# LONDON BOROUGH OF TOWER HAMLETS

# COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# OVERVIEW REPORT

# ‘DONALD’ AGED 35

# KILLED IN TOWER HAMLETS IN APRIL 2018

# REVIEW PANEL CHAIR AND REPORT AUTHOR

# BILL GRIFFITHS CBE BEM QPM

# 21 OCTOBER 2020

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## INTRODUCTION

1. This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Donald[[1]](#footnote-1), a resident of the London Borough of Tower Hamlets (LBTH) prior to the discovery in April 2018 of his death at home at the hands of his partner, Marilyn, for which she was convicted of manslaughter in July 2019 and sentenced to serve 7 years imprisonment.
2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
3. The review will consider agencies contact/involvement with the family from January 2002 to the day of the homicide in April 2018. Any relevant fact from their earlier life will be included in background information.
4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.
5. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Donald’s ‘voice’ at the heart of the process.Through the Chair, the Panel have offered Donald’s family their heartfelt condolences upon their loss.
6. The news that Donald had been fatally stabbed by Marilyn when he was asleep was devastating for his family because she and their child were held in high regard. Marilyn advanced the defence that she was suffering from PTSD (Post Traumatic Stress Disorder) at the time of the fatal incident and this will be a key issue for the review. For Donald’s family, a strong sense of injustice prevails at the Jury finding of manslaughter.

## TIMESCALES

1. The review began with a Panel meeting in September 2018 when Terms of Reference were agreed with scoping of agency involvement. Chronology reports were commissioned from all identifiable public and voluntary bodies that may have had contact with the family and reviewed at the second meeting in October. However, due to the impending criminal trial, the Crown Prosecution Service (CPS) directed that no further review work could be undertaken and all material would be subject to disclosure. A trial took place in December with the outcome that the Jury could not agree. At the third meeting in January 2019 an integrated chronology was reviewed but the CPS position remained and the review suspended pending the second trial that concluded in July 2019.
2. At the fourth meeting in August, Individual Management Reviews (IMR) were commissioned and reviewed together with a draft overview of the facts at the fifth meeting in October. The sixth meeting in November reviewed a second draft of the overview report to identify lessons learned and the seventh reviewed the third draft and discussed recommendations. A fourth version reflecting the discussions and input from Donald’s family was agreed with Panel members by email. This fifth anonymised version and an Executive Summary was presented to the Community Safety Partnership on 12 March 2020.

## CONFIDENTIALITY

1. The chronologies and IMRs are confidential. Information is available only to participating officers/professionals and their line managers.
2. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased will be referred to herein as Donald, with his children as Jo (with another partner) who was present at the fatal incident and Sandy (with Marilyn) also present, respectively. Similarly, the perpetrator will be referred to as Marilyn. To assist the reader, all persons that feature in the review are referred to by the false names and also listed in the glossary.

Donald Victim

Rita Donald’s mother

Frank Donald’s younger brother

Claire Donald’s former partner and mother of Jo

Jo Putative child of Donald and Claire

Marilyn Donald’s partner and perpetrator

Diane Marilyn’s mother

Eric Diane’s partner

Fiona Marilyn’s cousin

George Marilyn’s former partner

Sandy Child of Marilyn and Donald

Hannah Affair with Donald

1. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ‘Official-Sensitive’ for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. An integrated chronology and the IMRs were provided to all Panel members for review and discussion.

## TERMS OF REFERENCE

1. Terms of Reference (ToR) were agreed at the first Panel meeting and also shared with family members. They set out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and are set out in full in appendix 2. The main lines of Inquiry were:
2. Scope of review agreed from January 2002 to date of homicide with any earlier event of significance to be included
3. Identify relevant equality and diversity considerations, including Adult and Children Safeguarding issues
4. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it
5. Take account of previous lessons learned in LB Tower Hamlets
6. Identify how people in the LB of Tower Hamlets gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

## METHODOLOGY

1. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was commissioned by LB Tower Hamlets Community Safety Partnership and, in September 2018, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DHR Panel. Tony Hester supported him throughout in the role of manager of the DHR process.
2. This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1). The following policies and initiatives have also been scrutinised and considered:

* HM Government strategy for Ending Violence against Women and Girls 2016-2020
* Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
* Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
* Tower Hamlets Council website: <https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_safety__crime_preve/domestic_violence/domestic_abuse.aspx> updated in April 2017

1. There are seven published DHR reports in the LB Tower Hamlets and the Chair has examined them for repeat lessons and trends.

## INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

1. With the assistance of the police Family Liaison Officer, the Chair met with Donald’s brother Frank at the first trial in December 2018 who agreed to act as the point of contact for Donald’s family. The Home Office family information leaflet was provided and attention drawn to the advocacy services available to families in the DHR process through Advocacy After Fatal Domestic Abuse (AAFDA) and Victim Support Homicide Service (VSHS). The ToR were discussed and no additions were required.
2. The Chair also met with Marilyn’s mother and stepfather at their request to understand their perspectives. Liaison was suspended until the second trial when it was also possible to meet Donald’s mother and sister for their input. Following the trial verdict, the Chair followed this up through telephone contact and input from Frank to the third version of the overview report in January 2020.
3. A further meeting with Marilyn’s family members was offered in October 2019 but not taken up. Also in October 2019, Marilyn agreed to be interviewed by the Chair at the establishment where she was serving her sentence and her insights have been included.

## CONTRIBUTORS TO THE REVIEW

1. This overview report is an anthology of information and facts from the organisations represented on the Panel, many of which were potential support agencies for Donald, Marilyn and Sandy and each organisation provided a chronology of contact:

The local GP Practice for Donald

The local GP Practice for Marilyn and Sandy

East London Foundation NHS Trust (ELFT)

London Borough of Tower Hamlets (LBTH) Adult Social Care

LBTH Violence Against Women and Girls (VAWG) Team

LBTH Children’s Social Care (CSC)

LBTH Housing Options/East End Homes (EEH) Registered Provider of Social Housing (RPSH)\*

LBTH Drugs and Alcohol Services (DAAT)

LBTH Education Safeguarding Service (ESS)\*

Metropolitan Police Service (MPS)\*

Specialist independent domestic abuse advice was also provided by:

Victim Support

\*Following a review of the integrated chronology of contact with the family, also provided an Individual Management Review (IMR)

## THE REVIEW PANEL MEMBERS

1. *Table 1 – Review Panel Members[[2]](#footnote-2)*

|  |  |
| --- | --- |
| **Name** | **Agency/Role** |
| Menara Ahmed | LBTH Senior VAWG and Hate Crime Manager |
| Sarah Murphy | Joint Senior Strategic Safeguarding Adults Lead in the Local Authority and Clinical Commissioning Groups |
| Lisa Matthews | LBTH Adult Social Care |
| Geraldine O’Donnell | LBTH Children and Culture Directorate |
| Sarah Khalifeh | LBTH Drugs and Alcohol Services |
| Sharifa Chowdray | LBTH Education Safeguarding Manager, Education Safeguarding Service (ESS) |
| Edwin Ndlovu | ELFT Borough Director Mental Health Services |
| Dina Sahmanovic | Victim Support, East London Operations |
| Kelly Hogben | Detective Sergeant, MPS Specialist Crime Review Group |
| Bill Griffiths | Independent Chair and author of overview report |
| Tony Hester | Independent Administrator |

## AUTHOR OF THE OVERVIEW REPORT

1. Bill Griffiths is the author of the overview report. He is a former police officer who has had no operational involvement in LB Tower Hamlets. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010. Since 2013, he has been involved in more than twenty DHRs. Set out in appendix 2 are the respective background and ‘independence statements’ for Bill Griffiths as Chair and author and Tony Hester who managed the review process and liaison with the CSP and Panel.

## PARALLEL REVIEWS

1. The Chair set up liaison with the Case Officer and attended one day of the trial for family liaison. There are no known misconduct investigations pending. Following the trial verdict, the Coroner has decided to close the Inquest opened when Donald’s death was reported.

