or others and that he had no suicidal thoughts, plans or intentions.

The practitioners discussed with Sarim the role and function of the CHTT and he stated that he did not require further input and was happy to be discharged. He agreed for information to be passed on to his G.P and advice given regarding the crisis line if he felt he needed urgent support.

Although there was no direct contact after that, a letter is sent on 14th September to Sarim's G.P. confirming discharge from CHTT following presentation at A&E. The date of presentation and the reason for assessment are not included in the discharge letter.

NATIONAL SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN (NSPCC)

The NSPCC Helpline provides help by both phone and email. When staff receive information identifying a child at risk, a referral is made to the appropriate statutory agencies to ensure that action is taken to safeguard the child. There were five email contacts with the Helpline in this case. The Helpline made two referrals to RBK Children's Social Care as described below.

Contact 1

An email from Agapito was sent at 7.20am on Sunday 4 September 2011. She was expressing concern that her partner, Sarim, may be planning to abduct their daughter. She spoke about '*fighting'* with him in front of their daughter. Agapito was asking for advice on protecting her child; how to stop her partner taking the child away or leaving the country with her.

The email contained the senders name, her daughter's name and her date of birth, her partner's name and the home address.

The Helpline's email response later the same day informed Agapito that a referral was being made to RBK Children's Social Care. The referral would request that an initial assessment be carried out to determine the level of risk to Grace, and also to identify possible areas of support for Agapito. The Helpline's email response also provided contact details for the child law advice line and 24 hour domestic violence helpline. There is no record of any further contact between the Helpline and Agapito.

Referral 1

A referral to RBK Children's Social Care was made the following day (Monday 5 September 2011) by telephone and fax. The Helpline practitioner's written assessment of risk in the referral (based on

information in the email) was that *'the child may be witnessing domestic violence and could be at risk of abduction from her father'*. The referral recommended an initial assessment be undertaken to determine the level of risk to the child. The relevant email transcripts were also provided in the referral.

Contact 2

The first of four emails from Sarim was also sent on Sunday 4 September 2011 not quite four hours after Agapito's email. The email was long and talked about how he had met Agapito, their relationship and the birth of their daughter, Grace. He was concerned that Agapito was seeing her ex-partner and that she may take their daughter away. Sarim also said that he had attended hospital some time previously as a result of a paracetamol overdose.

The email contained the senders name and mobile number, his partner's name, his daughter's first name and her date of birth. No address was provided.

The Helpline's email response early the next morning (Monday 5 September) encouraged Sarim to prioritise his daughter's needs and to see his GP (in relation to the overdose and how he was feeling). Contact details were also provided for Families Need Fathers and community legal advice.

Contact 3

The second of four emails from Sarim was sent almost three weeks later on Friday 23 September 2011. He again describes difficulties in his relationship with his partner Agapito and her involvement with another man. He talked about getting angry '*last night*' and was seeking advice about controlling his emotions.

The Helpline's response again encourages him to prioritise his daughter's needs, seek counselling through his GP or contact Relate. Contact details were also provided for the Children's Legal Centre.

Contact 4

The third of four emails from Sarim was sent on the morning of Saturday 24 September 2011. He said that the situation had '*gotten worse today'*; Agapito and Sarim had argued and he had broken her mobile phone. Agapito had left the house with their daughter.

The Helpline's response informed Sarim that, as he had provided an address, the information would be shared with RBK Children's Social Care and that the Helpline would be recommending that an initial assessment be undertaken to determine the level of risk to his daughter. The Helpline also gave the number and email address for Respect who operate the national Men's Advice Line.

Author's note: Enquiries were made of Respect who did not receive any contact from Sarim.

Contact 5

The fourth and final email from Sarim was sent on the afternoon of Saturday 24 September 2011. His partner and their daughter had still not returned; he was asking whether he should contact the police now or wait.

The Helpline's response acknowledged that he sounded anxious about his daughter being taken away from home for most of the day but that '*it sound(ed) like he and Agapito needed some breathing space from one another*' and their daughter '*would benefit from not witnessing any further arguments and confrontations'*. Sarim was also informed that information from this email would be added to the referral to RBK Children's Social Care. There is no further record of any contact with Sarim.

Referral 2

A referral to RBK Children's Social Care was made on Monday 26 September 2011, by telephone and email. The Helpline practitioner's written assessment of risk in the referral (based on information from emails) was that there were '*concerns regarding Grace and that she is at risk of significant harm as a result of conflict between her parents'*. The referral acknowledges that *'the relationship between her parents sounds very complex'* that 'there *are arguments and possible domestic violence'*. The referral requests that an initial assessment is undertaken. At this point a records search was undertaken and a link was made to Referral 1.

METROPOLITAN POLICE

On 24 September 2011 Agapito went to Kingston police station and reported an incident that had occurred at her home on 22 September 2011. Sarim had been accusing her of being involved with an ex-boyfriend. He became angry and verbally abusive, and called her a prostitute. Their daughter was present when he played a pornographic video on a computer, and threw jewellery at Agapito, hitting her on the chest.

He accused her of performing the sexual acts seen in the video with another man. She challenged him, but fearing he may become violent, did not persist. She stated that he had never become physically violent before. Agapito also reported that her mobile phone had been damaged by Sarim. She did not witness the damage, but Sarim had admitted doing it and told her that she should get '*her other man*' to buy her a new one.

A crime report was initiated by the station reception officer, who asked a police officer to complete the 124D[14] and risk assessment. This process was overseen by a detective constable, who also spoke to Agapito. She was informed of the services available to victims of domestic abuse, including the One Stop Shop operating in Kingston.

A SPECSS+ risk assessment was completed and transferred to the crime report. The risk assessment revealed that Sarim behaved jealously and had made threats to kill Agapito, and as a result she was afraid of him. It was also suggested that he needed treatment for mental health disorders.

The following questions and answers were received:-

Question: *'Are they acutely jealous / controlling?'*

Answer: *'He is jealous'.*

Question: *'Have they made threats to kill you or your family?'*

Answer: *'Yes, threats to kill me.'*

Question: *'Do they have mental health problems?'*

Answer: *'Yes, I believe he does, but not receiving any treatment.'*

Sarim was subsequently arrested and following consultation with Agapito, released on bail. The conditions of bail were that he was to reside with his brother in a neighbouring Borough although he was to be permitted to travel to Agapito's home on a daily basis to provide childcare for Grace. A referral was also made to RBK Kingston Children's Social Care which incorrectly stated that there were no bail conditions in place.

VICTIM SUPPORT (VS)

In London, Victim Support (VS) has a central Victim Care Unit (VCU) which handles referrals received by automatic data transfer from the Metropolitan Police Crime Reporting Information System. Victims can self-

[14] 124d is the name of the SPECCS risk assessment form

refer to local support offices and outreach sites, and Victim Support also accepts referrals from other agencies.

Since February 2012 in Kingston, Victim Support (VS) also provide a Community IDVA and ISVA service to support survivors of domestic and sexual abuse. The services work in partnership within the Safer Kingston Partnership Strategy for Domestic Abuse. Victim Support co facilitate weekly at the One Stop Shop and various sites in the community including Kingston Hospital (A&E), Wolverton Centre and Churchill Medical Centre.

Victim Support first became aware of Agapito on 23 September 2011 when she self-referred to their Kingston Office by telephone.

Agapito said in that call that she had been recommended to call Victim Support by RBK Children's Social Care to whom she had reported the incident with the cigarette and her daughter. The case was dealt with by an experienced IDVA. Established practice at that time was for full risk assessments to be conducted face to face so the IDVA did not do this on the phone.

No referral was made to or professional conversation had with RB Kingston Children's Social Care regarding Agapito or her daughter as she said she had been had been referred from them. The IDVA at the time did consider Victim Support's Domestic Violence Service Delivery Operating Policy and assessed that there was no new information to add to what Children's Social Care already knew.

Victim Support's Domestic Violence Service Delivery Operating Instructions states:

'The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If there is a concern about risk to a child or children, ***we should always make a safeguarding referral no matter where the referral originated from****, to ensure that a full assessment of their safety and welfare is made. However, if it can be established that the Police have made a referral to Children's Services, then we do not need to make another referral* ***unless we become aware of new concerns or we are unable to confirm that Children's Services have been notified of the case.'***

Victim Support's Safeguarding Policy in use at the time states -

'2. As soon as possible, record in writing what was said or seen, using the Safeguarding recording sheet if possible. It is important not to try to interpret what has been said; record it using the words used by the person making the allegation. Record the date and time of this conversation and be sure to sign the form.

3. Immediately notify your line manager, who will notify the designated safeguarding officer (or deputy designated safeguarding officer) if the line manager is not available '

The IDVA at the time did not complete a safeguarding form or discuss the situation with either her line manager or Safeguarding Officer. The IDVA was guided only by the information the Agapito gave to her.

The IDVA made an appointment with Agapito in the safe environment of Victim Support's office in Kingston. The appointment was made for Thursday 29th because the IDVA was on annual leave from Monday 26th to Wednesday 28th, inclusive. The IDVA also informed Agapito about the One-Stop-Shop.

CHILDREN'S SOCIAL CARE

First Contact/Referral

The Safeguarding service was first alerted by telephone to Agapito by an NSPCC referral on 5 September 2011. Later that same day, a faxed written referral was received from the NSPCC stating that Agapito had emailed them outlining that: she had a 26-month old daughter; her relationship with Sarim was not good; they had been fighting in front of their daughter and she was afraid he would abduct Grace. Agapito wanted details of organisations that could prevent him taking her away or abducting her. These were provided by the NSPCC. The NSPCC recommended that an initial assessment be completed.

On 5 September 2011, the team on duty checked the electronic children records (ISA and ICS) to establish whether the family were known to children's services. The family were not previously known. Team Leader (TL1) made a decision that information and advice should be provided because the family were not previously known, there was nothing in the NSPCC referral to substantiate their request for an initial assessment and Grace was not aged under 1 when (according to her understanding of the Kingston LSCB procedures) an initial assessment should be undertaken. TL1 then authorised the duty social worker to email Agapito. The duty social worker (SW1) emailed Agapito on 8 September 2011 (three days after the referral) providing information about how Agapito could access domestic violence advice and support, solicitors and the Police. This was the same type of information and advice already provided by the NSPCC to Agapito.

Recording after the First Referral

The record of the contact and the social worker's email to Agapito was only placed on the ICS system on 12 September 2011 which was the first working day of the week after the team ended their time on duty and five days after the referral. ICS records show the Team Leader's (TL1) decision was finalised on 14 September 2011, seven days after the referral. In the interview with the IMR author TL1 was clear that all decisions and guidance were provided in a timely way but recording occurred later.

On 9 September 2011, Agapito emailed the social worker (SW1) saying the following, *'Thank you for your kind help. My partner and I sorted out and we talked about our problems, at least now I know what I am going to do just in case.'* SW1 responded, thanking Agapito for the update and telling her to keep Grace safe. This marked the end of the first phase of involvement by Children Social Care until two weeks later.

Referral Two

On Friday 23 September 2011, Agapito emailed SW1 (who had emailed from her direct work email address, not the more widely accessible safeguarding duty email address). SW1 forwarded the email from Agapito to TM2. Agapito's email said she thought things had been sorted out but they were not. Agapito and Sarim had had a big argument and she was shocked and scared because Sarim showed a sexual video to Grace whilst saying Agapito was a *'prostitute, whore and dirty woman'*. Sarim also left Grace to play with cigarettes telling Grace she would learn how to smoke in the future. Agapito said she was the breadwinner and Sarim looked after Grace during the week (Monday to Friday) which made her scared. This information reflected an escalation in Sarim's behaviour which was not met with action that reflected an escalation in concern about Grace or about Agapito. Instead in response, the Duty Team Leader (TL2) considered that whilst there were worrying things in Agapito's email, providing information and advice on the telephone was the most appropriate response.

On Friday 23 September 2011 when SW2 telephoned her, Agapito said she considered that she was the reason her partner was causing problems with her daughter. She had confided in an ex-boyfriend and Sarim found out. Agapito repeated that she had to leave her daughter with Sarim while she worked and she had no one else to help in the UK. He was from Pakistan and she was from the Philippines and both had unresolved immigration difficulties, Sarim being an overstayer and Agapito's papers being under consideration by the Home Office. She repeated her earlier statements about the pornographic images being shown to Grace and her worry that he was caring for her during the week while she worked. Agapito added that she heard he

had tried to commit suicide by taking 25 paracetamol[15] in front Grace. She also mentioned that Grace had a rash.

SW2 recorded that she asked Agapito about the nature of the domestic abuse and Agapito said it was not physical. It was verbal and that he (Sarim) shouted and used bad language. SW2 records, '*I advised her strongly to contact the Victim Support Independent Domestic Violence Adviser*.' SW2 also discussed with Agapito the Kingston Domestic Abuse One Stop Shop which provides free legal advice for housing issues and injunctions and other support services including CAB, the Community Safety Unit and Health Visiting Services.

SW2 then advised Agapito to contact the Health Visitor and asked Agapito for permission to contact the GP. The conversation ended with an invitation for Agapito to make contact again if needed.

TL2 discussed the telephone call with SW2. TL2's risk assessment was that whilst not appropriate, Sarim's action of showing the pornographic video to Grace was a demonstration to Grace of his feelings towards Agapito, '*it wasn't salacious'*.[16] Agapito's focus was more on the relationship between herself and Sarim; the abuse was not physical and Agapito had not sought an injunction hence the appropriateness of providing her with information and advice.

