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# Domestic Homicide Review

## Safer Croydon Partnership

## Executive Summary of the report into the homicide of Tracy 2021

Independent Chair and Author of Report: Patrick Hopkinson

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**Preface**

The Independent Chair and the Panel members of this Domestic Homicide Review (DHR) offer their deepest sympathy to all who have been affected by the death of Tracy and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Chair also thanks the Panel members for the professional manner in which they have conducted the Review and the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

## 1. The Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review Panel to review the homicide of Tracy who lived in Croydon. Tracy was killed by her partner, The Adult.

1.2 Pseudonyms are used to protect the identities of the deceased and their family members.

1.3 The decision to undertake a DHR was made by the Croydon Community Safety Partnership in consultation with local specialists. The Home Office was informed of this decision on 10th June 2021. An Independent Chair for the Review was then appointed on 21st October 2021 and the Panel met for the first time on 17th February 2022. IMRs were commissioned and agencies were advised to implement any learning arising from these as soon as possible. Five meetings of the Panel were held between 2022 and 2023 to enable members of the Panel also participating in other ongoing DHRs to be able to dedicate their time to all Reviews.

1.4 Agencies that potentially had contact with Tracy or The Adult were contacted and asked to confirm whether they had contact with them.

## 2 Contributors to the Review

2.1 Each of the following organisations submitted an IMR or information for the review.

| AGENCY | CONTRIBUTION(S) |
|---|---|
| Probation Service | • Chronology and IMR |
| GAIA Centre Lambeth | • Chronology and IMR |
| Lambeth MARAC | • Chronology and IMR |
| Metropolitan Police Service: | • Chronology and IMR |
| SLaM Lambeth IAPT | • Chronology and IMR |
| Bromley GP (for The Adult) | • Chronology and IMR |
| Lambeth GP (for Tracy) | • Chronology and IMR |
| FJC Croydon | • Chronology and IMR |

| | |
|---|---|
| London Borough of Greenwich Children's Services | • Chronology and IMR |
| London Borough of Croydon Housing | • Chronology and IMR |

## 3 Review Panel Members

3.1 The DHR panel, which met four times, consisted of the following members.

| Agency | Role on Panel |
|---|---|
| Probation Service | Member |
| FJC Croydon | Member |
| Lambeth MARAC | Member |
| Metropolitan Police Service: | Member |
| SLaM Lambeth IAPT | Member |
| South East London and South West London ICB | Member |
| Croydon GP | Member |
| Croydon Housing | Member |
| Croydon Health Services | Member |
| HERSANA CIC | Advisor |

## 4 Author of the Overview Report

4.1 The Chair and Author of this report, Patrick Hopkinson, is an independent adult safeguarding consultant, a Safeguarding Adults Review author and a Chair of Domestic Homicide Reviews.

4.2 Patrick Hopkinson is experienced in adult safeguarding and provides training, consultancy and service development services nationwide for the statutory and voluntary sectors. He was the Head of Adult Safeguarding for a London Borough, contributed to regional and national policy development and was the adult social services strategy lead on Violence Against Women and Girls (VAWG). Patrick has completed Modules 1 and 2 of the Home Office online Domestic Homicide Review training

4.3 Patrick is now an author of reviews following suicides and homicide-suicides. Patrick is an Associate of the Local Government Association and lectures, and supervises

research, at the Institute of Psychiatry, Psychology and Neuroscience for Kings College, London.

4.4 Patrick Hopkinson has no link with any of the organisations involved in this DHR.

## 5 Terms of Reference

### 5.1 Background

5.2 This DHR examines the circumstances leading up to the death of Tracy on 4th May 2021. Tracy was killed by her partner The Adult. The Adult killed himself after he killed Tracy.

5.3 This review, as commissioned by Croydon Community Safety Partnership, considers the involvement and actions of the different agencies with Tracy and The Adult since 7th December 2018. In addition, the review also examines past events 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 this holistic approach, the review seeks to identify appropriate solutions to make the future safer.

5.4 Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom she was related or with whom she was or had been in an intimate relationship, or;

b) A member of the same household as herself;

With a view to identifying the lessons to be learnt from the death.