## EQUALITY AND DIVERSITY

1. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:

Age – Donald was 35 and Marilyn was 24 at the time oif the fatal incident. Their age and the difference between their ages does not appear to have been a relevant factor. Jo and Sandy were under 18

Disability – Donald was an adult with care and support needs (a diagnosis of Attention Deficit Hyper Disorder (ADHD) with low levels of literacy) and Marilyn was said to be dyslexic

Gender reassignment – neither party had been, or were considering, gender reassignment

Marriage and civil partnership – they were a cohabiting couple, not married or in a civil partnership

Pregnancy and maternity – Marilyn was not pregnant

Race - all concerned are White British

Religion or belief – no information identified about religion or belief

Sex – Donald was male and Marilyn is female

Sexual orientation – the sexual orientation for each is believed to have been heterosexual

There is no evidence of differential service or ‘unconscious bias’ from any public body for anyone subject of this report. Nonetheless, it is acknowledged that the disability factors and the shared issues with drugs and alcohol may have inhibited their access to services.

1. Both Jo and Sandy were present at the time of the homicide and both were asleep when it happened. The Chair of the Local Children’s Safeguarding Partnership (LCSP) was twice consulted and, based on 16c(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), decided that a child safeguarding review was not required. Jo had a significant history with CSC in LB Barking and Dagenham (LBBD) prior to moving in with Donald and Marilyn in February 2018, about two months prior to the fatal incident. Jo was not known to LBTH services until after the fatal incident. The Panel debated whether the information about Jo whilst open to CSC in LBBD is relevant to the review and agreed that it is out of the scope of the DHR and would add no value to the purpose of learning lessons to prevent future harm. The limited involvement they had with Jo whilst living with Donald and Marilyn has been reported and considered by the Panel.

## DISSEMINATION

1. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

## BACKGROUND INFORMATION (THE FACTS)

**Donald**

1. Donald was born in Glasgow in 1982 and came to live in Tower Hamlets aged two years when his mother, Rita, fled an extremely abusive relationship with Donald’s father. He has two elder sisters and a stepbrother, younger by 7 years, and had a positive relationship with them and his mother. Donald had mild learning difficulties and between 1991 and 1998 attended a residential school in Sussex for students who present a range of complex, social, emotional and mental health difficulties with characteristics on the Autistic Spectrum ADHD (Attention Deficit Hyper Disorder).
2. Donald left school without reaching the standard for literacy and numeracy and with no qualifications. He attended but did not complete a ‘Painting and Decorating’ Course in Brighton. Consequently, he found it difficult to find work and subsisted mainly on benefits. He was provided with social housing in a housing block in Poplar in Tower Hamlets. Donald later developed an interest in boxing, particularly following the US boxing champion Shannon Briggs, and became involved in boxing promotions.
3. Donald met Claire when they were both 12 years old and they formed a relationship. She had a brief relationship with another male when she was 17 years old and became pregnant with his child, Jo, who was born in November 2001. Within a police report whereby Claire reported threats and verbal abuse from Donald, Claire told police that her relationship with him ended due to his violence towards her. She did begin a new relationship but this ended, and she resumed her liaison with Donald.
4. A number of domestic incidents were recorded between Donald and Claire between 2002 and 2003. In these reports it was recorded that Donald discovered he was not Jo’s biological father, despite being recorded as his father on the birth certificate. In July 2002 Donald was served with a Restraining Order from the Family Law Court that he breached and was taken to the Holborn Family Court. In 2003 Donald was arrested and charged for threats to kill towards Claire during a dispute over access to Jo. Donald believed he was Jo’s biological father, however, a DNA test confirmed that he was not. In her witness statement for the homicide investigation, Claire stated: “*that was our relationship - fight, break up and get back together*”. This continued until Jo was nearly two years old when the couple separated. Claire added that they: “*remained friends up to his death”*. Donald maintained an interest in Jo’s progress.
5. The police IMR author has noticed that there were some inaccuracies in reporting results and a lack of proper intelligence checks in respect of the incidents involving Claire. MPS quality assurance has improved substantially since 2003 and two recommendations have been made for implementation by the Continuous Policing Improvement Command (CPIC).
6. Donald acquired a number of criminal cautions and convictions between 1998 and 2015. He was cautioned for common assault in 1998 and possession of an offensive weapon in 2000. In 2001, he was conditionally discharged for a public order offence and received a Community Rehabilitation Order for attempted theft and breach of the conditional discharge. In 2009 he was again conditionally discharged for a public order offence, then fined for railway fare evasion. There were other relevant incidents in June/July 2015 occurring during the time of his relationship with Marilyn when Donald was with another woman and will be detailed below in the timeline.
7. Donald was a cannabis and cocaine user and was stopped and searched by police on numerous occasions. In January 2006, his flat was also searched by police under the Drugs Misuse Act following allegations from security that he was allowing its use for drug consumption. A strong smell of cannabis was noted, evidence of drug paraphernalia was observed and a small amount of cannabis found for which Donald accepted a verbal warning. In March, he was admitted to A&E following a fall downstairs whilst intoxicated with alcohol and cannabis. He admitted to clinical staff a cannabis consumption to the street value of £50 per week.
8. In May 2007, Donald attended his GP Practice with his sister because he had disclosed the problem to his family for the first time and he was referred to the Tower Hamlets Early Intervention Service (THEIS). The THEIS letter to the GP reveals that Donald was worried because he 1) had increased concerns about his drug use, 2) felt that he is ‘losing it’, 3) had stress from social services wanting him to return to back to work and 4) had violent thoughts in his head urging him to rob people and be aggressive. This disclosure estimated a cannabis ‘skunk’ habit costing £50 per day and £40 of cocaine every two days for the past two years. He had not used crack cocaine for the past year. The Job Centre had invited him on a training programme but he felt unable due to his impulsivity and angry outbursts.
9. On examination, there was no evidence of psychotic phenomenon or of clear depressive cognitions. There was, however, expression of increased frustration and periods where his emotions take control of him. He had significant ruminations about being rejected by his family and society in the past. He had anti-authority cognitions which lead to increased frustration and impulsivity. There was no current evidence of OCD or panic disorder. There were no current suicidal/homicidal ideations.
10. The impression gained was that Donald did not have a psychotic disorder but he had clear evidence of emotional problems and conduct disorder from a young age. The diagnosis was of Substance Misuse Disorder (Cocaine & Cannabis) with periods of withdrawal. There were ongoing personality traits with anti-authoritarianism, impulsive aggression and emotional instability. Donald was not suitable for THEIS ongoing contact but he was referred for benefit advice and to the local substance misuse service. The management plan was discussed with Donald’s mother.
11. In February 2008, Donald fractured his tibia playing football which required insertion of a steel pin. He was provided with sickness certificates for this leg injury until November.
12. Donald is described by his family as having a *“heart of gold”* and liked nothing more than helping others. He was very funny and loved banter, winding people up for a laugh. He was attracted to a ‘celebrity’ lifestyle and was particularly impressed with boxing promotions, where he sometimes found work, and jokingly referred to himself as ‘The Champ’ and would say: “Let’s go, champ!”.
13. His family have highlighted that Donald’s lack of literacy caused him frustration, particularly, when he wanted to articulate his thoughts on social media. They make this point because much was made at the two trials of his abrupt and aggressive communications style and the content of his voicemail and text messages which his brother, Frank, has described as: *“explosive, in the moment, and disgusting to listen to”*. However, he would apologise for his poor reactions and harsh words. Every day on his WhatsApp group, he would wish everyone ‘Good Morning’. Frank summed this up as Donald’s: ‘on-line persona’. But, on reflection, it was clear that Donald was “in trouble’ for the last 18 months of his life.

## Marilyn

1. Marilyn was born in Ilford in 1992 and lived with her mother, father and brother. In 1999, Marilyn’s mother, Diane, established a new relationship with Eric; her parents separated and subsequently divorced. Marilyn initially stayed with her mother at the family home and attended a secondary school in Goodmayes for the first year before moving to live with her father and completing secondary education in Bow. Diane reports that Marilyn found education in Tower Hamlets quite challenging. She is dyslexic but *“very clever”* and she soon found work in accounting.
2. The family on her mother’s side are from Plymouth and Marilyn had regularly visited on holidays. She aspired to live there with her family. Consequently, she was very close to her cousin Fiona, in whom she often confided.
3. There is no record of cautions or convictions against Marilyn. Police were involved when she was the victim of an indecent exposure in 2002 followed by two instances of mobile phone theft. In 2004 an incident was reported by a fellow pupil that resulted in Marilyn being sent a letter to avoid further contact.
4. In 2008, Marilyn reported an assault by her then boyfriend, George. They had been drinking and a verbal argument carried on to the street outside the public house. George grabbed Marilyn’s wrists and pushed her against the railings. Members of the public intervened and were assaulted by George. He was arrested and accepted a caution for the assaults. Marilyn had no injuries and did not want to pursue the earlier assault. She was referred to Victim Support but did not take up their services.
5. The couple broke up as a result of this and, in February 2009, Marilyn made an allegation of harassment by George. Investigation showed that she had been mistaken in seeing him loitering (it was someone else) and his text messages were assessed as non-threatening and responses to messages instigated by Marilyn. No further action was taken.