Recording of the Second Referral

Recording of SW2's conversation with Agapito and of the manager's decision only occurred on 27 September, which was two working days after the conversation and after the team ended their time on duty. It was also after a further referral from the NSPCC and after Agapito's death.

Contact/Referral Three

On Sunday 25 September 2011, a Police Notification (Merlin) was sent to the Children Social Care secure email address outlining that Agapito had reported an incident between herself and Sarim when he smashed her mobile phone. The Police had interviewed Sarim who told them he had accessed Agapito's emails and (allegedly) found out she had been communicating with her ex-partner with whom she was (allegedly) in love and she was playing with his emotions. He did not admit showing Grace the video but he did admit calling Agapito names. He admitted damaging the phone. This new information would suggest that there was an escalation of Sarim's behaviour. However, this context could not be understood to inform any actions because it was not on the electronic recording system and until after Agapito's death. The duty arrangements at that time did not compensate for the absence of recording because the memory of referrals was not held in any one place/team. Three duty teams, social workers and managers had a hand in making decisions and taking action in this case over a three week period.

Recording Contact Three

The Police Notification was not recorded onto the ICS (case management system) until 27 September 2011, two working days after it was received and the first working day after the murder. The reason given in interviews with the IMR author relates to the perception about the volume of notifications and other work needing to be progressed on duty. The notification was ticked for information and advice only when it should have been forwarded as a referral.

Contact/Referral Four

On the morning of 26 September the NSPCC telephoned the Children Social Care team on duty and followed up on the same day with a faxed referral about Sarim's three email contacts with them (once on 23

[15] The actual quantity is unknown but blood tests proved that the amount was less than twenty.
[16] It is wholly unclear how TL2 was able to make this assessment having not seen the video in question.

September and twice on Saturday 24 September). Sarim had stated in his emails that he was seeking advice because Agapito was:

- Doing her best to make him angry.
- In another relationship and talks to the man in front of him.
- Taunting him.
- Making a fuss about him taking his daughter to see his brother.
- He thought Agapito and Grace were missing but found out where they went and wanted to know whether he should contact the Police.

The specific comments from the NSPCC were, *'If the allegations raised in this referral are founded, there are concerns regarding Grace and she is at risk of significant harm as a result of the conflict between her parents. The relationship between her parents sounds very complex and both emails and a previous referral confirm that there are argument and possible domestic violence. It is concerning that Grace is subject to witnessing these arguments and that neither parent appears to be able to resolve their difficulties to ensure that Grace is protected. It is recommended that an initial assessment be undertaken to ascertain if the concerns raised in this referral are fact and if so, what action may be required to ensure that she is protected'*. The NSPCC therefore indicated the risk to Grace and made clear again that they considered an initial assessment to be necessary. There is no indication of any particular weight being given to the NSPCC recommendation; rather the decision was made by the Team Leader that because "the family were not previously known, there was nothing in the NSPCC referral to substantiate their request for an initial assessment and Grace was not aged under 1 when, according to her understanding of the Kingston LSCB procedures, an initial assessment should be undertaken".

SW3 created a contact record and had a brief discussion with TL3 about the NSPCC referral on 26 September. Interviews with TL3 revealed that the referral was not considered to be urgent and because it had been a busy day TL3 took home a hard copy of the Police Notification with the aim of reading it to make a decision within the 24 hours (the next morning).[17] TL3 did not directly view the electronic records albeit that only the first referral would have been on the electronic system.

Recording

SW3 recorded the contact on ICS (case management system) on 26 September but it had to be deleted and reinserted on 27 September to ensure the records were chronological after TL2 and SW2 belatedly inserted their record of the telephone contact, the conversation with Agapito and the decision. The Police Notification of 25 September was also not on the ICS (case management system) system until 27 September.

Action/Recording following Agapito's death

At 11 pm on 26 September 2011, TL3, who was the Emergency Duty Manager, was notified that Agapito had been murdered.

On 27 September at 9.06 a.m. TL3 alerted senior managers to Agapito's death. Sarim was imprisoned and Grace was appropriately and safely placed with Foster Carers.

The IMR author concludes that it is not clear that action taken or not taken made any difference to the outcome of Agapito being killed by Sarim and Grace witnessing it.

[17] Please see later section: disputed facts

However, this review has afforded the opportunity to secure learning about practice, management, systems and processes. At the time of writing the IMR, action plans were being developed to address duty practices to result in a more transparent systematic approach to duty. Plans were also being developed to achieve more timely screening and managerial decision making with a continued focus on good assessments including analyses of risk followed by interventions that are designed to mitigate risk.

Disputed facts

Within the narrative above which derives from the IMR, several facts are disputed. These are as follows:

- That the 'Rollback' procedure on ICS (case management system) was a common practice across Children's Social Care at that time and this case was thus not unusual (this is disputed by the former Acting Head at RB Kingston Children's Social Care)

- That TL3 took papers home with her (this is denied by TL3)

It is further alleged that key members of teams were not consulted or interviewed by the IMR author.

It has not been possible from the evidence presented, to firmly conclude which version of events is truthful. Rather than prolong the DHR still further, the Panel agreed to focus on what lessons could be learned which focused on:

- Clarity of procedures
- Timely record keeping
- Better communication with NSPCC Helpline and understanding of NSPCC Helpline's process (including communication channels) for referring out concerns to Children's Social Care and the availability of NSPCC staff for further discussion if required

Many of these are reflected in the attached action plan and are also part of a wider investment being made by RB Kingston to improve standards within Children's Social Care.

4. CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

The Panel began the conclusion phase of the DHR by considering what Agapito needed and how well local provision met these needs. It was agreed that gaps in what Agapito needed were:

- Reliable and affordable childcare
- Security of immigration status
- Her concerns to be taken seriously by all professionals
- A holistic intervention that took account of all her needs
- An appreciation by professionals that reports of abuse may be commonplace for them, but for Agapito this was unknown and often frightening territory

ANALYSIS

1. ***Each agency's involvement with Agapito, Sarim and their daughter, Grace.***

   Each agency provided an individual chronology of contacts with their agency and subsequent actions. These have all been merged into a single chronology attached at appendix A.

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

(a) Communication between services

Kingston services are to be commended with regard to this as there was evidence of clarity between agencies concerning their roles and responsibilities. For example, except where discussed in this report, evidence was provided of appropriate referrals, information sharing and matching records. However, in the following situations, information sharing was below standard:

The quality and detail of the discharge letter from the Crisis and Home Treatment Team (CHTT) to the GP is concerning since:

- The letter did not include any details of the nature and extent of the overdose. The letter says that Sarim presented at A&E but not the reasons why.
- There is no detail provided in relation to Agapito and Grace.
- There is no confirmation sought from the G.P. regarding Sarim's past medical or any psychiatric history.
- There is no information provided with regard to the risk assessment carried out by the mental health professionals.

The Police could have communicated Sarim's bail conditions to RB Kingston CSC more accurately.

Agapito's visit to the OSS did not result in a referral back to MARAC or indeed anyone else.

In all of the above, there is no evidence to suggest that had the standard been met, there would have been a different outcome.

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

The level and quality of information sharing regarding Sarim and his family held by South West London & St George's Mental Health Trust is concerning. Whilst he was only seen on three occasions over a five day period there was information that required sharing particularly in relation to Grace.

Sarim maintained that he had acted impulsively and had not been previously seen by mental health services. This was not questioned or confirmed with the G.P. and in the letter to the G.P. confirming discharge from CHTT the date of presentation and reason for assessment were not included.

There was no discussion amongst practitioners regarding whether the information regarding Grace should be shared with any other agencies or professionals. Sarim had taken an overdose and acknowledged that he was very upset and acted impulsively. The possible impact on his parenting and care for Grace was not fully considered and consultation did not take place with RBK Children's Social Care or the Trust named nurse or doctor for Safeguarding Children.

Sarim's third and fourth contact with the NSPCC Helpline was by email on Saturday 24 September 2011 and in response, Helpline made a second referral to RB Kingston CSC requesting an initial assessment be undertaken to assess the level of risk to the child. In preparing this referral a search was made of NSPCC records. A match was found to the previous referral to children's services arising from Agapito's email on 5 September. Although the match is noted on the second referral it does not make it immediately apparent that there had been a previous referral. Nor does the Helpline practitioner's assessment of risk in the second referral refer to the earlier information. This omission was not identified by the duty manager in their review of the referral. A recommendation to support expected practice is included in the action plan.

Victim Support did not complete a safeguarding referral to RBK Children's Social Care at the time based on the decision that the referral had come via CSC. In line with Victim Support policy on Safeguarding all cases of domestic violence where there is a child should have a safeguarding form completed and possible referral

to CSC considered with advice and support from the line manager and/or Designated Safeguarding Officer. Although, subsequent to the crime, Victim Support now has confirmation that RB Kingston CSC were already aware of this case, the IDVA did not follow the internal Safeguarding policy. The Victim Support IMR found that the Safeguarding Policy should have been applied and a safeguarding form completed and escalated to a line manager. In this case best practice would also require that a call should have been made to the referring officer from RBK Children's Social Care to have a professional conversation concerning information received from the victim.

When the first and second referral was received by RB Kingston CSC from the NSPCC, discussions were not held with them in line with section 5.32 of *Working Together to Safeguard Children – March 2010* which states, *'When a parent, professional, or another person contacts local authority children's social care with concerns about a child's welfare, it is the responsibility of the local authority children's social care to clarify with the referrer: the nature of concerns; how and why they have arisen; what appear to be the needs of the child and family and what involvement they are having or have had with the child and/or family members.'*

The reason discussions were not held relates to Team Leaders' perception about arrangements within the NSPCC being such that there would be no access to the person who communicated directly with Agapito. Feedback to the NSPCC about the action being taken was not provided for the same reason. The processes for joint communication between RBK Children's Social Care and the NSPCC help-line has since been clarified.

Checks and discussions with other agencies to establish their involvement if any, with Grace in particular, did not occur. Undertaking checks with other agencies would have been in line with paragraph 5.34 of *Working Together to Safeguard Children*, which states, *'the decision should normally follow discussion with any referring professional/service, consideration of information held in any existing records and involve discussion with other professionals and services as necessary.'* It was only SW2 who appeared to consider these necessary when she asked for Agapito's permission to contact the GP. Unfortunately she did not follow this through.

This is a matter of concern because the potential opportunities offered by multi-agency working to clarify or challenge decision making were lost. Initial work upon receiving referrals about children should include checks with other agencies before decisions about the appropriate course of action in response. These checks should take into account the published practice guidance on information sharing (DfE 2008). This should be embedded practice.

The CSC IMR was clear that Team Leaders' views about the actual or potential deluge of work if the type of referrals made in this case are to be comprehensively responded to required attention and a different approach. It recommended that performance information (which is collected in Kingston) should evolve to record all performance information relating contacts, referrals and assessments so that the impact can be evaluated with proper monitoring of volume. It recommended that Team Leaders should alert more senior managers if they are unable to manage volume instead of adjusting thresholds, although it is accepted that managers were trying to manage within their perceptions of the confines of resources. Team Leaders needed to understand that it is the responsibility of all managers including more senior managers to address the issues including those relating to work volumes. The CSC IMR also emphasised the importance of regularly refreshing managers' knowledge about domestic abuse and child abuse as well as their responsibilities. Many of these issues were also included within the Ofsted Improvement Plan and have since been addressed.

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

- ***(a) Professional standards***
- ***(b) Domestic violence policy, procedures and protocols***

At the time of the murder of Agapito on 26 September 2011, there was no information available to the UK Border Agency to suggest that Agapito or her child might be a victim of domestic violence or was at risk of significant harm. No referrals had been made by any agency to establish the immigration status of Agapito, Sarim or their child. Accordingly, no risk assessments were undertaken in respect of Agapito or Sarim.

Kingston Hospital Trust has policies and guidelines in place with regards to Information Sharing, Safeguarding Children, and Domestic Violence which are regularly updated and ratified in line with local and national legislation. In this case, the policy was not enacted as there was no disclosure of domestic violence.

As a specialist in child protection, the NSPCCs policies and procedures reflect this focus and they do not currently have organisational policies and procedures for domestic violence[18]. The professional standards set by the NSPCC were all met in this case. Nevertheless, when Sarim contacted the NSPCC Helpline for a second time by email on Friday 23 September 2011, although the email starts by saying that he had *'previously also talk with you about (his) situation with (his) partner'* it would appear that the Helpline practitioner did not undertake a search of the system to establish any previous contact. A search of Helpline systems should have established a link to the earlier email from Sarim as well as the email from Agapito and subsequent referral. This would have provided an opportunity for the Helpline practitioner to contact RB Kingston CSC to ascertain if action had been taken as a result of the referral for an initial assessment. It is not possible to say whether or not this would have made a difference to the outcome in this case. The IMR states that it is expected practice for practitioners to undertake a search of systems where there may have been previous contact. A recommendation to support expected practice is included in the action plan.

At the time of the NSPCC second referral to Children's Social Care on 26 September, there is no record that the Helpline practitioner asked about action by RB Kingston CSC as a result of the first referral on 4 September. For instance, whether or not an initial assessment had been undertaken, and if so what the outcome was. A recommendation to support expected practice is included in the action plan.

As a consequence of both this DHR and others, the Helpline now has a Domestic Violence Protocol in place and has introduced a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Model which includes the risk of abduction. Domestic Violence Referrals are now categorised as Priority 1 referrals and Children Services/EDT and Police are contacted.