5.5 The purpose of a 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 these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

5.6 The Domestic Abuse Act (2021) defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

5.7 For the definition to apply, both parties must be aged 16 or over and 'personally connected', which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

5.8 Controlling behaviour is defined as, "*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*".

5.9 Coercive behaviour is defined as, "*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.*

**5.10 Key lines of Enquiry**

**5.11** The following terms of reference were agreed by the DHR panel to guide the review

**5.12 Awareness of and response to domestic violence and abuse and coercive control**

**5.13** Was there any indication or escalation of the risk of domestic violence and abuse and were these indicators recognised and responded to? Were Tracy and the Adult open to MAPPA, MARAC any programmes or interventions for reducing the risk of domestic violence and abuse?

**5.14** Were any domestic violence and abuse tools such as DASH, DVPN, Right To Know and Right To Ask (Clare's Law) and were any ancillary orders considered or used and if so, how effective were these assessed to have been at the time?

**5.15** Were there any opportunities for professionals to routinely (i.e. during contacts that were not explicitly about domestic abuse) enquire about domestic abuse and coercive control experienced by Tracy and were these opportunities taken or missed?

**5.16** Were staff working with Tracy and The Adult confident about what service provision is available for domestic abuse locally for both victims and perpetrators?

**5.17** Were there any barriers to providing or seeking support with domestic abuse? What were they? How might these be overcome?

**5.18 Offender management**

**5.19** To what extent was information appropriately shared about The Adult's offending history with the appropriate parties (including organisations and relevant members of the public)?

**5.20** To what extent was information about The Adult's history of offending acted upon? Were there any missed opportunities for interventions with The Adult or other appropriate individuals based on The Adult's history of offending?

**5.21** Were the appropriate re-offending intervention and reduction programmes offered to The Adult and were effective monitoring systems in place.

**5.22 Information sharing and multi-agency working.**

**5.23** Was there any collaboration and coordination between any agencies in working with Tracy and The Adult individually and as a couple and comment on its effectiveness?

**5.24 Health and social care needs**

**5.25** Were there any causal or consequential links between any unmet social care needs or mental health problems/ substance use and domestic abuse?

**5.26** Were there any recent changes in Tracy or The Adults mental health and well-being that may have affected their behaviour?

**5.27 Individual and family factors**

5.28 Were there any cultural perceptions, beliefs or stereotypes, equality and diversity or deprivation factors that may have influenced how agencies engaged with Tracy and The Adult or how they assessed risk? How effectively was professional curiosity practiced?

**5.29 Organisational factors**

5.30 Did the context (i.e. demand management, response to Covid-19 etc) in which each agency was working at the time with Tracy, The Adult or their family have any impact of the type of interventions made and on their effectiveness?

**5.31 Learning and practice development**

5.32 What lessons can be learnt in respect of domestic and abuse and/or coercive control, how it can affect adults, children and young people and how agencies should respond to any impact?

5.33 Are there any training or awareness raising requirements for professionals or victims of domestic violence and abuse that are necessary to ensure a greater knowledge and understanding of the services available?

**5.34 Methodology**

5.35 The Review involved the analysis of a combined and annotated multi-agency chronology of involvement, IMRs and questions for professionals. Family members were also interviewed by the Chair.

5.36 Tracy was a 29-year-old Black British woman whose first language was English. Tracy was brought up as a Christian but in her adulthood was not observant. Tracy had no children. Tracy had mental health difficulties which at first were investigated as physical health difficulties.

5.37 Domestic abuse, and domestic homicide more specifically, is frequently regarded as gendered: women are more likely to be the victims of domestic violence and abuse than men are, men are more likely to be the perpetrators of domestic abuse than women are. However, the definition of domestic abuse and domestic homicide includes familial abuse and homicide.

5.38 This review is of the homicide of a woman, Tracy, by a man, The Adult, who then killed himself.

5.39 The Adult was a 29-year-old Black British man. The Adult did not have any overt religious beliefs or affiliations. He was known to have had mental health difficulties for which he received psychological therapies and was prescribed medication.

5.40 It is likely that there was an interaction between Tracy and The Adult's physical and mental health difficulties, which might have increased the risk of domestic violence and abuse and might have decreased awareness and recognition of it whilst at the same time increasing barriers to receiving support.