## Timeline of their relationship

2009

1. It is understood that Donald and Marilyn commenced their relationship in 2009 when he was 27 and she 17. Marilyn fell pregnant but miscarried and was then pregnant with Sandy who was born in Barkingside in December 2010. Marilyn had been provided with temporary accommodation in Tower Hamlets until allocated a social housing flat from East End Homes (EEH), an approved social housing landlord.
2. In August 2009, Marilyn (when pregnant for the first time) made a second report to police of harassment by George. This had consisted of more than two months of phoning and texting. He had made threats toward her brother, new partner (Donald) and the unborn baby. An arrest circulation was made and the investigation assigned to the CSU (Community Support Unit with specialist officers). George was arrested two weeks later, admitted the calls and messages but countered that Donald had made verbal threats to him. George accepted a criminal caution for harassment and the behaviour ceased. The IMR author has commented that there was a lack of professional curiosity to gather full information on Marilyn’s new partner, ‘Donald’, because that would have revealed that she was going from one abusive relationship to another with a male who had a domestic abuse history.

2011

1. In September Marilyn commenced the EEH tenancy on the 7th floor at a block of flats on the Isle of Dogs. She is recorded as living there with Sandy paying a weekly rent of £138.10. Donald moved in with Marilyn and Sandy and then sub-let his own council property.

2012

1. In early January, Marilyn reported a burglary at her home that had occurred during her absence over the Christmas period. There were no signs of forced entry and items such as a bed had been removed. Fingermarks found were eliminated as belonging to a regular visitor and nothing was seen on the CCTV for the block. No arrests were made and the investigation was closed.

2015

1. In January, when Sandy was about four years old, Marilyn discovered that Donald was having an affair with Hannah and she told him to leave. Marilyn then borrowed some money from her father and set up a children’s clothing website to sell from stock she had purchased and she ran that business from the flat. That year, Diane and Eric took Marilyn and Sandy on holiday to visit Fiona, the cousin in Plymouth, and that became a regular event. They also moved to Tower Hamlets to provide closer support to Marilyn which took the form of having Marilyn and Sandy at weekends and frequently taking Sandy to and from school. However, Marilyn always insisted that they meet in the car park of the block and Diane did not enter the flat. Donald returned to live with Marilyn about two months later but she did not disclose this to her family for some time.
2. In late June, Donald was recognised by patrolling officers as someone who had run off when they attempted to search him the previous week for drugs possession. When they spoke to him about the earlier obstruction to ascertain his name and address, Donald reacted badly and became aggressive and threatening to the officers. He was arrested and charged with obstruction and a public order offence, also criminal damage to the cell where detained. He was later fined and required to pay compensation for the damage.
3. In late July, police were called by a member of the public who had seen Donald hit Hannah on the back of the head while she was pushing a pram and he was spoken to walking with Hannah nearby. He admitted there had been an argument but questioned what this had to do with police. He pretended to call a solicitor but failed to convince when someone called him. Donald then ran off and was arrested for common assault after a chase. In interview he claimed he had pushed the back of Hannah’s head in a ‘jokey’ manner. Hannah said she had not been assaulted and had no injuries. Due to insufficient evidence, no further action was taken. A DASH (Domestic Abuse, Stalking and Harassment and Honour Based Violence) risk assessment was ‘Standard’ and a MERLIN[[3]](#footnote-3) PAC (Pre Assessment Checklist) regarding Hannah’s child in the pram was shared with the local MASH (Multi Agency Safeguarding Hub) where it was assessed on the London Continuum of Need BRAG (Blue, Red, Amber, Green) as ‘Green’, that is, the lowest level for sharing with Children’s Social Care (CSC).
4. The next day, Donald was leaving Court on the obstruction/damage matter above when he called police to say he was being chased by a group of men who had asked him for a cigarette. He then called back to say he had it wrong. Due to mental health concerns, Donald was located by police and escorted home.
5. In late September, Hannah called police because her ex-boyfriend Donald had come to her address that afternoon and she refused to let him in. He then rang all the other flat doorbells until he was given access to the building and banging and kicking at her front door. She said that he had no reason to attend the address as they had broken up several months earlier. When officers were speaking to Hannah, Donald sent a text message saying he would not be returning. In the DASH assessment, Hannah revealed her concerns that Donald had mental health issues and voiced threats to harm himself in the past. A record was made but no offences had been disclosed and no action followed. The BRAG assessment was ‘Blue’ meaning it would not be shared with partner agencies. The police IMR author has commented that proper intelligence checks as required would have linked other reports and has a made a third recommendation for future quality assurance.
6. In September, Sandy commenced reception class at her local school which is a ‘free school’. During October, Sandy disclosed to her teacher on two occasions, examples of parental chastisement. These were reported to the Principle, however, there is no record at the school that these events were discussed with Marilyn or referred to CSC as required by extant Local Children’s Safeguarding Board (LSCB) guidance and ‘Keeping Children Safe in Education’ statutory guidance, so it is not possible to investigate further.
7. In late October, Sandy had six separate toileting incidents while at school and the Principle was called in after the 5th incident in which Sandy had wet herself. Whilst chatting Sandy made a third such disclosure which, again, was not investigated further. Otherwise, Sandy appeared to be a happy and chatty child. In a subsequent meeting between staff and Marilyn about the toileting problems, Marilyn revealed that home life had been unstable but nothing had happened the night before that could be related to the toileting issue. She believed this was being used as a *“bargaining tool”*. Sandy was still using ‘pull-up’ nappies and Marilyn planned to use half term to encourage toileting progress.
8. During November regular contact between Marilyn and the school was maintained and it was noted that Sandy had otherwise made an excellent start to Reception, was: *“extremely well-mannered, tries [his or her] best, listens carefully, is enthusiastic about learning and is a pleasure to have in the class”*. The school agreed to make a referral to the Pupil Incontinence Service (PCS) but there is no record of a referral or outcome.
9. In November, Sandy was seen at the GP Practice for behavioural problems, such as anger outbursts and bed wetting for five months after Donald had left the home. Sandy was referred to CAMHS (Child Adolescent Mental Health Services) then on to the incontinence service.

2017

1. In mid-January 2017, the school have recorded a ‘Safeguarding Incident’ with respect to Sandy. There is no other information available from school records. This omission, especially when taken with the failure to investigate the three chastisement examples in October, is very concerning. Sandy’s school is one of a group of three Free Schools and the Chief Executive was interviewed about the lack of relevant records. The IMR author was given and examined every paper record pertaining to Sandy as well as unfettered access to the electronic record. The gaps in record keeping could not be explained and the Reception teacher had left the school so could not be interviewed. The Chief Executive had undertaken her own review and provided a comprehensive ‘lessons learned’ response to the IMR author. This has been incorporated into the consolidated internal recommendations from IMRs in appendix 3.
2. In March, Sandy was discharged from CAMHS for repeat WNB (Was Not Brought [by the parent]). It may be that the toileting problem resolved itself because there is no further mention in school records; nor is there any reference to father, Donald. The March teacher’s assessment of Sandy was positive: *“This term seems to have been a happier time at school for [Sandy]. [He/she] has made some new friends and is more confident in talking about [his/ her] feelings”*.
3. In April there were refurbishments to the block of flats where they lived and the contractor could not gain access to their flat. An East End Homes manager visited in early April and spoke to the occupant’s ‘partner’ who explained that Marilyn was at work and that he had waited in to facilitate the contractor access. About this time, Marilyn had started working for her father, an accountant in Harrow. She began studying for an accounting qualification. This encounter is one of only two references to Donald’s presence at the flat so far as the landlord is concerned.
4. In May, Marilyn fell behind with the rent to EEH, approached her mother for assistance and Diane settled the arrears of £5020 in time to avoid a ‘Warrant of Possession’ for the rent arrears being enforced. By this time, Diane and Eric had moved to LB Greenwich so support to Marilyn was less easy to manage.
5. By September, arrears had started accruing again and EEH sent Marilyn an email requesting contact to which she did not respond. A home visit was carried out in mid-September and a calling card left with the ‘boyfriend’ requesting contact. In late October a letter was sent warning of an intention to seek a possession hearing in mid-November.
6. In response, Marilyn emailed EEH in early November stating:

*“Firstly, I would like to take this opportunity to apologise for my tardy response but I have been slight overwhelmed of late. With work and a bereavement in the family. I had a few issues with the housing benefit department. They misplaced my first application which I was unaware of. I handed in a new application for housing benefit and you should expect to be in receipt of housing benefit in the next few weeks. Thank you for your continued patience and support”*.