TL1's comment that the procedures state that CSC should only be concerned when children are aged under 1 and involved in domestic violence situations is not substantiated by the local or Pan-London Procedures used by RB Kingston.

The Pan-London procedure provides a comprehensive framework for addressing situations where domestic abuse is a factor, particularly the guidance entitled *Safeguarding Children Through Domestic Abuse* as well as the accompanying Risk Assessment Matrix. The guidance addresses issues relating to culture, immigration status, social exclusion and addresses responsibilities within the preventative services framework as well as the responsibilities of safeguarding services in domestic abuse situations. There is also a local Domestic Abuse Guidance framework in place. It does not appear that procedures were correctly followed by RB Kingston CSC staff.

The Metropolitan Police did not meet their professional standards with regard to the welfare of Grace when setting bail conditions and in the undertaking of a risk assessment.

4. ***The response of the relevant agencies to any referrals relating to Agapito, her partner or their child, concerning domestic violence or other significant harm from 1st October 2008. It will seek to understand***

[18] The IMR Author has raised this within the organisation as a finding from this and previous Domestic Homicide Reviews.

what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- ***(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.***
- ***(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.***
- ***(c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made***
- ***(d) The quality of the risk assessments undertaken by each agency in respect of Agapito and Sarim.***

South West London & St George's Mental Health Trust assessed the risk in this case but the focus was on the possible impact of Sarim presenting overdose and his presentation to practitioners. This was the first occasion that he had been seen by mental health professionals and his actions were assessed as being an impulsive act in response to the emotional impact of finding that his partner was seeing another man. As a consequence, Sarim was assessed as not presenting a risk to others but this was not explored in detail in relation to his role as a father and carer for Grace and his relationship with Agapito.

Sarim shared with the practitioners his concerns and feelings with regard to the probable breakdown of his relationship with Agapito but his thoughts and feelings about his partner and how he might respond towards her or his daughter were not assessed in detail. This should have included a discussion with him about whether there was any violence, abuse, aggression or extreme anger in the relationship and if so what impact this had on Grace.

The potential impact of Sarim's actions on his role as a father and carer of Grace were not fully risk assessed and integrated with the responsibilities for safeguarding Grace. This is highlighted by Sarim's articulated plans to take Grace to Ireland and that it was not clear whether he had parental rights or whether these were with the mother. There was no recorded discussion with Sarim about how this might affect Grace and the impact of being separated from her mother. This should have formed a specific aspect of the risk assessment and have been checked with other agencies, and particularly the G.P.

Sarim's views and descriptions were accepted at face value and not questioned or confirmed with any external or third party.

The NSPCC Helpline's involvement in this case involved email contact with Agapito and Sarim as a result of which there were two referrals to Children's Social Care. In both referrals the Helpline's assessment of risk / need identified risk factors to the child in respect of domestic violence.

However, the Helpline's assessment of risk did not consider the risk to the mother, Agapito, as a result of her leaving the house with her daughter after an argument with her partner. .

No incidents came to the notice of the Metropolitan police until three days before Agapito died. There was no suggestion that physical violence had been used before this incident although Agapito had reported that threats had been made in the weeks before her death.

The form 124D in use by police on Kingston Borough was the older form which contained the older SPECSS+ risk assessment. The differing sets of questions have been compared and no additional information would have been elicited that would have changed the risk assessment. The issue of the outdated forms has been rectified and the newer form incorporating the DASH risk assessment is now in use. The issue around the older 124D forms was not just an issue for Kingston police, but an issue across the MPS area. This has since been addressed across the MPS and instructions have been issued to remove all the old pre DASH 124D's from all stations and in addition, ACPO have provided a briefing dictating the use of DASH as the risk model across the MPS.

Nevertheless, the incorrect risk standard was applied as it included a threat to kill Agapito. This, together with her other responses, should have been assessed as medium or high. A risk assessment above standard requires that positive action and risk management are considered. However, this was offset by the fact that the incident was identified as a domestic violence issue, and Sarim was arrested immediately. Agapito was allowed to remain with police until he was in custody, thus minimising the risk during this period.

A decision was made to bail Sarim in order to seek a case disposal decision. This course of action had the benefit that whilst Sarim was on bail, the police were able to retain a measure of control over him.

It is noted that bail conditions restricting Sarim's access to Agapito were considered, and were recommended to her. Unfortunately, Agapito requested that less stringent bail conditions were imposed, as she needed Sarim to look after their daughter whilst she worked.

What is apparent is that although bail issues and risks were considered towards Agapito by the Police, there was a lack of risk identification for their daughter Grace. It appears that the focus, particularly from the Community Safety Unit (CSU), was on the domestic violence and protecting Agapito, but did not in this case consider how to protect the child and whether Agapito had the ability to protect that child. It is not suggested that the bail conditions should have been different, but there was no rationale or consideration regarding Grace's safety. If this had been a child abuse investigation, irrespective of Agapito's wishes, the likely outcome would have been that Sarim would have been restricted access irrespective of how inconvenient it would have been for Agapito.

Unfortunately it appears that NSPCC's practice of requesting an initial assessment for every referral resulted in no specific consideration being given by RB Kingston CSC to progression to assessment as a result of this request. This was not acceptable practice and has since been addressed.

RB Kingston CSC did not carry out any form of risk assessment in response to the referrals.

When Agapito communicated her concerns for the second time via the email and during the subsequent telephone discussion with SW2, this additional information should have resulted in TL2 instigating an initial assessment and a formal risk assessment using the Pan-London Domestic Abuse Risk Assessment Matrix.

The Duty Managers' failure to read or screen referrals, their failure to identify risks, their failure to investigate and their general low level of vigilance are all of concern. If the referrals had been read and linked with their own information, a clear risk of Grace being abducted would have been evident. Practice by the managers and social workers involved in this case needs to evolve in the way the Eileen Munro suggested to reflect analysis not just of what is literally said but of what it means and of an evaluation of risk. Leaving the responsibility to take action to Agapito alone, particularly given research about child abuse and domestic abuse and its impacts, is of concern and was inappropriate. This has since been re-emphasised to managers and in general training of staff, including managers.

Recording on the ICS system did not occur in a timely way on a number of occasions with the resulting impact of decisions being made without full information, although there is no information to suggest that decisions would have been different if all the information had been recorded.

In summary therefore, the failure by CSC to record the contacts at the time they were received, together with a structure that had weaknesses, meant that a chronology of events was not built up to inform their risk assessment. The NSPCC system did not allow for an immediate link to be made between emails from Agapito and Sarim. The police did not take into account the safety of mother or child when making bail conditions.

The One Stop Shop did not refer back to CSC immediately when Agapito left their offices on the day of the murder despite the on-going risk to Grace.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

The Safer Kingston Partnership provides free training and guidance for local professionals in responding to domestic violence and a detailed local directory.

All staff in the A&E department at Kingston Hospital Trust receive safeguarding children training at a level relevant to their roles and responsibilities along with annual updates included in mandatory training sessions. The Trust also has an Independent Domestic Violence Advisor in post that spends time in the department advising, teaching, and supporting staff when victims of domestic violence attend although this post has subsequently been deleted. The Named Nurse Child Protection/Liaison Health Visitor has a high profile in the A&E department and staff will refer safeguarding queries to her as required. Staff are also aware that there is always a Paediatrician available for advice along with telephone numbers of local family safeguarding services for further advice or referral.

The Kingston LSCB has in place a training plan which outlines a rolling programme of training on Domestic Abuse Awareness and Domestic Abuse and Sexual Violence for practitioners and managers across all agencies. There is no record of RBK Children's Social Care managers attending either child abuse or domestic violence training in the 18 months prior to the incident although this was available to them through the LSCB training programme.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

One in ten people who commit homicide have a history of contact with mental health services within the previous 12 months[19] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness recently reported that the overall quality of risk assessments by Mental Health Services was considered unsatisfactory in 41% of the patient homicides. Risk formulations and management plans were the domains most likely to be judged unsatisfactory in both suicides and homicides.[20]

This case demonstrates, as many others before it, that leaving an abuser and having disputes over child contact are key risk factors for homicide. It also confirms research showing that the victim's assessment of the level of danger she faces is the most accurate[21]: Agapito expressed a fear that Sarim would kill her and that she was very frightened. Agapito's friend who gave evidence at the trial said: *'the last word she told me 'if you no longer contact me maybe Sarim killed me already. She was really scared.'*

This case also demonstrates the importance of understanding coercive control and framing domestic violence as a pattern of behaviour rather than isolated incidents. A focus on 'incidents' rather than on patterns of behaviour underestimates the impact and risks associated with coercive control and privileges physical assaults over other forms of control. As Evan Stark says: *'[the] typical experience involved frequent, but largely low-level assaults combined with non-violent tactics that ranged from being deprived of basic necessities and being cut off from the outside world to rules about how they should dress, cook or clean. .. Moreover, my clients insisted that being isolated and controlled could be even more devastating than being beaten, in part because these tactics undermined their capacity for independent decision-making and inhibited effective resistance or escape...I adapted the coercive control model of abuse because it captured the multi-faceted forms of oppression these women had experienced as well as the harms they described to*

[19] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2012) Annual Report and Shaw, J., Appleby, L., Amos, T., Mortensen, P.B., Harris, C., McCann, K., Keirnan, K., Davies, H., Bickley, H., & Parsons, R. (1999) Mental disorder and clinical care in people convicted of homicide: national clinical survey. *British Medical Journal* 318 (7193), 1240-1244.
[20] Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study, June 2013, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2013)
[21] Battered Women's Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Re-assault D. Alex Heckert and Edward W. Gondolf (2004)

their personhood, autonomy, dignity and equality as well as to their physical integrity'[22]. Given that coercive control is a more reliable predictor of homicide than physical assault, a focus on incidents rather than patterns leads to unreliable assessments of risk.

The Victim Support IDVA did not carry out a full DASH RIC assessment when Agapito called but IDVA did mentally check off a SPECSS assessment although this was not recorded. The IDVA reported that the victim confirmed that there was no physical violence at that point. She did not carry out a full DASH risk assessment as practice was to do this face-to-face. The IDVA concluded that no high risk factors were present even though there were difficulties presented by child contact, a separation, escalation and the incident regarding showing Grace pornography.

However, safety planning was discussed with Agapito and details of the One-Stop-Shop were also given. The Victim Support Confidentiality Policy was also explained.

Children's Social Care did not carry out a risk assessments in response to any of the referrals. Risk is a dynamic and as such, patterns of escalation can only be identified if all agencies undertake and share risk assessments. At the time of the third contact by Agapito (once with the NSPCC and twice to Children's Social Care), the thinking and actions by TL2 and SW2 did not reflect any analysis as to why Agapito was once again coming to their attention. Risk was incorrectly being assessed as low due to the lack of a history of physical violence which in reality, is only one of a range of risk. It also appears that the responsibility to analyse, evaluate, plan and take action based on knowledge about domestic abuse and child abuse was not fully understood. Nor was any consideration given to engaging with Sarim and the sole responsibility for protecting Grace was given to Agapito. However, a perception exists (articulated in interviews with the IMR author) that there wasn't time to respond comprehensively to this type of concern because of the volume of work being processed on duty.

Whilst MARACs perform a useful function, care must be taken to still have emergency interventions in place given the speed at which domestic violence can escalate.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

An issue that arose in the course of scrutinising the IMRs from St George's Hospital Trust; St George's Hospital Trust – Midwifery; Kingston & Lambeth GP; Your Healthcare CIC (Kingston) and Merton & Sutton NHS was a difference in the records regarding immigration status. This led to uncertainty over Agapito's eligibility to access NHS care which, on occasion, was withdrawn due to a mistaken belief that she was not entitled. This meant that Agapito and Grace did not have the continuity of care that is expected during pregnancy and post-partum. Whilst it is highly unlikely that this impacted on the subsequent events, it should not be forgotten that health professionals are frequently the recipients of disclosures of domestic violence precisely because of an on-going and trusting relationship.

There were no identified issues in any other agency.

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

See sections 2 and 3 above.

[22] Stark, E. (2007). *Coercive Control: How Men Entrap Women in Personal Life*. New York: Oxford University Press.

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

RBK at the time of homicide had only one operational Victim Support IDVA in the borough; an unsustainable arrangement when annual leave and sickness have to be covered. Victim Support now have another part time IDVA and part time ISVA who are externally funded. These staff members are not permitted to take annual leave at the same time, therefore providing cover for one another. In this case, the contingency was to give the victim details of the Kingston One-Stop-Shop which Agapito did take up.

The process of inquiry into Children's Social Care involvement, and further subsequent enquiry to establish whether the practice found in this case is similar to other cases, revealed that the new duty teams (following restructuring in 2011 when there was a move from an assessment and referral service to all safeguarding teams taking turns on a weekly basis to deliver a duty service) had struggled to meet what they perceived to be a new requirement of receiving and recording all referrals into children services, not just the safeguarding referrals.

This meant difficulties for all concerned with achieving timely recording. This, coupled with managers' and social workers' concerns about caseloads, appears to have contributed to higher than appropriate thresholds being implemented and interventions being minimised.

It has been confirmed that an erroneous understanding of responsibility for processing referrals that did not meet the threshold for CSC intervention had developed. This responsibility has now been returned to the Early Intervention and Prevention Service.

Following the completion of the Children's Social Care IMR, immediate action was taken by the then Acting Head of Children's Social Care which included meeting with all the Team Managers to discuss the finding of the IMR.

