Final Version for Publication

TOWER HAMLETS COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Overview Report into the homicide of CJ

February 2014

Independent Chair and Author of Report: Mark Yexley

Associate Standing Together Against Domestic Violence

Date of Completion: May 2016

1. Executive Summary

1.1 Outline of the Incident

1.1.1 In February 2014 police were called to a block of flats in the London Borough of Tower Hamlets. On arrival the police officers found CJ lying on the floor outside her flat, her teenage son GN was crouching over her with his hand inside her chest and holding a pair of scissors. The officers arrested GN. An ambulance attended the scene and found that CJ had serious head injuries and chest wounds. She was pronounced dead at the scene.

1.1.2 Criminal prosecution: GN later appeared before the Central Criminal Court charged with his mother's murder. He was found not guilty of murder by virtue of insanity and sentenced to a hospital order.

1.1.3 The panel would like to express its sympathy to the family of CJ for their loss.

1.2 The Review Process

1.2.1 This review was commissioned by the London Borough of Tower Hamlets Community Safety Partnership (CSP). The initial meeting was held on 28th May 2014 to establish the scope of the review and there have been six subsequent meetings of the Domestic Homicide Review (DHR) panel.

1.2.2 The DHR was established under Section 9 (3), Domestic Violence, Crime and Victims Act 2004.

1.2.3 The purpose of this and every DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate

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

1.2.4 This review process does not take the place of the criminal or coroners courts proceedings nor does it take the form of any disciplinary process.

1.3 Terms of Reference

1.3.1 The full Terms of Reference are included in **Appendix 1**. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 The Review Panel were asked to review all contact from 1st January 2012 up to the date of the homicide. Agencies were asked to summarise any contact they had with CJ or GN prior to that date. Those agencies who had contact with CJ or GN were required to complete Individual Management Reviews (IMRs) for submission to the panel.

1.4 Parallel and Related Processes

1.4.1 Two agencies conducted reviews parallel to this DHR: East London Foundation Trust's (ELFT) mental health services and London Borough of Tower Hamlets Children's Social Care (CSC).

1.4.2 ELFT Review: The ELFT service Tower Hamlets Child and Adolescent Mental Health Services (CAMHS) provided care to the perpetrator GN and to CJ's other two youngest children, her son HB and daughter MK. Therefore, ELFT conducted two internal management reviews. One review examined the care provided to the perpetrator GN prior to the death of his mother. The second review considered the care provided to HB and MK.

1.4.3 Tower Hamlets CSC: CSC conducted a thematic review on behalf of Tower Hamlets Safeguarding Children Board. The review considered the cases of six children concerned in cases of serious violence across the borough. GN was one of those children. The cases examined did not all involve inter-familial violence. The thematic review will use material gathered for the CSC IMR to consider the wider thematic review. It is the intention of that review to report and explore issues that fall outside the scope of this DHR's Terms of Reference.

1.5 Independence

1.5.1 The Independent Chair of the DHR is Mark Yexley, an associate of Standing Together Against Domestic Violence (STADV), an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Mark is an ex-Detective Chief Inspector in the Metropolitan Police Service with 32 years' experience of dealing with sexual violence and domestic abuse. Mark retired from the MPS in 2011. He was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. He was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Mark was a member of the Department of Health National Support Team and London lead on National ACPO and HMIC Reference Groups. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey and Sussex. This work involves independent review of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course. Mark has no connection with the London Borough of Tower Hamlets or any of the agencies involved in this case.

1.6 Contact with Family and Friends

1.6.1 The panel decided to make direct contact with the victim's mother and inform her of the process. The chair sent a translated letter to the victim's mother. There was no response to letters sent to the CJ's mother. The police were unable to provide contact details for other family members. At the time of writing CSC are attempting contact with another family member in order to facilitate contact with the DHR chair.