1. The next day an email was sent by EEH to the Department of Work and Pensions (DWP). DWP confirmed that Housing Benefit had last been paid to Marilyn in October 2016 and her claim had not been received. Three days later, EEH advised Marilyn that no claim had been received at DWP and that a claim could only be backdated to a maximum of 4 weeks in any event. In the same email a statement was attached showing arrears of £3176 and that the possession hearing had been set for mid-November. She was advised to claim Universal Credit and relevant information was provided.
2. On the day set for the hearing in November Marilyn asked EEH to not take out the possession order because a Universal Credit application had been made[[4]](#footnote-4). Nine days after that, a home visit was made by EEH but Marilyn was “not available for interview” and a calling card was left for contact. In early December, the following handwritten note is appended to the EEH file:

*“This tenant’s arrears were cleared by lump sum payment last time. If this happens again please can we refer to a money management budget advice service if the tenant consents”*

1. In December, Diane happened to be passing Marilyn’s flats and needed to use the toilet, so called in unannounced. She was shocked by the state of the place that was clearly damaged by excessive smoking. Sandy was sitting next to Donald and remained seated, avoiding eye contact with Diane. About this time, Diane noticed that when she made her daily morning and evening calls to her daughter, the evening calls were rarely picked up.
2. In late December, East End Homes received an anti-social behaviour report of verbal abuse toward another resident in the ground floor lobby. Marilyn did not attend a request to be interviewed and a warning letter was sent in early February 2018.

2018

1. In early February 2018, Jo was reported missing from home in LB Barking and Dagenham (LBBD) where living with the maternal grandmother (MGM) for the past year, by mother, Claire who lives in Essex. Jo was at the time aged 16 with a mental age of 13. Jo was said to be desperate for a father figure. It was feared that Jo was being groomed by a gang of older children, was drinking and smoking cannabis and was not attending school. Jo briefly reappeared two days after the report and seemed safe and well to the MGM. Her husband later gave Jo a lift to the Poplar area to meet friends. A short while later, Jo telephoned the MGM to say [he/she] was not coming back.
2. A CRIS (Crime Report Information System) report was opened on for the first report but the requisite MERLIN PAC was not completed until two days later and the rationale for making an original report on CRIS and the delay in the MERLIN is not recorded, which was contrary to extant policy. It was assessed by the duty inspector as HIGH[[5]](#footnote-5) risk due to Jo’s vulnerability but reduced to MEDIUM following the visit to the MGM. The IMR author has commented that a face-to-face ‘safe and well’ interview should have been conducted within 3 hours of the report that Jo had returned home and was available there for 5 hours. It has not been possible to ascertain exactly why this was not done but lack of available resources is the most likely explanation. The MERLIN report was shared with LBBD Children’s Social Care (CSC).
3. By mid-February, police were informed by the mother that Jo had been staying at various addresses, including her address in Basildon, with a friend in Tower Hamlets and an “old family friend” named Donald. She added that she had been in contact with Jo and who was due to attend her home for a family meal. She knew Jo had been staying with Donald and stated that Jo’s behaviour was apparently improving and engaging with family, which had been due to the positive influence by Donald. It transpired that Donald had seen a Facebook post, had made contact and taken Jo into the flat he shared with Marilyn and Sandy.
4. The police record shows that a social worker (SW) had informed police that they had contacted and spoke to Donald and Jo by telephone. Donald told them he was on Jo’s birth certificate and that he looked after him twice a week. The SW then spoke to Jo who confirmed that safe and well. Jo explained that Donald was recorded as father on the birth certificate but Jo was aware that Donald is not the biological father. Donald was informed that Jo should be seen by police. Donald refused to give his address to the SW and said that he was attending Jo mother’s address for a meal and could be seen there if required**.**
5. In late February, Donald accompanied Jo to Bethnal Green Police Station for a ‘safe and well’ interview in which Jo disclosed staying at various addresses with friends and, latterly with Donald and Marilyn. Jo objected to telling mum where staying. Donald provided his name but not his address. The officer completed an additional MERLIN report that was shared with LBBD CSC two days later. However, due to Jo’s mother living in Basildon and that Jo’s siblings were subject to CIN (Child in Need) plans, Essex County Council CSC were now dealing with the matter. They contacted Tower Hamlets CSC in early March with a request for action but were not able to provide a Tower Hamlets address.
6. The IMR author has reviewed the MPS ‘Missing Person Toolkit’ guidance when a missing child refuses to accompany police. With, for instance, an older child of 15, officers will need to consider the wishes of the child, the time/location found, who they are with, any identified risk and intelligence. It may be the case that police ascertain the child’s welfare, communicate the location of child to their carer and discuss with all parties the option of facilitating the child making their own way home. Such arrangements will be carefully documented. Officers must not assume there is an overriding need to remove the child just because they are reported as missing.
7. The IMR author also consulted the policy lead for missing persons in the Continuous Policing Improvement Command (CPIC). As Jo was almost 17 and mother knew where and with whom Jo was staying (friends or/and with ‘father’), it is felt that police would not have the power to require the address or to detain for this purpose, or to keep the child at the police station if refused/not given/not taken unless it was assessed that Police Protection was a necessity.
8. During February, Marilyn contacted her cousin Fiona who lived in Plymouth and disclosed her unhappiness that Donald had invited Jo to stay at her flat. Marilyn also had a disagreement with her father in that month and stopped working for him. She had only one more examination to pass for her accounting qualification. Later in that month, East End Homes undertook a tenancy audit visit and the household composition was recorded as Marilyn with Sandy.
9. In early March, Marilyn attended a school meeting regarding Sandy’s poor attendance which was causing concern as it was creating gaps in learning. Marilyn said Sandy had been unwell with a cold for a week. It was pointed out that there had been sporadic days of absences. Marilyn put it down to “night terrors” and being too tired. It was explained that late arrival was better than absence and Marilyn countered that Sandy was upset when late. Sandy was also avoiding homework. An incentive reward scheme was discussed. Sandy’s progress was otherwise good and had worked particularly well in paired activities. In this meeting, Marilyn disclosed she had left her job as she was unhappy with her boss.
10. By March, rent arrears of £6315 had accumulated and toward the end of the month a letter was sent to Tower Hamlets Homeless and Advice Services informing of the date and time of eviction. The household composition was described as: *‘’Tenant and dependent child aged 7”*. Marilyn was formally notified by the Court and landlord. A Rent Arrears Officer visited in early April, but Marilyn was unavailable for interview. A calling card was left asking that she make contact before the eviction date. A dog was barking inside the property when the calling card was left.
11. In mid-April 2018, the day of the homicide, part of the Prosecution case was that Marilyn was due to be evicted for unpaid rent arrears. Diane had discovered this fact after the fatal incident and expressed concern that EEH had not let her know that arrears had once again accrued, as they had undertaken to do in August 2017. EEH have no record of that request, nor written authorisation from Marilyn that her mother could represent her. Marilyn has confirmed that she did not let on to her mother about the new debt; she felt she could not ask again, saying: *“I made my bed so I should lie on it”*.
12. In the days before the eviction, Marilyn had researched the National Express website for bus times to Plymouth which also was alluded to in the Prosecution case. She told the Chair that she and Donald had discussed moving there so she had researched travel, housing and jobs.