A formal letter was sent to Team 2 and Team Manager 3 setting out the concerns raised by the IMR and action plan. These included:

- A failure to adequately review the case history at the point of contact
- Setting the threshold for intervention for Domestic Violence too high
- A failure to ensure that case records were up to date
- The use of 'roll back'. This relates to management authorisation for case records to amended or removed.

An experienced consultant was commissioned to shadow the duty managers and model good practice. This was followed by an external review of the Duty System.

In May 2012 a new Service Manager for Safeguarding joined Kingston and directed staff to ensure all contacts were recorded on the system within 24 hours of receipt. This is currently audited as part of a weekly senior management report.

Following an Ofsted inspection of Safeguarding and Looked After Children's Services in June 2012, which concluded that safeguarding services in Kingston were inadequate, an improvement plan was put in place overseen by an independently chaired Improvement Board. Since this time substantial changes have been made. These include a restructure of the way in which contacts to the service are received, with the establishment of a Single Point of Access Team to manage all incoming contacts to the service. Clear threshold documents have been developed and training to support staff in their consistent application. As part of the service's audit programme, practice in relation to domestic violence is subject to ongoing review. Training on domestic violence is now a mandatory requirement for social workers.

There were no additional issues identified for the other agencies and no additional issues identified for the remaining clauses within the terms of reference.

ADDITIONAL LESSONS LEARNED

In addition to the lessons detailed above in relation to the terms of reference, the DHR Panel also identified the following issues:

Child contact

Agapito was the sole earner and needed reliable free childcare. Effective separation from Sarim, therefore, even on a temporary basis, must have seemed impossible. This meant that Agapito was faced with a choice of staying in contact with Sarim, or foregoing her employment.

Immigration

The insecure immigration status of both Sarim and Agapito was given insufficient weight by agencies, especially when Sarim was articulating plans to remove Grace from the country.

5. WAS THIS HOMICIDE PREVENTABLE?

This Review found that there were two points where serious issues needed to be addressed: firstly the culture at RBK Children's Social Care as revealed by the lack of urgency in responding to NSPCC referrals, the decision by TL2 that showing pornography to a two year old was insignificant, the (disputed) allegation that TL3 took a report home with her and the retrospective record keeping. These were all suggestive of levels of complacency that are unacceptable within child protection. Although much has changed since, this homicide acts as a timely reminder of the necessity of maintaining consistently high standards.

Secondly, the risk assessment by SWL & St George's Mental Health Trust that Sarim was not a danger to himself or others is of concern as safeguarding children and potential domestic violence risks were not assessed in detail. The mental health assessment found that Sarim was not deluded nor for any other reason in need of secondary mental health services. He was acting on a belief about Agapito having an affair and less than three weeks later had killed her in front of their young daughter. This is not to suggest that individual staff were at fault but rather that the risk assessment did not give sufficient weight to potential child protection and domestic violence considerations.

There were also several more missed opportunities for intervention that had they been seized, may have led to a different outcome. Better joined up systems at the NSPCC help-line could have allowed for the different contacts to be linked; a more realistic staffing level for the IDVA service and a consistency in the use of risk assessment tools may all have led to an earlier response although the final outcome may still not have averted. A particular feature of this case is the rapid escalation and in considering all of the available evidence, it is difficult to see how this could have been predicted but the question remains open as to whether more robust responses may have prevented Agapito's death.

The Panel wishes to express its condolences to Grace, family members and friends of Agapito. May she rest in peace.

6. Recommendations

The above findings have been discussed and a set of recommendations developed to improve systems and processes. These have subsequently been developed into an action plan which is attached at appendix B.

It should be noted that many of the issues described in this report have subsequently been addressed or systems have changed beyond all recognition. Nevertheless, each of the recommendations has been included within the action plan to demonstrate the progress made.

Appendix A: Full chronology

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
UKBA	05/01/2001		SARIM		Visit visa application submitted by Sarim in person to the British High Commission, Islamabad, Pakistan	Six month visit visa issued, valid 05/01/2001 to 05/07/2001	480994 (visa application reference)	Full application details no longer available. The issued visa was not used to travel to the UK.
UKBA	06/07/2001		SARIM		Visit visa application submitted by Sarim in person to the British High Commission, Islamabad, Pakistan	Six month visit visa issued, valid 06/07/2001 to 06/01/2002	545754 (visa application reference)	Full application details no longer available. The issued visa was not used to travel to the UK.
UKBA	30/06/2003		SARIM		Student visa application submitted by Sarim by post to the British High Commission, Islamabad, Pakistan	Referred for interview at the High Commission	687188 (visa application reference)	Full application details no longer available.
UKBA	13/08/2003		SARIM		Interview held with Sarim at the British High Commission, Islamabad	Student visa issued, valid from 13/08/2003 to 30/09/2004 to study travel and tourism	687188 (visa application reference)	Full application details no longer available.
UKBA	17/09/2003		SARIM		Sarim entered the UK for the first time at Heathrow Terminal Three		N2098666 (Home Office reference)	
UKBA	06/09/2004		SARIM		Application for further leave to remain in the UK by Sarim received by UKBA	Application granted on 06/09/2004 to study the CTHCM Advanced Diploma in Tourism Management study at West London College, Parliament House, 35 North Row, London W1K 6DB until 31/12/2005. Sarim's address stated as	N2098666 and N2118464 (Home Office references)	Evidence supplied in support of the application stated that Sarim had studied a diploma in travel and tourism at West London College from September 2003 onwards.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						address 3		
GP Lambeth	28/09/2005		SARIM	Registers at GP practice in Prentis Road. Has a new patient health check with the nurse.			GP Notes	GP - NHS Lambeth PCT
UKBA	14/12/2005		SARIM		Application for further leave to remain in the UK by Sarim received by UKBA	Application granted on 16/01/2006 to study BSc Science in Hotel & Hospitality Management at XXX College 30/11/2006. Application documents returned to Sarim at address 4 on 18/01/2006	N2098666 and N2118464 (Home Office references)	Evidence supplied with the application stated Sarim had previously studied an Advanced Diploma in Travel & Tourism at London College of Computing & Management Sciences until Sept 2004 and then XXX College from October 2004 onwards.
UKBA	17/11/2006		SARIM		Application for further leave to remain in the UK by Sarim received by UKBA	Application granted on 09/12/2006 to study a masters degree at Halifax College until 31/12/2007. Application documents returned to Sarim on 13/12/2006 at Flat 2, 32 Gleneagle Road, London	N2098666 and N2118464 (Home Office references)	Sarim's leave to remain in the UK expired on 31/12/2007. No further application was received.
UKBA	25/04/2007		Agapito		Visit visa application submitted by Agapito via an agent to the British Embassy, Manila	Visit visa issued, valid 04/05/2007 to 04/11/2007	363101 (visa application reference)	Visa issued for family visit to brother for one month. Brother: ### Kingston Upon Thames. Subsequent embassy notes state remained in the UK for six

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								months.
GP Lambeth	26/09/2007		SARIM	Final attendance at GP surgery. Notes record: Cannot sleep - insomnia. Has been having a lot of stress at work.		Given short course of hypnotics	GP Notes	GP - NHS Lambeth PCT
UKBA	05/12/2007		Agapito		Student visa application submitted by Agapito via an agent to the British Embassy, Manila	Student visa issued, valid 17/12/2007 to 30/04/2009 to study English at XXX College	387051 (visa application reference)	Visa issued. Sponsored and supported by Agapito's brother###
UKBA	28/12/2007		Agapito		Agapito arrived at Heathrow TN3	Agapito admitted to the UK as a student of business at XXX College	Z01811490 (UKBA landing card reference)	
GP - Cricket Green Mitcham	11/01/2008		Agapito	Family Doctor services registration form. Patient indicated that she first came to the UK on 28/12/07			From copy of GP (General Practice) notes.	
GP Cricket Green	05/11/2008		Agapito	'Patient pregnant' For Obstetric referral			From copy of GP notes.	
	05/11/2008		Agapito		Letter from General Practitioner (G.P.) to Kingston Hospital Ante-Natal Clinic thanking them for accepting Agapito for shared pregnancy care. The expected date of delivery was 29/06/09	Agapito was never seen at Kingston Hospital for ante-natal care.	Kingston Hospital information technology (IT) system showed Agapito to have been discharged	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
							from the hospital to Wandsworth Primary Care Trust.	
	19/11/2008		Agapito	'Kingston Hospital maternity unit called today to say that this patient is not eligible for NHS treatment as she only has a student visa and is attending a private college. We need to review her status at the practice in light of this. Entered by Practice Manager.'			From copy of GP notes.	
	14/01/2009		Agapito	Antenatal appointment. '16/40, long chat about immigration status, visa expires prior to EDD, will go back to Philippines to have baby probably currently processing visa extension, urged to have private appts with gynae but declined because of cost, I am not able to arrange scans for anomalies etc, adv pregnancy is at risk if does not, [Agapito] understands this.'			From copy of GP notes.	
	15/01/2009		Agapito		hospital women's ultrasound centre		From copy of GP notes.	It appears from the notes that the patient had a private ultrasound scan. This is confirmed by a letter from a private hospital dated 13/01/09 referring to an ultrasound

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								as 'normal...'
	21/01/2009		Agapito	'Patient pregnant came with up to date copy of visa which states no recourse to public funds, rang PCSS who said this means not entitled to NHS treatment, advised to seriously think about going back to the Phillipines early as poss for pregnancy monitoring. See here in 3 weeks.'			From copy of GP notes.	
	11/02/2009		Agapito	Antenatal appointment. 'all well, given Mat B1, is going to work for another 5 weeks then stop and go home, so see again in 4 weeks...'			From copy of GP notes.	
	04/03/2009		Agapito	'now not sure will go home, wants to check entitlement to NHS services, advised I was told by PCA that is not entitled to NHS Rx, she should contact them to clarify but I am happy to try and refer elsewhere for NSH Rx and see where this goes...'			From copy of GP notes.	
	04/03/2009		Agapito	GP referral letter for antenatal care at St. Georges Healthcare NHS Trust (SGH)	Referral received and processed in the antenatal clinic	#### had referred Agapito for antenatal care. Having previously referred Agapito to Kingston Hospital for antenatal care which was refused.	Hospital records	Letter attached to referral from ###. Stating Agapito had been referred to Kingston hospital for antenatal care and was refused as it was though

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Letter sent on 4 March 2009. urgent appointments made due to gestation 20+2/40		she had no recourse to public funds and therefore was not entitled to NHS Care. SGH processed this referral as Agapito would have been entitled to NHS care as she provided evidence for the university that she is a full time student.
	24/03/2009		Agapito		'EMIS attachment reference code hospital antenatal booking office'		From copy of GP notes.	Letter from hospital dated 12/03/09 confirms antenatal services booked.
UKBA	28/03/2009		Agapito		Application for further leave to remain in the UK by Agapito received by UKBA	UKBA wrote to Agapito to acknowledge receipt of her application on 31/03/09 and wrote inviting her to a biometric appointment on 14/5/09. UKBA wrote to Agapito rejecting her application because of an incomplete form on 17/05/2009.	C1233857 (Home Office reference)	
	30/03/2009		Agapito	Booking appointment at SGH. Agapito attended the antenatal clinic.	Antenatal clinic midwife.	Noted to be 27+1/40 gestation at booking appointment.	Medical records.	Booked late in pregnancy was unable to have serum screening. Risk assessed as low risk and suitable for