1.6.2 There were no friends of the victim known to the panel members.

2. Summary of the case

2.1 Background

2.1.1 CJ was born in 1970 and was forty-three years old at the time of her death. She was born in Bangladesh and lived in the UK before marrying in Bangladesh. She spoke the Sylheti dialect and had limited proficiency in English. Her husband always remained in Bangladesh. The couple had six children, two boys and four girls: -

- LP: Daughter born in 1987 – twenty-six years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- TW: Daughter born in 1990 – twenty-two years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- RF: Daughter born in 1993 - twenty years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- HB: Son born in 1996 – seventeen years old at the time of his mother's death;
- GN: Son born in 1998 – fifteen years old at the time of his mother's death; and
- MK: Daughter born in 2000 – thirteen years old at the time of her mother's death.
- It is believed by the panel that the children all shared the same father, although their surnames are different.

2.1.2 CJ came to the UK in 2000 and gave birth to her youngest child, her daughter MK. When CJ came to the UK her two sons, HB and GN, remained in Bangladesh. They lived with their father in Bangladesh and moved to the UK in 2006. CJ and her children initially lived with her mother. CJ's husband remained in Bangladesh and he died there from a heart attack some months after the boys had moved to the UK.

2.1.3 In September 2009 CJ moved, with her children, to a three-bedroom rented flat in Tower Hamlets. The property was managed by Circle Housing Old Ford Housing Association (CHOF). The flat was on the eleventh floor of a block.

2.1.4 The perpetrator GN was CJ's youngest son. He was fifteen years old at the time of the homicide. GN spent a period of time in foster care between March and July 2013.

2.1.5 GN attended a number of educational establishments in the East London area. These have included a Pupil Referral Unit (PRU), local authority and independent education providers.

2.1.6 Assessments of GN concluded that he had an abnormality of mental functioning at the time of the killing. This means he is considered not to know the nature and quality of his acts. He was also diagnosed to be suffering from a mental psychosis believing his mother was a witch. There was considered opinion from his assessments that GN had previously suffered from conduct disorder.

2.2 Summary of Family Contact with Agencies

2.2.1 During 2011 CHOF had a number of contacts with CJ concerning the anti-social behaviour of GN. This continued into 2012 and GN was made subject of Acceptable Behaviour Contract (RFC).

2.2.2 Also in 2011 there was a referral made to the National Society for the Prevention of Cruelty to Children (NSPCC) concerning CJ's youngest daughter MK. The referral came from MK's school for matters of sexual exploitation from outside the family. During her dealings with NSPCC MK indicated that she was scared of her mother and brothers. These concerns were passed on to Tower Hamlets Children's Social CSC. Further concerns were passed on to CSC when HB was threatening and abusive towards his mother and controlled how sister dressed. The case was eventually handed over to CSC after a Child Protection (CP) conference.

2.2.3 In December 2011, the police were called to the family home to deal with two incidents where CJ's eldest son HB had become aggressive towards her. In January 2012 GN contacted police asking to be put in care as he was not happy at home.

2.2.4 During 2012 GN was convicted of a number of criminal offences including, theft, assault, and attempted robberies. These resulted in the sentencing him to curfews, use of tags and a three year ASBO.

2.2.5 On 11th July 2012 Child Abuse Investigation Team (CAIT) were notified by CSC of a disclosure made by MK at school. It was reported that HB had struck GN.

An Initial Child Protection Conference (ICPC) was held on 18th July 2012. There was considered to be a likelihood of repetition of violence. GN and HB appeared to be imposing rules on their sister MK. MK was being pressured by HB to wear a headscarf and was threatened with having her hair cut off. The conference decided that MK would be subject to a Child Protection Plan (CPP). The NSPCC closed their case after the meeting.

2.2.6 In January 2013 MK, was referred to CAMHS by her CSC social worker. The referral stated that MK was on a CPP after physical and emotional abuse from her older brother, HB, and limited protection and support from her mother, CJ.

2.2.7 On 5th March 2013 GN reported an assault by HB. GN stated that HB had slapped him after an argument in the local park. A further fight took place at the family home. Police spoke to both brothers. GN refused to support the allegation and it was closed by police. The matter was raised at a CP Conference the next day. It was concluded that GN and MK remain on a CPP. CJ agreed for GN to go to a short-term foster placement.