## Additional insights into their relationship

1. The lack of contact with safeguarding agencies in the course of Donald and Marilyn’s nine-year relationship prior to the fatal incident means that the window on their relationship from those sources is limited. It can be broadened by analysis of information gleaned from the criminal investigation, from Donald and Marilyn’s families and from Marilyn herself. As might be expected given the trial outcome, there is a difference of opinion between the two families’ perspectives. There is also a risk that Marilyn’s input could be viewed as ‘victim blaming’. On balance, it is felt that, subject to those caveats, the inclusion of their insights is important to inform the learning from this review.
2. It is known from evidence at the trial and from family members that Donald and Marilyn had developed a hedonistic lifestyle. They both heavily smoked cannabis and Jo had apparently been encouraged to join in for the two months living with them prior to the fatal incident. Donald did not consume alcohol. Marilyn acknowledged that she had a drink problem in her teens prior to meeting Donald and, at the trial, it was said that she drank six beers a day and even consumed one while waiting for the police to attend the homicide.
3. Donald had only casual work connected with boxing promotions and otherwise depended on benefits due to his ADHD condition. However, he had sub-let his flat while living with Marilyn and Sandy and received an income of £500 per month. He paid Marilyn £200 from that and the remainder was expended on cannabis. She was expected to find the other overheads of their life from her salary and child benefit. She ran up rent arrears in 2017 which were settled by her parents and again in 2018 to the point where she was to be evicted on the day of the homicide.
4. Donald and Marilyn had become involved in sexual activity with others. According to Frank, it began as a shared fetish via sexual acts on the internet that developed into group sex sessions that then provided revenue to support their combined cannabis habit. On Frank’s account this was consensual and mutually agreed; in Marilyn’s defence at trial and in her account to the Chair, the activity amounted to enforced prostitution, a form of sexual abuse by Donald. Marilyn informed the Chair that Donald believed that sex with her on demand was his right.
5. Marilyn also reported a history of physical abuse. This would take the form of pushing and body punching when Donald became frustrated or angry with her. She would detect this coming by an ‘edginess’ in his demeanour. It could be over quite trivial issues at times, such as, the TV needed tuning or his sandwich was not made correctly. On one occasion about 18 months before the fatal incident Marilyn alleges that Donald placed his hands around her throat but did not cause injury. None of these alleged incidents were reported to police or to anyone else with safeguarding responsibility.
6. The voicemails and text messages disclosed by the investigation[[6]](#footnote-6) clearly show that Donald would persistently phone Marilyn if she did not ‘pick up’, for example, 8 times in 12 minutes on a day in March 2018, followed by an abusive text message. He would freely use the ‘F’ and ‘C’ words in both audio and text in a demanding style, including at least one threat to lock Marilyn out of the flat. Donald’s family have acknowledged the challenging nature of his communication style, albeit attributed to his earlier learning difficulties, which was advanced at the trial as compelling evidence of emotional and psychological abuse.
7. Marilyn had her own WhatsApp group of female friends. They would use it for mocking banter about their partners. One message that was referred to in evidence at the trial was from a friend of Marilyn who wrote about tying her husband to a chair. Marilyn replied, querying: *“Was it to kill him or have sex with him?”* There were no references by Marilyn on this group that implied intended harm to Donald.
8. Donald acquired a knife in a sheath that Marilyn says he carried for protection. He had been involved in a dispute on social media with some football supporters. Confirmation that he possessed a knife derives from a message he sent to Marilyn in January 2018 asking if she had seen it and she wrote that it was on the sofa. This appears to be the knife that Donald habitually carried and took to bed with him and it was used by Marilyn in the fatal incident.

## Sandy

1. Donald’s family observed that Donald was loving and affectionate to Sandy at all times. Marilyn agrees that, when Sandy was a baby and toddler, Donald was keen to be involved and would regularly take Sandy to his mother’s to visit. When Sandy was school age he was less interested and hardly attended the school at all. He was inconsistent with Sandy. For example, Sandy was not allowed to interrupt him talking then, when it came to bedtime, he would allow Sandy to stay up late.
2. Donald’s affair with Hannah happened just before Sandy started school and he returned after Sandy had been enrolled. Marilyn noted this had affected Sandy’s relationship with Donald because this was when the anger outbursts and incontinence problems began. Frank has a different recollection that the problems with Sandy had already started.
3. From the disclosure by Diane about her unannounced visit in December 2017, it seems that Marilyn went to some lengths to lead a double life so far as her mother was concerned. Marilyn confirmed that she went so far as to mislead her mother by using a deodorant spray to conceal the odors of smoking and alcohol when they met to hand over Sandy.
4. Sandy was frequently taken to and from school by Diane. Apparently Donald never attended school in that role or any other function such as a parents evening. Marilyn said she was embarrassed by the casualness of his dress so did not encourage his attendance, but he did not show any interest in Sandy’s school progress. Donald may have felt constrained by his own childhood experience of schooling. From the school’s perspective, his absence could, and probably should, have raised professional curiosity in line with the ‘absent father’ concern that has been noted in some serious case reviews.
5. To counter this impression, Frank has recalled that Donald did collect Sandy from school on occasions when Marilyn and Diane were not available. He also remembers a time when Sandy was awarded a certificate for being the best reader in class and Donald was “over the moon”.

## Jo

1. Jo was invited to the flat by Donald who had regarded him as his child, albeit they both knew he was not the biological father, as he had lived with his mother through some of his early years. Jo was already troubled when joining the household as a missing person from the home of his MGM and was known to CSC in Barking and Dagenham. Jo had learning difficulties and was allowed to consume alcohol and smoke cannabis.
2. Jo’s presence added to Marilyn’s burden in running the household. She made her displeasure at his arrival known to her cousin Fiona. Marilyn acknowledged to the Chair that she considered that Donald had a soft spot for Jo because he still had feelings for Jo’s mother and she felt a pang of jealousy.

## The fatal incident

1. At about 8.30am in mid-April 2018 Marilyn called police saying she had just killed her boyfriend, Donald. She reported he had woken her up earlier that morning and an argument followed whereupon he took hold of a knife he kept nearby, waving it around. Marilyn said that she “*lost it*” and stabbed him in the neck.
2. The call was graded ‘I’ (Immediate Response) and attendance of the London Ambulance Service (LAS) requested. On arrival, police officers saw that Marilyn was standing inside the flat behind the front door holding a mobile phone to her ear. She was visibly shaking and there was blood on her bare feet.
3. Donald was found lying on his back in the rear bedroom on a mattress with a pillow over his face and blood-stained sheets covering his body. A knife was located beside the mattress and bedroom wall. Donald had a large laceration to the right side of his neck, was unresponsive and not breathing. Pending paramedics arrival, the officers commenced cardiopulmonary resuscitation (CPR). This was taken up by paramedics and a HEMS (Helicopter Emergency Medical Service) doctor but Donald was beyond saving. Life was pronounced extinct shortly after 9am.Marilyn was arrested and taken to Bethnal Green Police Station.
4. Jo and Sandy were present at the time of the killing but had been asleep when it happened. They were taken into Police Protection (PP) and Tower Hamlets CSC took over. Jo was placed into the care of mother, Claire, and Sandy was placed into the care of MGM, Diane.
5. Marilyn was interviewed twice by the Specialist Crime Homicide Team. She said Donald had woken her up earlier that morning, shouting at her because he could not find his ‘joint’. Marilyn found the joint on the floor and gave it to him. Donald pulled out a large hunting knife that was in a sheath which had been kept in the bedroom. He waved it about making a remark to her to the effect that she was lucky he had not used it on her yet. He then gave her the knife, smoked his ‘spliff’ and went back to sleep.
6. Marilyn carried on smoking her own spliff before taking the knife from the sheath. She said that she swung it towards Donald who immediately jumped up and there was blood pouring out of him. He started to make terrible gargling noises before laying down to die in front of her. She pulled the cover over him and wrapped her hand, which she had cut during the assault. When asked, Marilyn told the interviewing officers that she did not know what was going through her head at the time. She was not thinking about killing him.
7. The pathologist who examined Donald concluded that the cause of death was a single stab wound to the neck.