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								midwifery care. Routine questions regarding being known to social services, domestic violence and mental health. Questions asked and Agapito denied any involvement or social concerns. Next of Kin: Sarim (Partner)
	01/04/2009		Agapito		'Emis attachment refernce code letter to patient - DNA surgery appt.'		From copy of GP notes.	
	07/04/2009		Agapito	'Accidental injury NOS ceiling in room came down 3 days ago and caused bruising to right side, wanted to show me in case of future probs, but baby moving OK and not ill in self 6x4 cm bruise over right side, just above hip bone, baby is OK, has appts with midwifes at hospital now. came in to get injury documented as considering legal action.' 'EMIS attachment reference code hospital antenatal booking office.'			From copy of GP notes	
	01/05/2009		Agapito	'Patient pregnant getting some wrist pain over both tips of radius,			From copy of GP	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				will refer to physio gynae physio.. otherwise all well, will see again when midwife next requests...'			notes.	
	11/05/2009		Agapito	Routine antenatal check	Antenatal clinic midwife	Noted to have been seen by the GP at 31/40 gestation Referral for physiotherapy due to carpel tunnel syndrome. Plan made to see GP in 2/52 Midwife 4/52	Medical records.	### Named Midwife, St Georges Hospital Maternity Unit Routine antenatal care no problems identified
	03/06/2009		Agapito	Routine antenatal check	Antenatal clinic midwife.	Routine antenatal check-up 37+1/40. Has not received physio referral. No new problems	Medical records.	
UKBA	12/06/2009		Agapito		A second further leave to remain application received from Agapito by UKBA	UKBA wrote to Agapito to acknowledge receipt of her application on 15/06/2009. UKBA wrote to Agapito inviting her to a biometric appointment on 22/07/2009. UKBA wrote to Agapito on 14/08/2009 rejecting her second application due to submission of an out of date application form.	C1233857 (Home Office reference)	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
	15/06/2009		Agapito	Routine antenatal check	Antenatal clinic midwife	Routine antenatal check 28+1/40 All well antenatal check satisfactory	Medical records.	
	27/06/2009	11.15am	Grace	Maternity Unit		Grace is born at term.	Medical records for Grace	There is no reference to either parent at the birth.
	29/06/2009		Agapito	Gwillim Ward Postnatal	Gwillim Ward midwife	Mother and baby discharged home	Medical records	Discharged to care of the community midwife. Uneventful postnatal care, assisted with breastfeeding and baby care, reported as well supported and adjusting well to family life with new baby.
	09/07/2009		Agapito and Grace	New Birth Visit to Agapito and Grace by Health Visitor 1. Agapito and Grace had moved and were living in rented accommodation in Mitcham. Agapito was advised to register with a local GP. Grace had been discharged by Community Midwife and was gaining weight well. No concerns were identified. It was noted in the progress records that Father from Pakistan and mother from Philippines.		Plan: for HV 2 to contact on return from AL & establish if registered with a GP.	HV RIO records	No evidence of antenatal notification received by HV service from either St Georges Hospital or GP. Whilst the nationality of both parents were noted, no details of Grace's father were documented.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								Immigration status of the family was not documented.
	21/07/2009		Agapito	Family Doctor Services registration form indicated patient moved place of residence in London and changed GP practice. 'Ethnic category: Other Asian - eth cat 2001cens'	EMIS attachment reference code hospital mother & baby transfer report'		From copy of GP notes.	
	23/07/2009		Grace	'3 week old baby, parents noticed lump on left side of neck. Referred to physio.			From copy of GP notes.	
	23/07/2009		Grace	'Patient registration... Both parents present, [baby] well...'			From copy of GP notes.	
	23/07/2009		Agapito	Patient registration new patient health check done, template completed. 3 weeks post partum.' 'Alcohol consumption o units/week' Occupation - health care assistant.			From copy of GP notes.	
	03/08/2009		Grace		Entry in notes re Physiotherapy		From copy of GP notes.	. This entry suggests that the child was seen by the physiotherapist.
	06/08/2009		Agapito and Grace	Seen in Child Health Clinic by HV3. Lump noted on Grace's neck, seen by GP and referred to St George's		As a recent transfer into the area, local information given to	HV RIO records	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				Hospital.		Agapito.		
UKBA	08/08/2009		Agapito		Agapito wrote to UKBA requesting a refund for her invalid application.	UKBA wrote to Agapito on 14/08/2009 stating that an overpayment for her first application was still under consideration.	C1233857 (Home Office reference)	
	18/08/2009		Agapito	'Postnatal care. 1st baby born 8w ago...' '..may want another baby soon..'			From copy of GP notes.	No concerns documented.
	18/08/2009		Agapito	Agapito seen during 8 week review - NICE 45 questions asked - mother reports herself to be well		Not noted in records if Sarim attended this appointment.	HV RIO records	No concerns identified.
UKBA	01/09/2009		Agapito		A third further leave to remain application received from Agapito by UKBA	Application for study at XXX College from 11/05/2009 to 07/05/2010 accepted as valid by UKBA, but not concluded because the college had been suspended from the sponsor register.	C1233857 (Home Office reference)	
	15/09/2009		Grace	Second baby immunisations given with consent. 'Main spoken language English'			From copy of GP notes.	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
	23/09/2009		Agapito and Grace	Seen at child health clinic by Community Nursery Nurse. No concerns identified.		Plan: Review as necessary.	HV RIO records	
	15/10/2009		Grace	Third immunisations given with consent given by mother and father. 'well today..'			From copy of GP notes.	.
UKBA	16/02/2010		Agapito		Agapito submitted evidence of enrolment at a new college on the register, the Practical Development Unit, Derby, for an NVQ level 3 course in Health and Social Care.		C1233857 (Home Office reference)	
	26/02/2010		Agapito and Grace	8 Month Review by HV 5. Normal development noted for Grace. Agapito asked Nice 45 questions. No Postnatal depression reported - NO PND REPORTED		No Postnatal depression reported - NO PND REPORTED No follow up as PNC within normal limits	HV RIO records	Routine 8 month review with no concerns identified
	03/06/2010		Agapito and Grace	Seen by Community Nursery Nurse in Child Health clinic. Weight on centile chart noted to have fallen.		The plan was to review as required.	HV RIO records	Following Grace's weight loss there should have been referral to health visitor from the community Nursery Nurse. No follow up apparent as this was the last contact Sutton and Merton Community Services Health Visitors had with

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								the family.
UKBA	16/08/2010		Agapito		Agapito wrote to UKBA to inform of change of address and to request a photocopy of her passport	UKBA wrote to Agapito to acknowledge her change of address on 09/09/2010	C1233857 (Home Office reference)	
	24/01/2011				The PCSS received surgery server notification from GP practice of the mother and child's registration address '...Gardens' with the incorrect postcode.		Information given to Designated Nurse after discussion with the PCSS.	
	24/01/2011		Agapito	'Administration Adult Screening... other ethnic group Filipino New patient screen done... full time employment education/welfare/health prof Single....			From copy of GP notes	XXX Medical Centre notes give address as '..Gardens' with incorrect postcode. The New Patient Questionnaire filled in by the patient gives the correct address (handwritten) as '..Road' with a different correct postcode. This appear to have been incorrectly put onto the surgery's computer system. The patient has also given a mobile telephone number.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				Teetotaller'				
UKBA	15/02/2011		Agapito		Agapito obtained a photocopy of her passport in person from UKBA, Lunar House, Croydon		C1233857 (Home Office reference)	
	17/02/2011				GP Practice received 'a flag' from PCSS that the medical card sent to the mother on 27/01/11 was returned as undelivered mail. They gave the surgery 6 months to tell them the new address. There was no response.		Information given to Designated Nurse after discussion with the PCSS.	
	02/03/2011		Grace	'FP69 from FPC? Patient now pls check address, to be removed 17/08/11'				A FP69 notification has been sent to the practice. This clearly suggests that the patient's address should be checked but there is no evidence that the patient's mother was telephoned by the practice. Once a FP69 has been issued, the PCSS will off list the patient in 6 months unless the surgery contacts the PCSS to update the information and request that the patient stays on their list.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
UKBA	07/03/2011		Agapito		Agapito wrote to UKBA requesting progress on her leave to remain application	UKBA systems note receipt of letter on 10/03/2011 but no reply sent.	C1233857 (Home Office reference)	
UKBA	23/06/2011		Agapito		Letter received by UKBA from Edward Davey MP requesting a progress report on Agapito 's outstanding application	Reply sent to MP on 07/07/2011 stating that Agapito's application "is complex and requires further investigation some of which may be outside the UKBA".	C1233857 (Home Office reference)	
UKBA	04/08/2011		Agapito		Further letter received by UKBA from Agapito asking for progress on her application	Agapito 's letter linked to her UKBA file and sent to storage on 26/09/2011.	C1233857 (Home Office reference)	
	17/08/2011		Grace	'FP22 - returned undelivered'			From copy of GP notes. XXX Medical Centre	This is a request from the PCSS requesting return of the patient's notes. There is no evidence from the notes that the patient/family were contacted to check their address.
	17/08/2011		Agapito	'FP22 - returned undelivered'			From copy of GP notes. XXX Medical Centre	.
	17/08/2011				Mother and daughter were both		Information given	.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					taken off the surgery list and records were returned to the PCSS.		to Designated Nurse after discussion with the PCSS.	
	01/09/2011	17.24pm	SARIM	Personal attendance at Kingston Hospital Accident and Emergency (A&E) Department		Presenting complaint: Attending the hospital after taking an overdose of Paracetamol tablets (maximum 20) earlier in the afternoon. Reason: Told Staff his girlfriend was cheating on him On examination: Alert but tearful, appropriately dressed with good eye contact and in no obvious pain. Said to feel distressed but not suicidal. said that his partner had left their daughter in his care during the day (now with godmother) Plan: Blood was taken to	Kingston Hospital A&E records. A&E arrive 01/09/11 17.24 Hospital number: 4161306	Saim was the name given when registering in the A&E department. Date of birth: 28/02/83 Address: address 1 Arrival method: Ambulance was accompanied to A&E by a friend. On arrival at A&E was first assessed (triaged) by a Staff Nurse and was then seen by a Physicians Assistant and A&E Registrar who discussed and planned the appropriate treatment and assessment for with the A&E Consultant.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						check for Paracetamol levels to assess need for treatment (none required). Telephone referral then made to the psychiatric team for assessment (22.40)		
	01/09/2011	23.15pm	SARIM	Personal attendance at Kingston Hospital Accident and Emergency (A&E) Department	Telephone referral accepted by the Psychiatric Night Duty Doctor (22.40)	was seen by the Psychiatric Night Duty doctor in the A&E department giving a full history of events leading to him taking the overdose. He talked about translating messages on Yahoo, finding out that his girlfriend and her exboyfriend were meeting. He mentioned how they had talked about the situation but still she went to meet her ex boyfriend switching her phone off. He then felt 'he couldn't cope'.	Kingston Hospital A&E records. A&E arrive 01/09/11 17.24 Hospital number: 4161306	The psychiatric assessment gave a very detailed account of events along with all aspects of family, social, cultural life. It also took into account the safety and wellbeing of both the girlfriend and child with clear follow up arrangements.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						He said that he had informed several friends of the situation and a friend was on his way over to see him. He wanted to 'cry for help' and 'wasn't thinking straight' then he took the tablets. His daughter was now being cared for by her godmother at his home until her mother returned (21.00) who cried at home when told of events. The assessment also looked at his social, ethnic and religious background in order to gain a complete holistic picture. He also said that he was due to get British nationality later this year.		

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Impression: An impulsive overdose after finding out that girlfriend with whom he has a child had re started a relationship with her ex boyfriend. Plan: Discharge home, godmother staying overnight at the home with him, girlfriend and child. Home treatment team to contact him (02/09/11). Crisis Line phone number given.		
	01/09/2011	23.15pm	SARIM	Assessment of Sarim at Kingston A&E following overdose of 15-20 paracetamol. Accompanied by 2 male friends but seen alone. Written assessment.		Sarim confirmed that he had taken the overdose after discovering that his partner Agapito was seeing another man. Said that he had not intended to kill himself and that he had thought about the consequences for his daughter Grace who is 2 years old. No mental health concerns and assessed as an impulsive act. Godmother is looking	Mental Health Trust RIO records	Sarim told assessing doctor that he wanted to look after his daughter and take her away from his partner. He said that he had been in contact with a solicitor about this and due to see the next day Partner is from the Philippines and he believes

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						after Grace and staying overnight.		she may have been using him for his British nationality. Parental responsibility not discussed Assessed as low risk to himself and others Plan for Sarim to be followed up by Kingston Home Treatment Team (KLHTT) Placed on Red Zone as known to have taken an overdose and still engaging with services.
	02/09/2011	14.26pm	SARIM	Telephone call from KHTT to Sarim to arrange meeting		Plan to meet at Tolworth Hospital on Sunday 4th September at 2pm.	Mental Health Trust RIO records	
NSPCC	04/09/2011	07.20am	Agapito		Email from Agapito to NSPCC Helpline	Referral out to referral and Assessment Team, Children's Services, Kingston upon Thames	NSPCC Helpline records: Email transcript (service request/referral	Agapito expressed concerns that her partner may try to abduct their 26 month old daughter. She

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
							created)	also talked about "fighting" with her partner in front of the child. She was seeking information about protecting her daughter so that her partner could not take her away. The email included the following information: - The senders name (Agapito) - her daughter's name and date of birth - her partners name (Sarim) - the home address
NSPCC	04/09/2011	11.09am	SARIM		First email from Sarim		NSPCC Helpline records: Email transcript (advice email)	A long email which talks about how he met his partner (Agapito) their relationship, and birth of their daughter. He thinks his partner is now seeing her ex-partner and is concerned that she will take their daughter away. He had previously taken an overdose of paracetamol and had been to hospital.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								He is seeking advice. The email included the following information: - The senders name (Sarim) - his partner's name (Agapito) - his mobile number
NSPCC	04/09/2011	11.13am	Agapito		Email response from NSPCC Helpline to Agapito	Email response to Agapito from Helpline Practitioner	NSPCC Helpline records: Email transcript	The email informed Agapito that a referral was being made to children's services recommending an initial assessment be carried out to determine the level of risk to her daughter and identify possible areas of support. Contact details for the Child Law Advice Line and 24 hour domestic violence helpline were also provided in the email.
	04/09/2011	14.50pm	SARIM	Telephone call to Sarim as he had not attended		He said that he had been expecting directions to be sent to him and was now	Mental Health Trust RIO records	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						unable to attend. Said he was hoping to meet with his lawyer on the 5th but would contact HTT to re-arrange.		
NSPCC	04/09/2011	15.56pm	Agapito		Referral to children's services reviewed and approved by duty manager. The email was received and responded to on a Sunday. As part of the manager's approval it was agreed that the referral should be made to children's services w/c Monday 5th September.		NSPCC Helpline records	Referral out includes the practitioners assessment of risk or need based on the information provided. It also includes transcripts of Agapito 's email and the NSPCC response.
NSPCC	05/09/2011	05.14am	SARIM		Email response from NSPCC Helpline to first email from Sarim		NSPCC Helpline records: Email transcript	Email encourages to prioritise his daughter's needs, and to see his GP (in relation to the overdose and how he is feeling) Contact details were provided for Families Need Fathers and community legal advice.
Social	05/09/2011	11.39am	Agapito		Telephone referral made by NSPCC to Safeguarding Duty -	Referral stated: Agapito made contact on 4.09.11	ICS Records	The information was recorded on ICS 12