2.2.8 On 14th March 2013 the Family Intervention Project (FIP) Service Manager emailed the Youth Offending Service (YOS) and CSC social worker, requesting that a DASH (Domestic Abuse, Stalking and Honour Based Violence) risk assessment be completed and to raise this family for consideration at MARAC. When the assessment was completed GN was not residing in Tower Hamlets. CSC were asked to refer to the borough where GN was residing, this was not done. It was later agreed that CSC hold the referral and would pass the referral on when GN returns home. The referral to MARAC was never progressed.

2.2.9 GN was referred to CAMHS by his social worker. On 20th May 2013 the child psychologist met GN with his foster father for an initial assessment. The notes record: “Mr GN is at present highly defended and cannot contemplate having the need (for therapy). However, he may benefit from encouraging the development of a therapeutic experience”.

2.2.10 On 21st June 2013 Lifeline substance misuse services received a referral from GN’s social worker. The referral was taken and actioned for a practitioner to see GN at his school, City Gateway, and then report back to the social worker. At this point GN was outside the borough on a foster placement; the case was not progressed and case was later closed.

2.2.11 On 4th July 2013 GN threatened school staff and others with a snooker cue. GN also made sexually abusive remarks to staff. It was decided to move GN to a new education provider. He eventually moved to Peacocks Gym. GN later had problems at the Gym, shouting and swearing at staff.

2.2.12 On 23rd July 2013 CSC noted that GN was at home and the risks were high because of all three children being at home. On 2nd August 2013 the Troubled Families Team Data Manager emailed CSC reminding them of the recommendation that a MARAC referral should be made when GN was at home with HB.

2.2.13 On 14th August 2013 CAMHS held a family meeting. It was reported that HB was focusing himself on his family responsibility. There were concerns over GN's associates outside the home. It was agreed that GN would be offered a CAMHS appointment. MK would be seen by her CAMHS worker at school. A further meeting was held the following month with GN and CJ. It was reported that GN was more settled and it was good to be home with his mother. He valued his work with Youth Offending Team (YOT) worker. GN did not want individual work. He was given the offer of contacting CAMHS directly in the future or through his YOT worker.

2.2.14 On 9th November 2013: GN was arrested for breaching his ASBO through association and being concerned in the violent robbery of a woman. He was sentenced to a six-month Youth Rehabilitation Order with a supervision requirement.

2.2.15 On 18th December 2013 CSC had a strategy discussion and decided to hold an ICPC on 24th January 2014 for GN. It was considered that GN continued to suffer significant harm to his emotional social and educational development.

2.2.16 On 29th December 2013 CJ phoned police to report that she had had an argument with her son GN. MK told police that her mother had been assaulted and was 'bleeding from the hands' and had been 'hit with a hoover' by GN. The police attended the family home. It was recorded that no assault had taken place and CJ was not bleeding. With the agreement of GN and CJ, they took GN to his grandmother's house. This was not recorded as a domestic incident as GN was 15 years old at the time.

2.2.17 A friend's mother agreed to look after GN whilst CJ was away visiting family in Birmingham. GN was reported to be fine, well behaved and no problems. CJ was believed to be in Birmingham until 7th January 2014.

2.2.18 On 9th January 2014: GN was referred to CAMHS as an emergency by the social worker. He was assessed by the family therapist and a trainee psychiatrist. The mother of GN's friend had become concerned about GN's behaviour changing two days before. GN had smoked cannabis and talked of black magic and so she made the emergency referral to CAMHS. He described in the assessment as having two parts to him, one part good and one bad. GN also described three years of hearing voices and sounds in his head. On more detailed examination of GN, it was decided that he did not appear to be suffering from true hallucinations or delusional ideas. The CAMHS assessors wished to request neurological assessment or a brain scan. The risk assessment was determined as low to self and others. The plan was for GN to be reviewed the following week and the family therapist would liaise with GN's social worker.

2.2.19 On 10th January 2014 a professionals meeting was held and included CJ and GN. The CSC social worker reminded the meeting that GN had little stability. It was agreed that CAMHS would explore the recent altercation between mother and GN. CJ became frustrated during the meeting. She stated that if GN did not stick to the rules, at sixteen years old she would 'tell him to leave and die'. It was pointed out that such comments were not appropriate. The agreement between mother and son was eventually made.