## The trial outcome and reactions

1. There were two trials, the first in November/December 2018 and the Jury could not agree a verdict. During the second trial in June/July 2019 on a re-framed indictment, the defence again presented their case that Marilyn was suffering from Post-Traumatic Stress Disorder (PTSD) at the time of the fatal assault. A Psychiatrist and a Psychologist assessed Marilyn and provided reports concluding that she had ‘*underlying post-traumatic stress disorder with associated mood disturbance and dissociative symptoms at the time of the fatal assault*’. Each opined that Marilyn was the victim of controlling and coercive domestic abuse whereby she had been intimidated, sexually assaulted and abused over a long period and that this had led to the PTSD condition that had peaked on the day of the assault.
2. A Psychologist instructed on behalf of the Crown Prosecution Service (CPS) presented an opposing view following an assessment of Marilyn, challenging the diagnosis of PTSD. This professional opinion was that, when assessing PTSD, the entirety of the individual’s life had to be considered and posited that, at the time of the fatal assault, Marilyn was not, and had not been, suffering from PTSD.
3. Following a second four-week trial, the Jury found Marilyn not guilty of murder but guilty of manslaughter which is indicative that they were persuaded that Marilyn was indeed suffering from PTSD at the time she inflicted the fatal stab wound. She was sentenced to seven years imprisonment.
4. Donald’s family are disappointed in the verdict. Their initial reaction on hearing the news of Donald’s death was one of sympathy for Marilyn because they knew Donald’s faults and they were very fond of Marilyn and Sandy. When they discovered that Donald was actually asleep when Marilyn struct the fatal blow, they had an adverse reaction and feel strongly that, with the manslaughter outcome, she has “got away with murder”. They questioned why, if there was an argument as Marilyn described, it did not wake the sleeping children. They firmly hold the view that Marilyn struck the fatal blow with full intent to kill and came up with the PTSD suggestion having realised what she had done under the influence of cannabis, which she casually continued to smoke, as well as drink beer, while waiting for the police to arrive.
5. Marilyn’s family support the PTSD psychological assessments and can themselves point to controlling and coercive behaviours by Donald over the years. When interviewed in October 2019, Marilyn was pleased to be ‘clean’ from alcohol and drugs, had given up smoking and intends never to go back to those addictions. She had reflected hard on what had happened and expressed remorse and sorrow for her actions. Despite the terrible events that had happened, she still regarded Donald as the love of her life.
6. When asked what intervention could have led to a different outcome, say, if she had been offered a way of managing the rent arrears, Marilyn responded that debt was just one of many factors affecting her. She was explicit that feeling pressurised to do the sex work was the worst aspect than the rest. Marilyn still cannot recall what was in her mind when she struck the fatal blow.

## ANALYSIS

1. Marilyn admitted causing the death of Donald and she has been convicted of his manslaughter. Despite the undisputed fact that she struck a single stab-wound to the neck while Donald lay sleeping, Marilyn is not guilty of his murder because the Prosecution were unable to convince a Jury beyond reasonable doubt that she intended to kill Donald or cause him serious harm. At the time, she was believed to be suffering from PTSD and therefore was not capable of forming intent. This apparent contradiction may be irreconcilable for Donald’s family and, possibly, others who seek understanding. However, this review is not about guilt or blame; it should draw its learning from careful analysis.
2. Donald had lifelong learning and functioning challenges that limited his ability to work and he had become an habitual and heavy user of cannabis. On the one hand, he was witty, charming and kind-hearted; on the other he was frustrated by his limitations, edgy and quick to temper. He was known to the police between 1998 and 2015 for relatively minor offences of assault, offensive weapon, public order and fare evasion for which he was variously cautioned and fined, with one community order.
3. In 2002/3, he is known to have been abusive in his relationship with Claire, the mother of Jo, yet this had settled into friendship in the longer term. In his relationship with Marilyn from 2009 to 2018, there were no incidents between them reported to police or any other agency. In 2015, Donald had an affair with Hannah and two connected domestic incidents were reported to police.
4. Marilyn was known to police only as a victim of crime, including an assault case, then harassment by her former partner, George, when she formed the relationship with Donald aged 17 in 2009. They had Sandy together in 2010 and, in 2011, Marilyn and Sandy were allocated a flat. This enabled Donald to sub-let his flat for a monthly rent and move in with them. The first few years were uneventful until Donald’s affair with Hannah in 2015 that affected the dynamic, including his relationship with Sandy.
5. This may have contributed to Sandy’s difficult first year in reception class in 2016 when ‘chastisement’ at home and a struggle with toileting routine was disclosed. The school’s safeguarding response to the alleged abuse was lacking and non-compliant with extant procedure. Nonetheless, Sandy’s situation settled in the following years and good progress was made at school. Donald appeared not to have an active interest in Sandy’s schooling[[7]](#footnote-7) which could have been a trigger for a ‘think family’ approach and a whole family assessment that may have encouraged Marilyn to disclose the nature of the relationship.
6. The relationship between Donald and Marilyn did not otherwise feature on the ‘radar’ of any agency responsible for safeguarding until February 2018 when the police in LBTH and Children’s Services in LBBD learned that Jo had joined the household. There were insufficient grounds for intervention by either agency, albeit there could have been more ‘professional curiosity’ displayed, for example, to establish the address where Jo was living for a risk assessment.
7. East End Homes do not have a formal safeguarding role but, as responsible social landlords could have been more proactive with their tenant, Marilyn, in November 2018 by referring her to a ‘money management budget advice service’ as was noted on their file regarding the second build-up of rent arrears. A letter was sent to LBTH Homeless and Advice Service two weeks before the eviction date regarding Marilyn and Sandy (“dependent child aged 7”) and this was not acted upon.
8. These are considered to be missed opportunities rather than failures in service. Greater understanding of what was happening in the relationship would have been helpful, but this prospect only emerged with hindsight as a result of investigations for the trial.
9. Consideration has been given to perceived barriers to reporting domestic abuse. The Community Safety Partnership in Tower Hamlets conduct work with the community to encourage bystander action, including to report any concerns they may have for family, friends and neighbours, for example, by signposting sources for safeguarding services such as Victims Support and active promotion of the Crimestoppers Domestic Abuse Campaign that provides an anonymous reporting facility[[8]](#footnote-8).
10. As assessed by two experts, challenged by another, the trial Jury accepted through their decision that Marilyn was suffering from PTSD at the time of the fatal incident and was unable to function rationally. She was also making heavy use of alcohol and drugs. This review has not been provided with access to the reports but can examine what was known in respect of the wider Government definition of controlling and coercive behaviour, specifically, sexual, psychological, emotional and financial abuse
11. Mainly, this derives from Marilyn’s account and Donald’s family are sceptical, for example, in their belief that Marilyn was a willing participant in the sexual contact arranged for payment. However, there is ample and compelling evidence available from the social media content adduced at the trial that Donald was controlling and aggressive toward Marilyn in daily aspects of their life which impacted on her psychologically and emotionally. Some of the messaging relates to the sexual activity with others for which payment was secured to support their joint drugs consumption, that Marilyn came to view as enforced prostitution.
12. Donald also benefited financially from living with Marilyn so that he could rent out his flat. He did share some of the revenue with her, but the ever-looming rent arrears on the flat in her name meant she was left to deal with this herself, apparently without support from Donald. It may be more than a coincidence that she and Sandy were due to be evicted on the day of the homicide.

## CONCLUSIONS AND LESSONS LEARNED

1. The MPS IMR author has identified that personal information was not always recorded accurately or in full, thus undermining the quality of risk assessments. This also extends to updating the conclusion of disposal outcomes and this needs to be given attention in the current review and upgrade of the crime recording system. The quality of intelligence checks was lacking as well. Three internal recommendations have been identified as system improvements.
2. The ESS IMR author has concluded that the ‘chastisement’ disclosures made by Sandy were not referred to Children’s Services as should have been and intervention by CSC could have potentially highlighted difficulties in the parental relationship. Staff failed to recognise the toileting issue as potential neglect and did not follow up the referrals to the School Nurse and Paediatric Incontinence Service. An Early Help Assessment (EHA) should have been undertaken to enable an action plan with a multi-agency approach, review and monitoring. Three internal recommendations have been made to improve awareness and training.
3. In addition, the Panel have identified strategic learning points from the above analysis and these will form the basis of Panel recommendations and the Action Plan:
4. Registered Providers of Social Housing should be required to respond to rent arrears as a possible indicator of financial abuse and improve awareness of the support available
5. Free Schools in Tower Hamlets should be reviewed by the Education Safeguarding Service to ensure that the required standard for accurate recording, CSC referral and staff training is universal
6. An ‘absent parent’ should be noted as the trigger for a whole family assessment

## RECOMMENDATIONS

1. Recommendations for internal consideration and implementation were made by authors of two of the IMRs received[[9]](#footnote-9):

Metropolitan Police Service

1. That Central East BCU Senior Leadership Team (SLT) remind officers of the importance of accuracy when recording and inputting information to MPS computer systems in compliance with MPS data accuracy standards and the Data Protection Act 2018
2. That CPIC review the CRIS Policy and include guidance in relation to recording Court results, Sentences and Orders for domestic violence offences onto the MPS CRIS system ‘Accused Page’
3. That Central East BCU SLT should remind officers to complete the required 5 year intelligence checks for Domestic Abuse incidents. This should include mandatory searches of databases including PNC, CRIS, Merlin and CRIMINT ensuring that the intelligence check results are recorded on the CRIS report. Compliance should be monitored by dip sampling DA flagged CRIS reports