5.41 The Adult was the subject of three stop and search actions by the Metropolitan Police between February and May 2020. Tracy was with The Adult during the stop and search in February 2020. On each occasion, the stop and search produced no result. Home Office statistics for 2019-2020 (Police powers and procedures England and Wales, year ending 31 March 2020 second edition) showed that black people were almost nine times more likely to be stopped and searched than white people were. This may

therefore represent discrimination based on one of the nine protected characteristics under the Equality Act 2010.

## 6 Summary Chronology

6.1 Tracy first came to the attention of the Metropolitan Police in 2017 when she reported that she and her sister had been physically assaulted by their father but refused to provide statements.

6.2 The Adult had been arrested on twelve occasions for offences relating to possession of class B drugs, rape, public disorder and domestic abuse. In 2009 he had assaulted his then partner twice whilst she was pregnant and had received a Community Service Order. In 2016 The Adult was imprisoned for the rape of stranger committed in 2013. Tracy came to the attention of the prison and probation services when she visited The Adult in prison, and it appears that they had known each other prior to this. Whilst in prison, The Adult also used IAPT (Improving Access to Psychological Therapies) Services ostensibly for depression and anxiety but he used these sessions to persuade the therapist to advocate for better conditions in prison for him.

6.3 Tracy and The Adult's ex—partners were notified of The Adult's offence of rape and subsequent prison sentence under Clare's Law (the Right to Know) upon The Adult's release in 2019. Tracy appears to have been in denial about The Adult's offending history and the risk this might pose to her.

6.4 The Adult lived in Probation Approved Premises, from where he was recalled to prison in April 2019 after knives were found in his room. The Adult was released in January 2020 to further Approved Premises and then moved to a supported living service in Croydon. The Adult was fearful that he would be targeted by people that he knew and so was moved to another supported living service still in Croydon.

6.5 In July 2020, Tracy raised a further concern about domestic abuse by her father and said that she wanted to move from Lambeth where she lived with her family to Croydon. Tracy was contacted by domestic abuse services but only wanted to discuss the incident with her father rather than the risk that she faced from the Adult. Tracy's family believed that Tracy had been manipulated by The Adult into separating from her family.

6.6 Tracy was in contact with her GP for physical and mental health needs and also used IAPT services for anxiety and thoughts of suicide. Tracy maintained that the Adult was a protective factor in her life who supported her with her relationship with her family. At the final session that she attended on 8th April 2021, Tracy disclosed that she was experiencing difficulties in her relationship with The Adult but denied any abuse. The next day Tracy said that her suicidal thoughts had reduced that she had returned to live with her mother and was much happier.

6.7 On 25th April, The Adult told the Police that people in the supported living service were trying to kill him. The Police found kitchen knives in his room and made a Criminal Intelligence report. No further action was taken since the criteria for a Merlin report

has not been met, the Adult was not in breach of his bail conditions and the possession of kitchen knives in supported living accommodation was not restricted as it was in Probation Approved Premises.

6.8 Tracy and The Adult travelled together by a rented car on 2nd May 2021 to a hotel in Harrogate, which they had booked on the internet the previous day.

6.9 On 4th May 2021 staff at the hotel were notified by guests of a water leak, coming from an upstairs room. Staff identified the room as that used by Tracy and The Adult and gained entry by overriding the locking mechanism with a swipe card.

6.10 Tracy was discovered lifeless, in a state of undress. Tracy had been handcuffed with her arms in front of her body. Tracy had multiple stab wounds to her body. Yorkshire police were called by hotel staff and secured the room. The Adult's body was found in the bath. He was holding a knife and also had a number of significant wounds. Within the room there was evidence of alcohol and cannabis use. After a detailed investigation to trace the last movements of both Tracy and The Adult, Yorkshire Police were satisfied that no third party was involved in the deaths of Tracy and The Adult and concluded that Tracy had been killed by The Adult who then killed himself.

## 7 Conclusions

**7.1** The purpose of this review was to examine:

**7.2 Awareness of and response to domestic violence and abuse and coercive control**

**7.3** The Adult had a history of domestic abuse and sexual violence which had brought him in to contact with the criminal justice system and he had served three years of a six-year sentence for the rape of a stranger.