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					Team 2.	to say: she had a 26 month old daughter and her relationship with Grace's father is not good. She was scared that he may take Grace and would like details of organisations to approach to prevent him from taking Grace away. The NSPCC recommended that an initial assessment be completed. Response Checks were made of internal records to establish whether known. The family were not previously known. Outcome: Decision made to respond with information and advice.		September 2011
NSPCC	05/09/2011	11.39am	Agapito		(Monday) Telephone referral to Kingston upon Thames Children's Services. Referral followed up by fax at 1314 hrs on the same day.			
Children's Social Care	05/09/2011	13:14pm			Faxed confirmation of NSPCC referral received.			
	09/201		SARIM	Telephone call to re-schedule		Agreed to meet on the	Mental Health Trust	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				meeting		7th September at 10.00 outside McDonalds in Kingston.	RIO records	
	07/09/2011		SARIM	Meeting at cafe in Kingston		wanting to know why the relationship breakdown had happened to him. They are living together but she will leave and get married when the boyfriend has got divorced. Says he is embarrassed by what has happened but he wants to save the relationship. Advice given regarding Relate or counselling through his GP. Says that he will move to Ireland soon with his daughter and help with his uncle's business. Planning to see his lawyer today and to discuss options of sole custody. Assessed as of no risk to himself or others. Says that he does not	Mental Health Trust RIO records	Issues of parental responsibility and sole custody not raised or discussed. If sole custody was contested what would his response be? No weight apparently given to threat of abducting a child.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						require further input and agreed to be discharged from the service today. Advice given regarding Crisis Line.		
Children's Social Care	08/09/2011	13.09	Agapito		Email sent to Agapito by Children Social Care Safeguarding duty social worker - Team 2	Response Information provided about three possible local domestic violence contact points. A list of solicitors to approach for legal advice regarding Grace being abducted was also provided.		
Children's Social Care	09/09/2011		Agapito		Email from Agapito to duty social worker - Team 2	Thanks expressed for the information provided and the matter has been sorted out.		
Children's Social Care	09/09/2011	2.14pm	Agapito		Email sent to Agapito from duty social worker - Team 2	Response Thanks expressed for the update.		
	14/09/2011		Sarim		discharge letter to GP	Described as 'settled' in mental state and all risk as low. If more information required told to contact the HTT.	Mental Health Trust RIO records	
	16/09/2011		SARIM		Letter re SARIM received from	Discharged from KHTT	GP Notes	GP - NHS Lambeth PCT No

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					Kingston Home treatment team (KHTT): Letter dated 14/09/11 states that he was referred to their service following his attendance at A and E. He was seen and assessed by KHTT and presented as settled and all risks low.			indication why he attended at A and E and why he was referred to KHTT. No information about his A and E attendance in GP notes.
Police	22/09/2011	Sort this one out - all the wrong columns		CRIS report Re: damage to mobile phone on 22/09/11, during above incident. Complete at Kingston police station public office on the 24/09/11.		Reported on 24/09/11. was arrested on the same date. Admitted causing damage to the phone, but not to abusing Agapito. He was bailed pending a case disposal decision. Only bail condition was to live at his brother's home in LB Lambeth. This report included the Standard risk assessment included in the Form 124D.	Cris 0409878/11	
Children's Social Care	23/09/2011	10.09	Agapito		Email from Agapito to duty social worker - Team 2	An argument had taken place the previous evening (22/09/11). Sarim showed a pornographic video to Grace and kept saying "this is what your mommy's doing, she is a prostitute, whore, dirty		

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						woman". He let Grace play with cigarettes and told her that in a future she will learn how to smoke. Agapito was worried because she works while Sarim stays home with Grace.		
Children's Social Care	23/09/2011	10.18	Agapito	Email to Team Leader Team 3 from duty social worker Team 2		Copy of email (@ 23/09/11 10.09) from Agapito . Outcome Decision to respond with telephone contact to provide information and advice to Agapito .		
Children's Social Care	23/09/2011	12.36	Agapito		Telephone call made to Agapito by duty social worker - Team 3	Agapito said she had confided in an ex-boyfriend and Sarim had found out. Showed a pornographic video to Grace. He had tried to commit suicide by taking 25 paracetamols in front of Grace, but she was not clear when this took place. Grace had a rash. She was worried about Sarim's care of Grace. Response Advice given to contact Domestic		

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Violence Coordinator. Permission obtained to contact the GP. Agapito was encouraged to make contact again if needed.		
victim support	23/09/2011	14.27	Agapito	Self referral by telephone - Victim Support Kingston IDVA	Victim called VS on advice of Social Worker	Details as recorded on VS CMS: Social Worker suggested she call me. She is a nanny and also a cleaner. Last night had an argument - swearing and pornographic video in front of 2 year old. Let daughter play with cigarette. He looks after daughter. Felt frightened from his look. Verbal abuse. She will come and see me on Thursday 29th at 2pm in office. IMR interview notes: 1. Victim explained her fear of partner 'felt frightened from his look'. Victim said partner had given child a cigarette to play with. Victim said she had told SS about cigarette incident. 2. VS confidentiality policy explained to victim. 3.	Case Management System Risk level RED (DV) Complete case summary included in appendix.	1. No VS Safeguarding form completed as referral came from Social Services. 2. Policy states service is confidential unless serious risks are identified and confidentiality may have to be broken. 3. CAADA risk assessment not completed on the phone - borough practice is to always try to complete at face to face meeting. IDVA checked off SPECSS. 4. No CRIS number given/ recorded 5. Emergency advice given 6. 7. Meeting delayed due to IDVA annual leave on Monday 26th - Wed 28th. 8. Safety info always given to victims.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Victim asked if there was any violence - replied no. No indication given of serious or immediate risk. 4. Victim asked if she had reported to police - replied no. 5. Victim wanted to know what to do. 6. Victim informed of One Stop Shop. 7. Office meeting arranged with victim for Thursday 29th 2pm to discuss options and give support. 8. IDVA confirmed with victim it was safe to send meeting details by text.		
victim support	23/09/2011	14/01/1900	Agapito	Victim Support Kingston		Details as recorded on VS CMS: Text her with our address details for our meeting next week and emergency numbers. Text read: Hello. It was good to speak to you. I look forward to meeting you on Thursday 29th at 2pm. Address XXX. In an emergency please dial 999. The Domestic Violence helpline number is 08082000247. Take care	Text message and recorded on Case Management System	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						[Name of IDVA].		
NSPCC	23/09/2011	10.30am	SARIM		Second email from Sarim		NSPCC Helpline records: email transcript (Advice email)	Sarim describes difficulties in his relationship with his partner Agapito . They have a 26 month old child. He said that Agapito was "always trying her level best to get me angry". "Last night I got angry cause wherever she goes now she takes my daughter..." He said that Agapito had been in a relationship with Mr X who is married with an 11 year old son. Recently took their daughter to his brother's place, Agapito did not like this and they had a big argument. Was seeking advice about controlling his emotions. This email included the following information: - The senders name (Sarim) - his partners name

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								(Agapito)
NSPCC	23/09/2011		SARIM		Email response from NSPCC Helpline to second email from Sarim			Email encourages to prioritise his daughter's needs, seek counselling through his GP or contact Relate. Contact details are provided for the Children's Legal Centre in respect of legal advice and contact with his daughter.
NSPCC	24/09/2011	11.37am	SARIM		Third email received from Sarim		NSPCC Helpline records: email transcript (service request/ referral created)	The email form says that the situation with his partner had "gotten worse today". Claimed that they had argued and he became angry and broke her mobile phone. Agapito had left the house with their daughter and a man who lived downstairs. does not know where they have gone. Claimed (inaccurately) that Agapito does not let him have any contact with their daughter.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
								He mentioned in the email that he was aware that Agapito had previously contacted the NSPCC. The email included the following information: - The senders name (Sarim) and mobile number - The home address - His daughter's name and date of birth - his partners name (Agapito)
NSPCC	24/09/2011	15.34pm	SARIM	Referral out to children's services reviewed and approved by duty manager. The email was received and responded to on an Saturday. As part of the manager's approval it was agreed that the referral should be made to children's services w/c Monday 26 September 2011.				The referral indicates that a NSPCC records search was undertaken and a match was found to the earlier referral (4/09/11) following email from Agapito. However, this is not considered in the practitioner's assessment of risk in this referral. The search did not highlight the earlier email from 04/09/11.
NSPCC	27/09/2011	16.02pm	SARIM		Fourth email received from		NSPCC Helpline	His partner and daughter

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					Sarim		records: email transcript (service request/ referral previously created)	still have not returned. is asking whether he should contact the police now or should he wait.
NSPCC	24/09/2011	17.21pm	SARIM		Email response from NSPCC Helpline to fourth email from Sarim			Acknowledging that sounds anxious about his daughter being away for most of the day and that he did not have to wait 24 hours before reporting someone missing. "It sounds like you and Agapito need some breathing space from one another and certainly your daughter would benefit from not witnessing any further arguments and confrontations." NSPCC Helpline told Sarim that they would add the additional information to the referral they were making to children's services.
NSPCC	24/09/2011	18.44pm	SARIM	Referral to children's services updated with new information (from 4th email) and approved by				

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				duty manager. The email was received and responded to on a Saturday. As part of the manager's approval it was agreed that the referral should be made to children's services w/c Monday 26 September 2011.				
Police	24/09/2011			Agapito went to Kingston police station on the 24/09/11 to report the incident which occurred on the 22/09/11	Form 124D - completed at Kingston Police Station re the incident at Cambridge Rd on the 22/09/11	Form 124D which included the older SPECCS+ risk assessment was completed during Agapito's visit to Kingston police station to report damage to her mobile phone.		
Police	24/09/2011			Custody record re: Sarim's arrest re damage to Agapito's mobile phone. Wimbledon Police station custody office.		Custody record for the detention of in connection with the damage to Agapito's mobile phone. was released on bail (see above).	Custody WW/2410/11	
Police	24/09/2011				This PAC was sent to the Safeguarding Kingston Team	Merlin Pre assessment report, concerning Grace. It describes the incident for which Sarim was arrested above. The report concludes that	Merlin re Grace for incident at address 1 on 22/09/11 Merlin 11PAC153239	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Grace was otherwise in good health and well cared for.		
NSPCC	24/09/2011		SARIM		Email response from NSPCC Helpline to third email from Sarim		NSPCC Helpline records: email transcript	Email acknowledges received on his email dated 24/09/11. It informs Sarim that as he has provided as address, information will be shared with children's services. The NSPCC will recommend to children's services that an initial assessment be carried out to determine level of risk to his daughter and discuss support for him and his partner. It also suggests that, if his partner and daughter do not return, he could contact the police to report them missing. Contact details provided for Relate (men's advice line) and children's legal centre.
Police	25/09/2011	14.35PM	Agapito		Police Merlin to Children Social Care received via secure email	Merlin referral for information only. Merlin	ICS Records	The Merlin was not entered onto the ICS

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					by Team 1	stated: On 24/09/11 and 25/09/11 Agapito attended the police station and outlined that on Thursday 22/09/11 at around 19.30 p.m. Sarim returned home displaying strange behaviour. He could have been on drugs or under the influence of alcohol acting in an aggressive manner, shouting and swearing at her. He put the computer on, played a sex video and picked up a few rings and threw them at her. These hit her in the chest but there were no injuries. He allowed Grace to play with the cigarette packet indicating that she will be smoking. She let him calm down and went to bed. He stayed in the room. On Saturday 24/09/11, while getting Grace ready, she left the phone charging and when she picked it up it had been smashed. Sarim admitted that he smashed it. She was		system until 27/09/11

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						shocked, picked up the phone and left the house. Sarim was interviewed by the Police. He stated that on 27/08/11 he managed to get into Agapito 's emails and found out she had been communicating with her ex-partner. He claimed that the pair had apparently falled in love again. Agapito was supposed to have gone to Legoland but lied and had taken the week off. She was openly talking and texting the ex-partner, playing with his emotions. He denied showing Grace pornography but admitted calling Agapito names. He admitted damaging the phone. The police contacted Agapito , discussed bail conditions and concluded that it was difficult as looks after Grace while she works. Bail conditions were not imposed. Sarim was told that any further incidents would be construed as		

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						witness intimidation.		
Children's Social Care	26/09/2011	10.30am	SARIM		Telephone call from NSCPP Helpline and faxed referral received by Children Social Care duty - Team 1	Referral stated: If the allegations are founded, there are concerns regarding Grace who was at risk of significant harm. Request made for an Initial Assessment. Fax referral included copies of Sarim's emails to NSPCC. The first email from Sarim to the NSPCC on Friday 23/09/11 at 11.37am stated: Agapito is trying to make him angry, she is in another relationship and she talks to the person in front him, taunts him and makes a fuss about taking their daughter to see his brother. He asks how he is to control his emotions when he loves her and she is trying to torture him. The second email from Sarim to the NSPCC on Saturday 24/09/11 at 12.31pm stated: Agapito had done a lot of things to make him angry, including	ICS Records	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						taking his daughter out. The third email from Sarim to the NSPCC on 24/09/11 at 16.02pm stated: He found out where Agapito had taken Grace and asked whether he should go to the Police. Outcome: On 27/09/11 a decision was made to record the referral.		
NSPCC	26/09/2011	10.30am	SARIM		(Monday) Telephone referral to Kingston upon Thames Children's Services. Referral followed up by fax and password protected email the same day. Social worker rang to confirm that the referral had been received at 15.13 the same day.			
Children's Social Care	26/09/2011	11.00pm	Agapito		Police notification to Children Social Care via secure email to Team 1	On 26 September 2011 at 9 p.m. Agapito was murdered	ICS Records	
Your Healthcare	26/09/2011		mother, Sarim 28/02/82		Receipt of Notification of Children of Young Persons Pre-Assessment checklist (Police Merlin). Information shared electronically via CJSM (secure	Copy of Merlin forwarded to Health Visiting team at XXX Medication Centre. Rio record keeping system indicated that the family	Merlin Ref 11PAC153239	Named Nurse Your Healthcare Provider Police information gave the family address as address 1. This was the first Merlin

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					email) from Kingston Community Safety Unit to Your Healthcare Safeguarding Children Team. The report stated that on 22/09/11 Agapito had been concerned about her partner's behaviour, describing him as possibly drunk and weird. She says he was acting in an aggressive manner, shouting and swearing. Agapito said that involved their daughter in the verbal arguments. Agapito said that during the argument she did not answer back in case he became violent even though he had not been in the past. 23/09/11 no incidents reported. On 24/09/11 Agapito said that he phone was smashed. Sarim admitted to doing this. Agapito was shocked, picked up Grace and left the house. Victim was interviewed at 17.20pm and referred to the One Stop Shop. was interviewed and stated that on 27/08/11 he had accessed Agapito's emails, and found that she had been in contact in an ex. boyfriend. denied putting on pornographic films in front of his daughter but admitted	were registered at XXX Medical Centre. Copy of Merlin retained by Named Nurse Safeguarding Children.		received by the Safeguarding Team. On entering the information on Rio it was noted that the family had not had contact with the XXX Health Visiting Team.