2.2.20 The City Gateway targeted support team worker tried to contact the friend's mother and eventually spoke to her on 13th January 2014. The woman who GN was staying with was very concerned about his mental health. She had taken GN to CAMHS. The mother also mentioned that locally people were claiming that GN was possessed. On 14th January 2014 the school confirmed with GN's social worker that she was aware of the events reported.

2.2.21 On 17th January 2014 the City Gateway safeguarding lead took GN to his CAMHS appointment where he met with the family therapist and trainee psychiatrist. GN only stayed for ten minutes. He denied hearing voices or paranoid thoughts. He believed that he may be possessed by a ghost. He felt there was no need for treatment and would not go for a neurological review. He agreed to see the family therapist again. He was assessed to be low risk to self

or others with no suicidal ideation or thoughts to harm others. It was decided that the family therapist would review in three weeks.

2.2.22 On 22nd January 2014 a CSC review noted that GN's circumstances had continued to deteriorate and he presented a risk to himself as being beyond parental control. GN's circumstances were considered as 'bleak'. Concerns were recorded on his mental health with reports of him hearing voices and seeing shadows and faces. It was noted that GN was engaging with CAMHS. The family were considered to have a good network of professional support. It was considered that GN's emotional and mental health were key at that stage. It was recommended that GN was made subject of a CP Plan.

2.2.23 On 24th January 2014 a CP Conference was held. GN was present and his mother was absent. The trainee psychiatrist and family therapist were unable to attend the meeting and it does appear that the care co-ordinator was briefed on the latest position with GN. The CAMHS worker was on leave at the time but due to conduct a home visit in two weeks. GN expressed concern about hearing voices and trouble sleeping due to nightmares since December 2013. GN said his relationship with his mother had been improving. It was considered that many agencies were working with GN but no agency had been successful in fully engaging him. The conference decided that GN should be subject of a CPP for Emotional Abuse.

2.2.24 On 27th January 2014 GN was arrested by Tower Hamlets police officers for breaching his ASBO through association. It was noted on his custody record that GN was under the influence of cannabis. During the detention GN became aggressive for no apparent reason. He then began kicking at the cell door and shouting. GN then later said that he felt anxious and wanted to see the nurse. He told the nurse that his head was 'vibrating'.

2.2.25 On 30th January 2014 GN appeared at court for the offence of robbery. A YOS report on GN considered as being 'medium' risk and his vulnerability was viewed as 'high'. YOS advised the court 'GN's risk of harm is high and this relates to his pattern of robbery offences and historical aggression within education and close relationships… Despite this, there is no evidence to suggest that he presents an imminent risk of serious harm to others'.

2.2.26 On 4th February 2014 YOS conducted a home visit. CJ was present with GN. It was considered that GN may have been 'stoned' he had red eyes and switched

between thoughtful silence and giggling. CAMHS family therapist emailed the YOT worker to state they would continue to monitor GN's wellbeing 'for the time being'.

2.2.27 On 6th February 2014 GN arrived late at Peacocks Gym. During a gym session he was seen to be coughing uncontrollably. He was sick and was sent home. GN failed to attend a number of sessions at Peacocks Gym between 7th and 10th February 2014. He reported feeling unwell. GN was sent a formal warning by YOS for breaching his curfew between 8th and 10th February 2014.

2.2.28 In February 2014 a housing officer and social worker attended the family home an interpreter was arranged for the meeting. When they arrived at CJ's block they found the police were present. The interpreter just found a boy stabbing a woman on the eleventh floor. They went up in the lift to the eleventh floor and saw a woman they believed to be CJ lying outside her door and the police arresting GN.

3. Key Issues Arising from This Review

3.1 Preventability

3.1.1 This case has allowed examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. In working with the family there was a clear focus on the children living at home with CJ. The systems for managing the family were child centred. This view applied to both social and criminal justice agencies. There was limited focus on the potential for domestic violence and abuse towards CJ.

3.1.2 GN's psychotic condition was not diagnosed at the time. It took a team of medical experts several months to diagnose the nature of the illness and a considerable period of time to stabilise his condition. The panel did not believe that the extremity of the attack by GN on his mother could have been predicted. The fact that GN was likely to assault his mother should have been predicted.