**7.4** Upon The Adult's release from prison in February 2019, there was multi-agency working to manage the risks that The Adult posed and to alert further potential victims, including his ex-partners with whom he had children. A connection had been identified in 2018 between Tracy and The Adult when she visited him in prison and so Tracy was recognised to be at risk from The Adult.

**7.5** Tracy's initial contact with domestic abuse services had been in response to her report of the domestic abuse she and her sister had experienced from their father. Despite Tracy stating that it was not safe for her to talk to domestic abuse services and multiple attempts to contact her by telephone, the domestic abuse service closed Tracy's case. Further consideration of offering alternative methods of, or location for, contact would have been appropriate.

**7.6** Tracy was notified about The Adult under the Right to Know but did not want to know and maintained that The Adult had been the victim of a miscarriage of justice. The disclosure of The Adult's offending history to Tracy appears to have been somewhat confused with the Jigsaw Team and borough policing not notifying each other of the

actions they were taking. Since Tracy was killed by The Adult, there have been two relevant Metropolitan Police policy changes. The first is to consider a 'locate trace' marker on the PNC (Police National Computer) where there is difficulty contacting a subject requiring a Domestic Violence Disclosure Service contact. The second is that high risk domestic abuse perpetrators have a PNC marker added to them to focus the attention of police officers on welfare considerations when they encounter them.

**7.7** Domestic abuse services in Croydon attempted engagement with Tracy about the risk she faced from The Adult but Tracy considered him to be a protective factor in her relationship with her family. Tracy wanted to move from the family home and this might have been an opportunity to have worked with Tracy to achieve a goal that she wanted whilst at the same time continuing to work with her on recognising and accepting the risks that she faced from The Adult. Further support for Tracy with her relationship with her family might also have been helpful to reduce her feelings of dependency on The Adult for this.

**7.8 Information sharing and multi-agency working**

7.9 MAPPA and MARAC processes were used to coordinate interventions, but The Adult was not referred to MARAC after his second release from prison in January 2020. As a result there was no multi-agency review of the risk management plan. The Adult's Probation Service active management and risk assessment also decreased as his supervision period progressed, despite some indications that there had been declines in The Adult's presentation.

**7.10 Offender management**

**7.11** There was generally effective disclosure of The Adult's offending history, but The Adult's GP was not aware of this due to the way in which the information was provided by the Prison Service as one part of many records. A front-page summary would have been helpful. When The Adult's GP became aware of The Adult's offending history there was effective liaison with his housing provider.

**7.12** Additionally, no information was received by The Adult's GP following The Adult's recall to, and release from, prison. This was significant given the history of mental health concerns and previous medication issued to manage The Adult's health conditions and suggests a need for wider sharing from MAPPA and MARAC processes to include GP surgeries.

**7.13** Appropriate license conditions were used, for example, on 12th April 2019, when the Adult was recalled to prison when he was found to be in possession of knives in Probation Approved Premises.

**7.14** The Adult used a knife to kill Tracy and had a previous history of being found with them, for example, on 12th April 2019, for which he was recalled to prison. On 25th April 2021, police officers found the adult in possession of knives in his room when Tracy was present with him. No further action, except for the creation of a CRIMINT report, was

taken since the criteria for a Merlin report had not been met and the Adult was not in breach of his license conditions. The possession of kitchen knives in supported living accommodation was not restricted as it was in Probation Approved Premises. The actions by the attending Police Officers was the subject of an IOPC enquiry which found no case for the officers involved to answer.

**7.15 Health and social care needs**

7.16 Tracy accessed both primary care and secondary mental health services with several physical and mental health needs. There were concerns that Tracy had heart problems and Tracy's GP made appropriate referrals to specialists to investigate the symptoms including chest pain and collapse. The cardiology service concluded that Tracy's symptoms were psychological. The nature of some of Tracy's symptoms could have prompted questions about domestic abuse.