LBTH Education Safeguarding Service

1. Safeguarding Training for all staff in the school offered by the LA Education Safeguarding Service, this training will encompass the local protocol and local arrangements for dealing with child safeguarding issues
2. Continue to update Advance Child Protection and Safeguarding Training for the Designated Safeguarding Leads in the school
3. Key staff members in the school to receive training on undertaking Early Help Assessments.
4. The Panel are satisfied that the recommendations from both reviews have and will be implemented as shown in appendix 3. IMR authors did not make recommendations for wider consideration, however, in line with the strategic learning points, the Panel has identified the following for implementation in the Action Plan at appendix 4:
5. Registered Providers of Social Housing should consider the ‘Whole Housing Toolkit’ and Domestic Abuse Housing Alliance (DAHA) accreditation[[10]](#footnote-10) to improve their responses to victims of domestic abuse, in particular to highlight possible indicators of financial/domestic abuse and improve awareness of the support available
6. Commission an audit of Free Schools in LB Tower Hamlets to ensure standards are being met for accurate recording, CSC referral and staff training
7. Revise LB Tower Hamlets policy on its response to instances of ‘absent parent’ resulting in a whole family assessment.

## Author

Bill Griffiths CBE BEM QPM

21 October 2020

## Glossary

ADHD Attention Deficit Hyper Disorder

ASC Adult Social Care

CCG Clinical Commissioning Group

CPIC Continuous Policing Improvement Command

CRIS Crime Report Information System

CSC Children’s Social Care

cjsm Criminal Justice Secure eMail

DA Domestic Abuse

DAAT Drug and Alcohol Service

DV Domestic Violence

DHR Domestic Homicide Review

EEH East End Homes

ELFT East London Foundation NHS Trust

ESS Education Safeguarding Service

GP General Medical Practitioner

gsi Government Secure Internet

IMR Individual Management Review

LBBD London Borough of Barking and Dagenham

LBTH London Borough of Tower Hamlets

MGM Maternal grandmother

MPS Metropolitan Police Service

NHS National Health Service

PAC Pre Assessment Checklist

PTSD Post Traumatic Stress Disorder

pnn Police National Network

RPSH Registered Provider of Social Housing

ToR Terms of Reference

VAWG Violence Against Women and Girls

## Name references used

Donald Victim

Rita Donald’s mother

Frank Donald’s younger brother

Claire Donald’s former partner and mother of Jo

Jo Putative child of Donald and Claire

Marilyn Donald’s partner and perpetrator

Diane Marilyn’s mother

Eric Diane’s partner

Fiona Marilyn’s cousin

George Marilyn’s former partner

Sandy Child of Marilyn and Donald

Hannah Affair with Donald

## Distribution List

|  |  |  |
| --- | --- | --- |
| **Name** | **Agency** | **Position/ Title** |
| Will Tuckley | LB Tower Hamlets | Chief Executive |
| Asma Begum | LB Tower Hamlets | Councillor for Community Safety; lead on domestic abuse |
| Charles Griggs | LB Tower Hamlets | Head of Community Safety Service |
| Menara Ahmed | LB Tower Hamlets | Senior VAWG and Hate Crime Manager |
| Rafiqul Hoque | LB Tower Hamlets | Service Manager, Housing Options |
| Lisa Matthews | LB Tower Hamlets | Safeguarding & MCA Coordinator, Adult Social Care |
| Keith Daley | LB Tower Hamlets | DAAT Coordinator |
| Ronke Martins-Taylor | LB Tower Hamlets | Head of Service, Youth & Community Learning |
| Richard Baldwin | LB Tower Hamlets | Director of Children Service |
| Dr Somen Banerjee | LB Tower Hamlets | Interim Director of Public Health |
| Samantha Spillane | Barts Health | Adult Safeguarding |
| Chetan Vyas | Clinical Care Group | Director of Quality and Service |
| Karen Sobey Hudson | NHS England | Patient Safety Projects Manager (London Region) |
| Marcus Barnett | Metropolitan Police | East Central BCU Commander |
| Jonathan Macdonald | Metropolitan Police | Detective Sergeant Specialist Crime Review Group |
| Jo Elbourne | Metropolitan Police | Detective Chief Inspector for Safeguarding |
| Rachel Nicholas | Victim Support | Head of Domestic Abuse |
| Members of DHR Panel | Various appointees (listed in Table 1) | - |
| Quality Assurance Panel | Home Office | - |
| Cressida Dick | Metropolitan Police Service | Commissioner |
| Sophie Linden | Mayor’s Office for Crime and Policing | Deputy Mayor |
| Baljit Ubhey | Crown Prosecution Service | London Chief Crown Prosecutor |

**Appendix 1**

## Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: Agreed on 26/09/18 to commence from January 2002 to the date of the homicide]
2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Current membership to continue and LBTH Housing to be asked for a chronology]
3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [The homicide trial concluded in 09/19. There are no known misconduct issues]
4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [All parties are White British by heritage. There is a possibility that Donald had learning difficulties. It was felt that the Panel would benefit from mental health advice and the victim support perspective]
5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [There are no records at MARAC or MAPPA]
6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [Agreed that the Chair of the LSCB should be consulted]
7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were ‘an adult with care and support needs’ [There are no records but BG will keep this under review as the facts are gathered]
8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she was looking after, prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [It is reported that Donald’s family are devasted and, initially, quite supportive of Marilyn but, as the facts emerged, they have hardened their view. Liaison with the family of Marilyn has been challenging and only recently restored. There are Family Court proceedings regarding Sandy who is with the maternal grandmother/step-grandfather in LB Greenwich]
9. To identify how the review should take account of previous lessons learned in the LB Tower Hamlets and from relevant agencies and professionals working in other Local Authority areas [This is the 8th DHR in LBTH since the legislation. The Chair is sighted on all]
10. To identify how people in the LB of Tower Hamlets gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [As above and will be kept under review]
11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

## Panel considerations

1. Could improvement in any of the following have led to a different outcome for Donald and Marilyn, considering:
2. Communication and information sharing between services with regard to the safeguarding of adults and children
3. Communication within services
4. Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services
5. Whether the work undertaken by services in this case are consistent with each organisation’s:
6. Professional standards
7. Domestic abuse policy, procedures and protocols
8. The response of the relevant agencies to any referrals from January 2002 relating to Donald and Marilyn. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
9. Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Donald and Marilyn
10. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
11. Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
12. The quality of any risk assessments undertaken by each agency in respect of [insert names]
13. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.
14. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.
15. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
16. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
17. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

## Operating Principles

1. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)
2. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system
3. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned
4. The review findings will be independent, objective, insightful and based on evidence while avoiding ‘hindsight bias’ and ‘outcome bias’ as influences
5. The review will be guided by humanity, compassion and empathy with the victim’s ‘voice’ at the heart of the process.
6. It will take account of the protected characteristics listed in the Equality Act 2010
7. All material will be handled within Government Security Classifications at ‘Official - Sensitive’ level

## Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

* psychological
* physical
* sexual
* financial
* emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

## Appendix 2

**Independence statements**

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Tower Hamlets CSP as Independent Chair of a DHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner, he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the LB Tower Hamlets, nor direct management of any MPS employee.