3.1.3 The propensity for GN to display violence towards women was clear from his offending history and behaviour with agencies. When speaking to statutory workers GN had expressed his hatred of his mother saying how he could hurt her. The report of domestic abuse at the end of December 2013 and the consistent expression of anger by GN towards his mother made the likelihood of continued violence towards her predictable.

3.2 Policies and Processes

3.2.1 There were opportunities for CSC and YOS to refer this case to MARAC. This would have allowed an experienced panel to consider the overall levels of concern for this family, offer appropriate support and risk management. Those opportunities were missed.

3.2.2 The option of a making a MARAC referral should be considered at CP meetings. It appears that the first option for dealing with the risk to CJ was covered by an action that she should contact the police if her sons became violent. There was no consideration of a multi-disciplinary response to CJ's vulnerability as a victim of domestic abuse.

3.2.3 The conflict of government policies has also resulted in criminal justice agencies' failure to consider the incidents in CJ's home as domestic abuse. The cross-

government definition excludes persons under sixteen from other systems that would identify risk of domestic violence.

3.2.4 In this case the fact that the abusive sons within the family were under the age of sixteen did not affect CSC's ability to identify a potential MARAC case. This definition did hinder police processes.

3.2.5 When considering police procedures, the cross-government definition of domestic violence had a marked effect on the police identification of risk.

3.2.6 The Asset system structured assessment tool used by YOS in England does not effectively work as a tool to manage adolescent violence in the home.

3.2.7 There were good levels of communication between agencies. In particular, there was regular communication between City Gateway College, CSC and YOS.

3.2.8 It should be noted that a new Anti-Social Behaviour Partnership Action Group (ASBPAG) was established in Tower Hamlets in February 2015. This is chaired by the Police (Chief Inspector) and is attended by Registered Providers of social housing, victim support, FIP and CMHT. This provides agencies with the opportunity to refer and case-manage vulnerable victims of anti-social behaviour as well as prolific perpetrators of ASB.

3.2.9 It is not known to what extent GN's substance misuse contributed to his psychosis. It is apparent that despite knowledge of GN's substance misuse problems he was only referred to local services on one occasion. There were missed opportunities for CAMHS, CSC and YOS to refer GN to Lifeline substance misuse services.

3.2.10 The failure of CAMHS to send staff, with sufficient knowledge of GN's mental health assessments to the Child Protection conference shortly before the death of CJ was critical to his care. At that point CSC had assessed that CAMHS support was a priority for GN. It is not apparent that any further steps were taken to prioritise GN's assessments at CAMHS following the CP conference.

3.3 Recommendations

3.3.1 The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations. It is suggested that the single agency action plans should be subject of review via the action plan hence the first recommendation.

3.3.2 Recommendation 1: That all agencies report progress on their internal action plan to the relevant task and finish group of London Borough of Tower Hamlets CSP.

3.3.3 Recommendation 2: That the Home Office amend their definition of 'domestic abuse' to incorporate incidents involving perpetrators of domestic abuse under the age of sixteen years.

3.3.4 Recommendation 3: The Home Office and Ministry of Justice review the Asset Plus structured assessment tool used by YOS in England to ensure that the system considers children and young people as perpetrators of domestic abuse and has clear pathways to DASH risk assessment and MARAC.

3.3.5 Recommendation 4: That ELFT, London Borough of Tower Hamlets, Lifeline and MPS – Tower Hamlets Borough review processes and referral pathways to substance misuse services. This should be followed up with an awareness training programme for all staff. Training should include understanding a young person presentation with substance misuse problems and how to refer to support services.

3.3.6 Recommendation 5: That London Borough of Tower Hamlets CSC and YOS conduct a review of training on domestic violence procedures and processes, including DASH risk assessment and MARAC.

3.3.7 Recommendation 6: The London Borough of Tower Hamlets, ELFT, Tower Hamlets CCG, MPS and Non-Government Organisations involved in this DHR process. Scope, develop and deliver training on cultural sensitivities in the borough.

3.3.8 Recommendation 7: London Borough of Tower Hamlets CSP review the work of the new High Risk Management Panel and promote any good practice identified to the Home Office and London Safeguarding Board.