7.17 Tracy self-referred to IAPTS in 2021, during which she spoke about low mood, poor self-esteem and suicidal thoughts. Tracy also disclosed a previous history of domestic abuse. There was, however, no exploration of whether Tracy was currently being domestically abused by The Adult, despite her references to flashbacks when with him. Tracy maintained that The Adult was a protective factor in her life and he was included as a contact in her crisis plan. Tracy only talked about problems in her relationship with The Adult at the last IAPT appointment that she attended. Tracy's thoughts of suicide and low self-esteem might have been identified as warning signs of the presence of coercion and control and domestic abuse in her relationship with The Adult. However, Tracy denied that she faced risks from The Adult.

7.18 The Adult was in contact with his GP surgery and also self-referred to the IAPT service whilst in prison. The Adult disclosed a history of trauma and dismissed his conviction for rape as unfair. The Adult also tried to persuade the IAPT therapist to advocate on his behalf for access to better facilities in prison and did not use the therapeutic input offered.

7.19 Both Tracy and The Adult referred themselves to IAPTS and there was limited multi-agency information sharing and no mechanism in place to link both Tracy and The Adult together. Consequently, IAPTS had no intelligence or knowledge that would link the risks associated with The Adult to Tracy. The IAPTS service does not have access to SLAM records and uses its own IAPTS system.

7.20 The SafeLives report, "Safe and Well: Mental health and Domestic Abuse" (2019) highlighted the lack of progress in integrating responses to domestic abuse within health services, resulting in a lack of support for victims and a lack of challenge to perpetrators. As a result, domestic abuse often goes undetected in mental health services and domestic abuse services are not always equipped to support people with mental health needs. The report made a number of recommendations for greater recognition of the links between domestic abuse and the mental health needs of victims and perpetrators and for greater integration between health and domestic abuse services, including the use of the NICE (National Institute of Clinical Excellence)

2016 quality standards for domestic abuse recognition and response to monitor the effectiveness of health services.

**7.21** The Crime Survey for England and Wales (March 2020) estimated that 5.5% of adults aged 16 to 74 years (2.3 million people) experienced domestic abuse in the last year. It may be worthwhile, therefore, to consider domestic abuse to be a concern to be suspected, explored and eliminated, rather than to consider it as an exception.

7.22 Trauma informed approaches to engage flexibly and sometimes assertively with Tracy and The Adult may have been helpful.

**7.23 Individual and family factors**

7.24 The victims of domestic homicide are overwhelmingly women whilst the perpetrators are men. Tracy was a black British woman who was killed by a black British man. It is likely that both had experienced discrimination as a result of racism, inequality and mental health needs. Tracy had told her GP that she was being discriminated against at work but the reasons for this were not explored.

7.25 Tracy's denial of The Adult's offending history may have been influenced by statements made by The Adult and her own understanding of the disproportionate number of black men in prison and that black men were treated less favourably than other ethnic groups. The three Metropolitan Police stop and search procedures between February 2020 and July 2020, at which Tracy was present during at least one, may have been perceived by Tracy to vindicate this.

**7.26** No organisations involved in this review identified that their services had discriminated against Tracy or The Adult and there was no evidence, apart from the three incidents of stop and search, to suggest that there was.

**7.27 Organisational factors**

7.28 The contact with services by Tracy and The Adult took place within the context of the Coronavirus pandemic. The clearest impact of the response to the Coronavirus pandemic was the lack of face-to-face contact with both Tracy and The Adult by health services, which may have hampered disclosure and identification of domestic abuse risk factors.

7.29 The pandemic, however, appears to have led to an increase in reported domestic abuse to both partners and to family members, but a decrease in reported abuse from ex-partners, probably as a result of the lockdown restrictions (Ivandic et al, 2020). The increase in reports was driven by third parties (neighbours etc.) rather than by victims themselves, which suggests some underreporting from homes where there were no external witnesses or suspicions. This does not appear to have applied in Tracy's case. Perhaps because they did not live together, there were no reports of incidents of domestic abuse or the coercion and control of Tracy by The Adult from professional or private sources.

7.30 Gregory and Williamson (2021) found that the lockdowns were exploited by perpetrators to further abuse their victims, but that "informal supporters" (friends, family, neighbours and colleagues) had found ways to support victims and to report their concerns about abuse. Again, this did not happen in Tracy's case. These findings support the need to continue to raise public awareness about domestic abuse and what to do where it is suspected.