Secretary to Panel

Tony Hester has over 30 year’s Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

## Appendix 3

**Consolidated internal recommendations from agency IMR’s**

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| **Rec No** | **Agency/Source** | **Action taken or to be taken within agency** | **Outcome of action, what has been achieved and date of completion** |
| 1 | Metropolitan Police Service | That Central East BCU Senior Leadership Team (SLT) remind officers of the importance of accuracy when recording and inputting information to MPS computer systems in compliance with MPS data accuracy standards and the Data Protection Act 2018 | Officers at Central East BCU are routinely reminded of accurate data entry at multiple points, whether on briefings, Professional Development Days, QA dip sampling, Detective / Street duties training or one to ones |
| 2 | Metropolitan Police Service | That Continuous Policing Improvement Command (CPIC) review the CRIS Policy and include guidance in relation to recording Court results, Sentences and Orders for domestic violence offences onto the MPS CRIS system ‘Accused Page’ | A new service-wide IT system incorporating these changes will be rolled out in the FY 2021/22 |
| 3 | Metropolitan Police Service | That Central East BCU SLT should remind officers to complete the required 5 year intelligence checks for Domestic Abuse incidents. This should include mandatory searches of databases including PNC, CRIS, Merlin and CRIMINT ensuring that the intelligence check results are recorded on the CRIS report. Compliance should be monitored by dip sampling DA flagged CRIS reports | 5-year checks and which indices to include is routinely refreshed with all officers at CE and any shortfalls are addressed through QA and line management |
| - | Sandy’s school  Learning Points identified by Chief Executive in EES review | 1. Improved follow up procedures for dealing with Outside agencies 2. Heightened awareness that neglect at home can be masked by outward appearance 3. Additional reviews of vulnerable children will enable those closest to the child in school are not missing, or ignoring a significant sign or action 4. Additional Level 3 trained safeguarding team members have been brought in to increase level of experience and knowledge 5. All staff to now be trained to be aware of local context and borough procedures | Completed February 2020. Executive Headteacher is now mentoring the DSLs. Staff now aware of their responsibility in relation to escalation of concerns.  Safeguarding Governor now in place to review all safeguarding cases. TH Neglect Practice Guidance in place and will be highlighted at staff meetings across the Trust. Safeguarding training for all staff Sept 2020 which will cover indicators and signs of neglect. This will ensure that staff have a better understanding of safeguarding issues and are able to pick signs of neglect early and take appropriate action.  Completed February 2020. The trust now has a team of DSLs who are trained to level 3. Termly safeguarding meeting ensures that all vulnerable children are discussed, tracked and monitored.  Completed February 2020.  Completed February 2020 for all staff. This training has enabled staff to better understand the local context and the LA procedures. |
| 4 | LBTH Education Safeguarding Service | Safeguarding Training for all staff in the school offered by the LA Education Safeguarding Service, this training will encompass the local protocol and local arrangements for dealing with child safeguarding issues |  |
| 5 |  | Continue to update Advance Child Protection and Safeguarding Training for the Designated Safeguarding Leads in the school | Follow up undertaken with the school September 2020 which ensured that current DSLs in the trust have attended Advance Child Protection and Safeguarding Training. This has resulted in improved safeguarding awareness and understanding of roles and responsibilities.  The school submitted the Tower Hamlets Safeguarding Audit and Self-Evaluation (Section 11, Children Act 2004). This has been evaluated by THESS and feedback to given to the school end of September 2020. |
| 6 | LBTH Education Safeguarding Service | Key staff members in the school to receive training on undertaking Early Help Assessments. | Complete September 2020. THESS liaised closely with the school to ensure key staff apply and attend the EHA training. |

## Appendix 4

## ACTION PLAN

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| **Recommendation** | **Scope of recommendation**  **i.e. local or regional** | **Action to take** | **Lead Agency** | **Key milestones achieved in enacting recommendation** | **Target Date** | **Completion Date and Outcome** |

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| **Learning Point 1: Registered Providers of Social Housing should be required to respond to rent arrears as a possible indicator of financial abuse and improve awareness of the support available** |

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| 1 Registered Providers of Social Housing should consider the ‘Whole Housing Toolkit’ and Domestic Abuse Housing Alliance (DAHA) accreditation to improve their responses to victims of domestic abuse, in particular to highlight possible indicators of financial/domestic abuse and improve awareness of the support available. | LB Tower Hamlets | To present recommendation to Tower Hamlets Housing Management and Executive Boards for RPSH to consider DAHA accreditation and Whole Housing Toolkit. | LBTH Housing/LBTH VAWG Team | Present to Board  Secure funding for Housing IDVA and Floating Support Worker co-location within Housing Options Team.  Commission Housing IDVA and DV caseworker.  Refresh gap analysis,  Engage with key stakeholders including  IDVA, THH, RPs and update procedures.  Establish DAHA Accreditation Steering Group.  Make improvements to processes, procedures and service to attain accreditation. | November 2020  May 2020  August 2020  February 2021  July 2020  December 2021 | (Delayed due to covid)  Complete. Funding secured from MHCLG and Local Community Fund. Floating Support Worker has ensured support and protection for victims.  Complete. Commissioned to Women’s Aid.  Contract will commence 4th January 2021.  Steering Group established and 4 meetings have convened. |

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| Learning Point 2: Free Schools in Tower Hamlets should be reviewed by the Education Safeguarding Service (ESS) to ensure that the required standard for accurate recording, CSC referral and staff training is universal |

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| 2 Commission an audit of Free Schools in LB Tower Hamlets to ensure standards are being met for accurate recording, CSC referral and staff training | LB Tower Hamlets | Divisional Director for Education and Partnership to consider whether the current safeguarding audit process will cover this through a safeguarding review or to commission separate review.  All schools in the LA including independent, free schools and academies are required to complete Section 11 (Children Act 2004) Safeguarding audit and Self Evaluation and submit to the LA for evaluation. | LBTH ESS | The school’s Safeguarding Audit and  Self-Evaluation has been evaluated by THESS and feedback given to the school with recommendation for the schools to implement and resubmit the audit.  THESS will consider undertaking a safeguarding overview depending on the outcome of the resubmitted audit evaluation.  The Section 11 Audit which was submitted covered all three schools within the MAT. In the LA’s feedback it was recommended that each school in the trust should complete the audit individually and resubmit.  Two out of three schools have completed their individual audit incorporating the previous feedback and resubmitted to the LA. Both audits were evaluated, and RAG rated Green.  The completion and submission of the audit by the third school has been delayed due to Covid-19 priorities. THESS is currently following up with the Executive Headteacher of the trust regarding the school completing the audit. | 30 June 2020 | July 2020  The trust has taken on board the LA’s recommendation in relation to the need for each school in the trust to complete individual Section 11 safeguarding audit. Two out of three schools have completed and submitted the audits. Both schools took onboard the feedback from the previous audit covering all three schools. Audits for both schools were RAG rated Green.  Sept 2020  A full day safeguarding training was delivered on 4th Sept 2020. There was a high level of engagement from staff attending the training.  Feedback from participants on their learning from the training included:   * “Not to be scared to whistleblow as it can be a small part of a bigger picture” * “To take appropriate and necessary action where needed. To look out for signs of abuse and neglect of children through their mental and emotional state” * “Increased vigilance with every aspect of the job. Report every small thing as it could make a difference when the wider picture is looked at” * “Aside from prompt reporting and referral it’s important to offer emotional support and create a safe and trusty environment” * “importance of links between services e.g. LA, Police, GP, School and…additions to KCSIE 2020”   It would be up to the school to continue to evaluate impact of the learning on practice and reinforce it with continuous updates and further refresher training. |
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| Learning Point 3: An ‘absent parent’ should be noted as the trigger for a whole family assessment |  |  |  |  |  |  |

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| 3 Revise LB Tower Hamlets policy on its response to instances of ‘absent parent’ resulting in a whole family assessment | LB Tower Hamlets | LBTH to review current policy so that an absent father will be considered as an indicator for a whole family assessment. | LBTH CSC | A Lead Social Worker on “absent fathers” has been identified within Children’s Social Care.  The lead SW for absent fathers has delivered presentations to SW team meetings, the CSC Managers Forum, the CSC Improvement Board about absent fathers.  The Social Work Academy has reviewed and updated the audit tool to include absent fathers, have been considered as part of a child’s assessment and if they weren’t that a rationale is recorded about this. | February 2020 | Complete March 2020. Improved whole family assessment practice in place to include instances of absent parent. This has been achieved by increased awareness activities, an appointed specialist SW and through the help of the Social Work Academy. |

1. Not his real name. His and the other pseudonyms were suggested by family members [↑](#footnote-ref-1)
2. Panel members are all senior managers with no operational involvement with the family [↑](#footnote-ref-2)
3. The police report form for sharing with agencies [↑](#footnote-ref-3)
4. There is no record of a Universal Credit application by Marilyn [↑](#footnote-ref-4)
5. On a Low/Medium/High scale [↑](#footnote-ref-5)
6. Amounting to “tens of thousands of pages” of evidence according to Prosecution Counsel [↑](#footnote-ref-6)
7. An impression that is not shared by his family [↑](#footnote-ref-7)
8. See Tower Hamlets Council website link in paragraph 14 [↑](#footnote-ref-8)
9. The IMR from East End Homes did not make any recommendations [↑](#footnote-ref-9)
10. [www.Dahaalliance.org.uk](http://www.Dahaalliance.org.uk) [↑](#footnote-ref-10)