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
					damaging the phone. He agreed to live at his brother's address.			
Police	26/09/2011		Agapito		Agapito gave consent for her details to be shared with other agencies.	One Stop Shop Referral Information, containing a 24 question DASH risk assessment. This form resulted in 14 questions answered 'yes'. Agapito consented to a MARAC referral, and to have her details passed to other agencies.	One Stop Shop' referral form, completed when Agapito visited the OSS on this date.	
Children's Social Care	26/09/2011	11.00pm	Agapito		Police notification to Children Social Care via secure email to Team 1	On 26 September 2011 at 9 p.m. Agapito was murdered	ICS Records	
Police	26/09/2011			Homicide and Serious Crime Command (SCD1) take command of this investigation.		At 21.21pm police were called to address 1. Sarim was arrested for murder.	Cris report re murder of Agapito Cris 0409988/11	
Police	26/09/2011		SARIM	Wimbledon police station custody office.		Sarim was charged with Agapito's murder and remanded in custody. The risk assessment indicated that Sarim was a potential self harmer. Also, that he may have undiagnosed mental health issues.	Custody record re: Sarim's detention for the murder of Agapito at Wimbledon police station. Custody ww/2428/11	
Police	26/09/2011			Telephone advice taken from Child	Information passed to Kingston	This report concerns	Merlin - Re: Grace	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
				Abuse Investigation Team (SCD5).	Social Services/Safeguarding children board, in order to initiate the Emergency Protection Order (EPO).	Grace being present when her mother died. Grace was taken into police protection, and placed in foster care.	11pac154488	
	04/10/2011			Nursery Nurse Informed by Named Nurse that Grace's mother died a week ago - subject to murder enquiry. Grace has been placed by Kingston Local Authority in Foster Care. Records transferred out to Hawkes Road Clinic.				
Children's Social Care	18/10/2011		Grace	Children Social Care Safeguarding Team 1		Core Assessment Completed.	ICS Records	
Children's Social Care	21/10/2011		Grace	Children Social Care Safeguarding Team 1		First Looked After Children Review held.	ICS Records	
Children's Social Care	26/10/2011		Grace	Children Social Care Safeguarding Team 1		Medical carried out.	ICS Records	
Children's Social Care	26/10/2011		Grace		South West London Family Proceedings Court	Section 38 - Interim Care Order granted and date set 7.11.11 for further interim order.	ICS Records	
Children's Social	01/11/2011		Grace	Looked after Children Team		Case transferred to Looked after Children	ICS Records	

				Communication				
	Date	Time	Family contact	Within agency	External to agency	Response or outcomes	Source of evidence	Comment
						Team.		

Appendix B: Action plan (attached)

Safer Kingston Partnership

DOMESTIC HOMICIDE REVIEW

Action Plan

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST All mental health risk assessments must include an assessment of any actual or potential Children's Safeguarding concerns. This is imperative when there is an identified dependent child in the family and also where there is reported parental discord.	**ACTION 1:** The Trust to develop robust system for recording the details of dependent children or regular contact with children.	Named Nurse for Safeguarding Children. Trust Nursing and Governance Department.	The need to Safeguard the welfare of children is integral to all mental health assessments.	Trust Safeguarding Children Group.	September 2012	**RAG RATING: GREEN** **DATE:** April 2013 System for recording dependent children in place and monitored under the Quality Accounts system.
	ACTION 2: Impacts of parental mental illness to be embedded in safeguarding and risk training.			Trust Safeguarding Children Group.	September 2012	**RAG RATING: GREEN** **DATE:** January 2013 Safeguarding Children training reviewed and revised.
	ACTION 3: Impact of Domestic Violence to be embedded in safeguarding and risk training.			Trust Safeguarding Children Group.	September 2012	**RAG RATING: GREEN** **DATE:** January 2013 Safeguarding Children training reviewed and revised.
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST	**ACTION 4:** Domestic Abuse to be	Trust Lead for Clinical Risk.	Knowledge and understanding of	Trust Safeguarding	September 2012	**RAG RATING: GREEN** **DATE:** Amended and

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
Mental health assessments for suicidal actions or ideation should include whether there is a risk of domestic abuse	included as a specific risk indicator in the trust risk assessment tool.		Domestic Abuse embedded in practice.	Children Group.		ratified March 2014. Trust Risk policy updated.
	ACTION 5: Domestic Violence and Mental health embedded in Safeguarding Children training for all practitioners.			Trust Safeguarding Children Group.		**RAG RATING: GREEN** **DATE:** January 2013 Safeguarding Children training reviewed and revised.
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST Where there are identified dependent children practitioners must assess, discuss and record how this information will be shared with other agencies. This includes seeking advice and consultation with the Named Professionals within the Mental Health Trust or making direct contact with the Local Authority to discuss or refer the case.	**ACTION 6:** The Trust to develop robust system for recording the details of dependent children or regular contact with children.	Named Nurse for Safeguarding Children. Trust Nursing and Governance Department.	Improved information sharing and multi agency working.	Trust Safeguarding Children Group.	September 2012	**RAG RATING: GREEN** **DATE: APRIL** 2013 System for recording dependent children in place and monitored under the Quality Accounts system.
	ACTION 7: Trust to develop clear process for escalation of safeguarding children concerns.			Trust Safeguarding Children Group.	September 2012	**RAG RATING: GREEN** **DATE:** March 2013 Escalation process in place and shared with LSCBs.
	ACTION 8:			Trust Safeguarding	September 2012	**RAG RATING:**

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
	Information sharing and confidentiality embedded in safeguarding training.			Children Group.		**DATE: JANUARY 2013**
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST Discharge letters must conform to the trust template	**ACTION 9:** Discharge information to include: • Confirmation of the patient's details and the context and reason for presentation • A summary of the risk assessment. • Any safeguarding concerns for children or adults.	Trust Nursing and Governance Department	Improved discharged planning and information sharing	Trust Safeguarding Children Group.	September 2012	**RAG RATING:** **DATE:** Trust wide review and revised policy published in MARCH 2014

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
KINGSTON CHILDREN'S SOCIAL CARE The timeliness of recording contacts to the service should be monitored.	**ACTION 10:** All contacts in CSC will be put on the system within 24 hours.	Single Point of Access (SPA)	Information will be up to date and readily available on the electronic system and will inform decision making	Via audit and LSCB Q&A Subgroup	Ongoing audit of recording via clip sample (16 per month) by January 2013.	**RAG RATING: GREEN** **DATE:** Jan 2013 Ongoing audit demonstrates consistency of threshold application and progression in timescales.
KINGSTON CHILDREN'S SOCIAL CARE Emails should not be sent from individual accounts and should only be used in exceptional circumstances	**ACTION 11:** All staff to be informed that email should not be used for giving information and advice.	Head of Children's Social Care	Staff will not use email to correspond with children/young people and families. If email is used the reasons for use will be recorded.	Ongoing monitoring and reinforcement as part of supervision.	30th April 2013	**RAG RATING: GREEN** **DATE:** April 2013
KINGSTON CHILDREN'S SOCIAL CARE There should be clear thresholds for intervention in place. These should be audited.	**ACTION 12:** Threshold document to be developed and made available to staff.	Director of Standards & Improvement	All staff will be aware of thresholds and apply them.	Draft considered by the LSCB and document reviewed one year after publication.	Sept 2013	**RAG RATING: GREEN** **DATE:** 12 Mar 2013 Draft to LSCB for consideration **DATE:** 1 Sept 2013 Document approved and published.

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
	ACTION 13: Use of thresholds to be audited as part of ongoing audit process.		The application of threshold will be consistent and in line with agreed timescales	Ongoing audit as part of monthly audit process.	Ongoing	**RAG RATING: GREEN** **DATE:** June 2013 Themed audit undertaken of 101 cases. **DATE:** Mar 2014 Ongoing audit of 14-16 cases per month evidences consistency of threshold application. Threshold determined by SPA since Jan 2013.
KINGSTON CHILDREN'S SOCIAL CARE All staff including managers should be trained in the use of threshold and risk assessment.	**ACTION 14:** All staff to receive training on thresholds and risk assessment, and new staff to undertake training as part of mandatory induction training.	Learning and Development Team Leader	All staff adequately trained. Thresholds are applied consistently.	Learning and development dip sampling. Monitored by regular reporting and bi-monthly feedback to CSC Managers meeting on uptake and	Jan 2013	**RAG RATING: GREEN** **DATE:** Jan 2013 All staff are trained and new staff are undertaking training as part of mandatory induction training. Dip sample of work

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
				progress.		completed. Threshold application is good.
KINGSTON CHILDREN'S SOCIAL CARE All staff to be made aware of changes to practice.	**ACTION 15:** Feedback changes to practice to staff	Head of Children's Social Care	All staff will be aware of practice and change.	Continual audit of threshold application via monthly audit	November 2012	**RAG RATING: GREEN** **DATE:** Nov 2012 All staff notified and information is part of induction material
KINGSTON CHILDREN'S SOCIAL CARE The duty system should ensure a systematic application of threshold	**ACTION 16:** Duty stem to be reviewed	Service Manager, Children's Safeguarding	All contact into the service will be screened according to a consistent threshold. Children will be seen in a timely manner.	Ongoing audit of 14-16 cases per month.	22nd Jan 2013	**RAG RATING: GREEN** **DATE:** Oct 2012 Review and consultation finalised. **DATE:** 22/01/13 Single Point of Access in place **DATE:** 06/02/13 Referral and assessment Teams in place **UPDATE:** Mar 2014 Ongoing audit of 14-16 cases per month evidences

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
						consistency of threshold application. Threshold determined by SPA since Jan 2013.
KINGSTON CHILDREN'S SOCIAL CARE Usage of 'roll back' (the deletion and reinsertion of records to ensure that contacts are on the system in chronological order) to be reviewed	**ACTION 17:** Review of the usage of 'roll back' and develop new guidance	Head of CSC	'Roll back' will only be used in exceptional circumstances.	Changes implemented and ongoing reinforcement during training of new staff	Changes implemented by Feb 2013	**RAG RATING: GREEN** **DATE:** Feb 2013 Agreement that the use of 'roll back' will be curtailed and only used if agreed by a senior manager unless it is the correction of an immediate issue (i.e. uploading a document onto the incorrect file) ICT systems do not allow 'roll back' without managerial approval.