## 8 Lessons to be learned: Learning and practice development

8.1 A number of risk factors for domestic abuse, coercive control and homicide-suicide were present, but these were not explored further at the time. A lesson from this DHR is that even when the way that a person presents themselves to services might be explained and understood as due to physical and mental health problems, the presence and effects of domestic violence and abuse should still be explored.

8.2 There is a need to improve communication between agencies about potential risk factors of known domestic violence incidents and to consider the transfer of risks to other victim groups, for example from strangers to partners.

8.3 When domestic abuse agencies contact GP surgeries requesting information it is important that the surgery responds promptly and puts a flag in the records to ask the patient about domestic abuse when they next speak to a clinician.

8.4 There is a need to share information on the support services locally available for perpetrators of Domestic Abuse.

8.5 When working with someone who is in denial about the risk of domestic abuse, attending to interventions which they will accept, such as help with housing, may help to develop a relationship and may open up opportunities for further engagement.

8.6 GP practices should consider how to enable people who are known or suspected to be experiencing domestic abuse to see the same GP at each consultation since this might facilitate probing and disclosure.

8.7 There is a need for improved recording and storage of MARAC minutes to enable a continuous record of domestic abuse work on Probation Service systems. This action has been completed with new guidance issued across London Probation following internal review of this case in 2021.

8.8 There is a need for improved clarity on Police roles for Probation staff when seeking additional risk information on offenders and this could have improved timely intelligence sharing to contribute to risk assessment and management.

8.9 The increased use of MAPPA/MARAC at the point of re-release from prison following recall would have allowed a more robust multi-agency approach to risk management and release planning.

## 9 Recommendations

### 9.1 Single Agency Recommendations

### 9.2 Probation Service

9.3 There is a need for increased professional curiosity about mental health and emotional well-being when indicators in this area arise. There appears to be over-reliance on self-engagement with services, which could have been supported by additional onwards referrals.

9.4 There is a need for improved reviews of risk management planning for re-release post-recall to prison. Neither MARAC or MAPPA re-referrals featured as part of the re-release preparations in this case, and this would have served to strengthen the multi-agency review mechanisms.

### 9.5 Metropolitan Police

9.6 The Central South (AS BCU) Senior Leadership Team should perform dip sampling of the use of the Domestic Violence Disclosure Scheme to evaluate the current procedures and to establish if there is effective supervision of completing the process.

9.7 **South London and Maudsley NHS Trust**

9.8 Within IAPTS services, when reference is made to experiences of domestic abuse it should be followed up with advice, guidance and signposting to appropriate agencies and it should clearly be documented: priority areas should be discussed identified, some of which need to be responded to by others such as DA services.

9.9 **General Practice/ ICB**

9.10 It is important that Lambeth surgeries follow up on communications from domestic abuse agencies requesting information. This will facilitate agencies working together collaboratively and the practice to find out information from the patient which may help in treating patients and identifying safeguarding risks. IRIS training, or an equivalent, is likely to increase the awareness of front-line staff of the local domestic abuse agency and how the agency is involved in helping to safeguard patients at risk of domestic abuse. (IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial).

9.11 Front line clinicians should consider the possibility of domestic abuse when patients present with medical conditions which could be indicators of domestic abuse and then make appropriate enquiries of the patient. IRIS training has been undertaken by the Lambeth practice at which CG was registered and this would have covered professional curiosity in relation to domestic abuse.

9.12 The Lambeth practice did not have a domestic abuse policy separate to its safeguarding adult policy. SELICS has developed policy template guidance document which has been distributed to all Lambeth practices with the intention that it can assist practices in developing their own domestic abuse policy.

9.13 **Multi-Agency Recommendations**

9.14 Each agency involved in this review should identify how Clare's Law information is received, recorded and shared and the improvements that could be made. They should report their findings back to the Safer Croydon Partnership, which should then consider how these changes could be supported.

9.15 Domestic abuse services in Croydon and SLAM should agree how IRIS (or other appropriate Violence Against Women and Girls and Domestic Abuse training) can be provided to IAPT staff and mental health commissioners should consider funding an IDVA to be part of the IAPT service.