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ST GEORGE'S MATERNITY SERVICE The maternity service will ensure that women are asked about domestic abuse on two occasions during the antenatal period and once during the postnatal period (when it is safe to do so) and that this is safely recorded in the notes	**ACTION 18:** Ensure that the antenatal assessment tool has a 'prompt' to remind midwives to ask the question. Redesign the question about domestic violence to ensure clarity in the notes that the question has been asked, and if the response is negative or positive.	Safeguarding Specialist Midwife and Named Midwife	All midwives are aware of the process whereby: Women are routinely asked at least twice antenatally and once postnatally about domestic abuse and that the records reflect that this has taken place	Audit of records in six months	24/06/13	**RAG RATING: GREEN** **DATE:** 24/06/13 Audit of midwives understanding and review of records has been undertaken
ST GEORGE'S MATERNITY SERVICE That there is a clear process to alert the midwife at all contacts to check that the question has been asked	**ACTION 19:** Question asked prompt will be on all antenatal pages of the maternity notes Flowchart in safeguarding folders demonstrating process for questioning Introduction of a flowchart All midwives are aware of	Safeguarding Specialist Midwife and Named Midwife	Midwives will review records at each contact with the woman, to ensure the question has been safely asked & safely recorded in the notes	Audit of records on six months	24/06/13	**RAG RATING: GREEN** **DATE:** 24/06/13 Audit has been undertaken Flowchart for asking the question and how to manage the answer has been placed in all safeguarding

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	the flowchart					folders in the clinical areas
ST GEORGE'S MATERNITY SERVICE Mandatory safeguarding training for all midwives to be updated to level 3	**ACTION 20:** Level 3 to be updated with specific relevance to midwifery. Deliver 3 hour sessions to include scenario situations in managing DV.	Specialist Midwife for Substance Misuse and Domestic Abuse and Safeguarding Specialist Midwife	Enhanced awareness and understanding of safeguarding issues		24/06/13	**RAG RATING: GREEN** **DATE:** Jan 2014 Mandatory training has been updated to include real scenarios and role play
	ACTION 21: Safeguarding training to stress the importance of safely writing in the woman's hospital notes if the answer to the question is 'yes'.	Safeguarding Specialist Midwife and Named Midwife				**RAG RATING: GREEN** **DATE:** Mar 2014 This has been highlighted in the Risk newsletter, and the Supervisor of Midwives' newsletter
ST GEORGE'S MATERNITY SERVICE Question to be added to antenatal booking questionnaire clarifying who the woman's partner is and	**ACTION 22:** Add question to booking demographics on K2	Lead midwife for Clinical Governance	Notification of partner's details	Requested with K2 operators		**RAG RATING: AMBER** **DATE:** MAR 2014

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contact details	system					Cannot be added to current K2 – will be added to new E3 later in 2014.
ST GEORGE'S MATERNITY SERVICE Late booking women are referred to safeguarding midwife for further investigation	**ACTION 23:** Safeguarding midwife contacts children's services to ascertain if family is known to them	Safeguarding Specialist Midwife	Ensure early intervention where required	In place and ongoing	In place	**RAG RATING: GREEN** **DATE:** Jan 2014
ST GEORGE'S MATERNITY SERVICE Safeguarding issues template in hospital records on lilac paper (Lilac launched as safeguarding colour and is easily identified)	**ACTION 24:** Template in use and in hospital notes with clear summary of safeguarding concerns	Safeguarding Specialist Midwife	Effective team communication and safe discharge of women and babies	Template in place and in use	In place	**RAG RATING: GREEN** **DATE:** Sept 2013

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
VICTIM SUPPORT Ensure there is always adequate IDVA/DV support and advice available across SW London Division	**ACTION 25:** DV Manager will keep record of all annual leave requested and booked for 10FTE IDVAs from across Division. No IDVA will be given annual leave until it has been established that there is sufficient cover to give a holding/advice service using other IDVAs, DV Workers, Service Delivery Managers and volunteers.	IDVA Manager to keep record of all annual leave of IDVAs. Senior Service Delivery managers to sanction all annual leave	Adequate cover across the Division of available IDVAs and DV support to be able to support, offer advice and cover for absent IDVAs		August 2013	**RAG RATING: GREEN** **DATE:**01.08.13 Practice now in place – IDVA AL managed on a Divisional basis, not borough. Cover for Christmas period is organised and managed to ensure cover across the division.
VICTIM SUPPORT All IDVAs should know they can ask other IDVAs or local Service Delivery Managers to provide a 'holding service' to their clients during periods of extended leave.	**ACTION 26:** Inform all IDVAs that they must ensure their current clients have access to our service even when they are away from work for extended periods. No client must be asked to wait for support because an individual is going on annual leave. All IDVAs will be reminded through supervision	Divisional Manager	To ensure no client is left without immediate support because of an individual IDVA's absence.		August 2013	**RAG RATING: GREEN** **DATE:** 01.08.13 Action has been completed and implemented. **DATE:** 01.08.13 All IDVAs from across the Division now attend the hub office in Clapham once a week to build support with

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	meetings with line manager. New recruits will be informed of process as part of induction.					colleagues.
VICTIM SUPPORT Ensure that there are the right number of high risk trained DV volunteers across the Division	**ACTION 27:** All Service Delivery Managers to create list of high risk DV trained volunteers.	SDMs to collate information	Ensure that all staff are aware of who can be contacted should a client need support		February 2013	**RAG RATING: GREEN** **DATE:** 01.08.13 SDMs are collating lists and arranging training for volunteers considered suitable for this kind of work on an ongoing basis.
	ACTION 28: Analysis to be completed to ascertain whether we have the right amount available	SSDMs and DM to analyse and decide on optimum numbers required			February 2013	**RAG RATING: GREEN** **DATE:** February 13 This analysis will be ongoing and funding for more IDVAs/caseworkers tendered for
	ACTION 29: Contact list published and distributed amongst IDVAs and SDMs. Contact list will also be held on public drive. Service Delivery Assistant to				August 2013	**RAG RATING: GREEN** **DATE:** 01.08.13 List held on public drive of all IDVA contacts. Also included in business

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	be tasked with monitoring and updating list					continuity plan
VICTIM SUPPORT Divisional IDVA meetings to be held regularly	**ACTION 30:** At least quarterly Divisional IDVA meetings to be scheduled	VS SSDM tasked with setting up meetings for all IDVAs to attend. SSDM and DM will be in attendance	Meetings will be minuted to allow best practise and learning to be shared.	Minutes of meeting and actions will be recorded	12.09.13	**RAG RATING: GREEN** **DATE:** 12.09.13 Implemented. These meetings held quarterley.
VICTIM SUPPORT Refresher updates on VS policy and process, and relevant legislation will be communicated more effectively to IDVAs	**ACTION 31:** Standing agenda item at IDVA Meeting will include – • New DV VS policy and process • New DV legislation IDVA meetings will be arranged to review this DHR and lessons learnt.	VS SSDM to arrange meeting DV Manager, SSDM, and DM will collate and formulate all information to be shared	All IDVAs will be up to date on policy, process and legislation	Minutes of meeting and actions will be recorded.	12.09.13	**RAG RATING: GREEN** **DATE:** 12.09.13 Implemented.
	ACTION 32: Record sheet included in HR files for IDVAs to sign indicating they have read relevant policies including: • DV SDOI	New policy when published will be highlighted to IDVA by direct line manager		Recorded in supervision notes when new policy/ procedure/ legislation has been read	August 2013	**RAG RATING: GREEN** **DATE:** August 13 Will be reviewing as and when new documents are published

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	• Safeguarding					
VICTIM SUPPORT Ensure accuracy of records in line with policy and process.	**ACTION 33:** Each SSDM will dip sample 10 cases per quarter for IDVA and review findings in supervision sessions	VS SSDM	Ongoing audit process to ensure accuracy of data records in line with policy and process	Monitoring to be done through PQASSO Audit on DV	First dip sampling done in March 2014 as part of PQASSO audit	**RAG RATING: GREEN** **DATE:** March 2014 This is now also being addressed through Quality Assurance Audits (PQASSO) which has a focus on DV.
VICTIM SUPPORT Training London-wide for Divisional managers and IDVAs on DHRs	**ACTION 34:** Design and create a training package for Divisional Managers, Senior Service Delivery managers and IDVAs on DHRs	London Learning and Development team	Improvement to our service and response to DHRs		DMs - 11.10.13 IDVAs – 2014/15 for delivery to IDVAs	**RAG RATING: GREEN** **DATE:** 11.10.13 The first training for DMs has been arranged 11th October 2013. **DATE:** Delivery across London 2014/15
NSPCC Ensure that in their assessment of risk in a case Helpline practitioners should take account of any immediate risks to adults (including increased risks to women arising from domestic	**ACTION 35:** Ensure that in their assessment of risk in a case Helpline practitioners should take account of any immediate risks to adults (including increased risks to	Head of Child Protection Operations	Assessment takes account of immediate risk to adults. The Helpline now use a DASH Assessment	-	Recommendation was completed May 2013.	**RAG RATING: GREEN** **DATE:** May 2013 This recommendation is complete (May 2013).

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violence).	women arising from domestic violence).		model which forms part of the Helpline Manual.			
NSPCC Where a subsequent referral is made to children's services within 30 days of the previous referral, Helpline practitioners should seek an update on action taken and record the response on the case file.	**ACTION 36:** Where a subsequent referral is made to children's services within 30 days of the previous referral, Helpline practitioners should seek an update on action taken and record the response on the case file.	Head of Child Protection Operations	Referral protocols and template amended accordingly.	-	Recommendation was completed May 2013.	**RAG RATING: GREEN** **DATE:** May 2013 This recommendation is complete.
NSPCC Consider and review the application of thresholds for immediate referral out to statutory services when concerns are raised out of office hours.	**ACTION 37:** Consider and review the application of thresholds for immediate referral out to statutory services when concerns are raised out of office hours.	Head of Child Protection Operations	Considered and Reviewed: Immediate Action Referral Out Protocol (June 2013) includes thresholds for referring out.	-	Recommendation completed June 2013.	**RAG RATING: GREEN** **DATE:** June 2013 This recommendation is complete.
NSPCC Ensure that Helpline practice meets expected standards.	**ACTION 38:** Audit a sample of cases to establish levels of compliance.	Head of Child Protection Operations	Consistency of practice.		May 2013	**RAG RATING: GREEN** **DATE:** May 2013 This recommendation is complete.

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
NSPCC Review current Policy and procedure and consider the following actions:	**ACTION 39:** Explore whether the practice of checking back 30 days for recent referrals should be raised to 40 days, in light of research that suggests that the next domestic abuse incident is likely to happen within 40 days	Head of Child Protection Operations			May 2013.	**RAG RATING: GREEN** **DATE:** May 2013 The Helpline checks all past referrals across a time period of 15 yrs. Any referral found will be highlighted in any new referral generated.
	ACTION 40: Explore whether the application of thresholds for immediate referral out to statutory services (when concerns are raised out of hours) are appropriate.	Head of Child Protection Operations			Recommendation completed October 2013.	**RAG RATING: GREEN** **DATE:** May 2013 Any allegation of domestic violence where there is a recent episode of abuse (during the previous 6 months) is referred out to police immediately for information and appropriate response. This recommendation is complete (October

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						2013).
	ACTION 41: Explore whether to advise adults in possible domestic abuse situations to delete emails so that email cannot be read by others	Head of Child Protection Operations			Recommendation completed October 2013.	**RAG RATING: GREEN** **DATE:** Oct 2013 This advice is included in the domestic violence protocol.

Additional actions defined at the final meeting of the DHR panel

RECOMMENDATION	ACTION	BY WHOM	OUTCOME	MONITORING	BY WHEN	PROGRESS / RAG
ONE STOP SHOP PARTNERS Undertake a review of the one stop shop including a focus on its capacity and resources to ensure that those who present at the service are offered ongoing support if required.	**ACTION 42:** Hold a multi-agency review into the protocols and practices of the One Stop Shop.	Chair of the Domestic Violence operational group	Reduce the number of clients who present at the DV support service and then do not access ongoing support.		Nov 2014	**RAG RATING: GREEN** **DATE:** To be completed following the establishment of the new DV hub service in January 2015
DOMESTIC VIOLENCE STRATEGIC BOARD A referral of a parent to MARAC should also trigger a referral to CSC and to	**ACTION 43:** MARAC referral form to be developed to prompt the referrer to consider referral	Chair of the Domestic Violence Operational	All services are aware of high risk domestic violence victims and their		Nov 2014	**RAG RATING: GREEN** **DATE:** To be completed following the establishment

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Safeguarding Adults where relevant.	to CSC and ASC, and to state whether parallel referrals have taken place.	Group	children in the borough.			of the new DV hub service in January 2015
DOMESTIC VIOLENCE STRATEGIC BOARD Clarify locally who manages the risk in between referrals to MARAC, Children's Social Care and Adult Social care.	**ACTION 44:** MARAC referral form to clearly state who will manage the risk, and emphasise that the risk is not managed by the MARAC post-referral	Chair of the Domestic Violence Operational Group	A clear statement of responsibility for risk management is included in all MARAC referrals.	Domestic Violence Strategic Board	Nov 2014	**RAG RATING: GREEN** **DATE:** To be completed following the establishment of the new DV hub service in January 2015
KINGSTON LSCB Explore the local response to threats to abduct a child/remove from the jurisdiction.	**ACTION 45:** Ensure appropriate guidance on child abduction is circulated to LSCB member agencies. All agencies to ensure that their risk assessment tools in relation to domestic violence and safeguarding children, include reference to the threat of child abduction. Multi-agency and single agency safeguarding training to reinforce the need for practitioners working with families to take threats of abduction into account when assessing the risk to the	Chair of the Kingston LSCB	Practitioners in all agencies give sufficient weight to threats of child abduction when assessing risks to the child	LSCB Chair	August 2014	**RAG RATING: GREEN** **DATE:** Complete

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	child.					
DOMESTIC VIOLENCE STRATEGIC BOARD To ensure that lessons learned from this Domestic Homicide review are considered in the development of the remit, terms and conditions of the Kingston Strategic Board for Domestic Violence.	**ACTION 46:** Ensure that lessons learned from this Domestic Homicide review are considered in the development of the remit, terms and conditions of the Kingston Strategic Board for Domestic Violence.	Chair of the Domestic Violence Strategic Board	Ensure that the lessons learned from this review are a part of continued development of services and practices in Kingston		March 2014	**RAG RATING: GREEN** **DATE:** Complete

Appendix C: Glossary of Acronyms

A&E	Accident and Emergency
CHTT	Crisis Home Treatment Team
CSC	Children's Social Care
CSU	Community Safety Unit
DASH	Domestic Abuse, Stalking and Honour-based violence (a risk assessment tool)
ICS	Case management system used by RBK Children's Social Care
IDVA	Independent Domestic Violence Adviser
ISVA	Independent Sexual Violence Adviser
LSCB	Local Safeguarding Children Board
NSPCC	National Society for the Protection of Cruelty to Children
OSS	One Stop Shop
MARAC	Multi-Agency Risk Assessment Conference
RB	Royal Borough
RBK	Royal Borough of Kingston
TL	Team Leader
SW	Social Worker