Safer Lambeth partnership

Domestic homicide review

Overview Report into the death of Elaine

April 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date: November 2019

Though nothing can bring back the hour
Of splendour in the grass, of glory in the flower;
We will grieve not, rather find
Strength in what remains behind;
In the primal sympathy
Which having been must ever be.

Ode: Intimations of Immortality from Recollections of Early Childhood
By William Wordsworth

Included in the Eulogy read by Isabel and Charles at Elaine's funeral

"She was the smallest of our five babies and was so beautiful with lots of long black hair! From the moment she was born we loved her so deeply and being young parents, she was our absolute everything and a dream come true".

"Elaine was a very determined young lady who would take chances in life and if she failed, she will try again, she was very ambitious and adventurous and full of life. Her life had a great impact on her husband, family and friends, but most of all her precious [child] … her No1. Elaine was very much a family girl who enjoyed family times together and they meant the world to her".

"We say goodbye to our eldest child - first daughter, Elaine - and seek true Justice! Her compassionate, loving, caring beautiful SMILE will forever remain in our hearts."

"Elaine was very loving, caring, kind, compassionate, who was well organised and professional, incapable of hurting anyone in any form or shape. She was very responsible, generous, ambitious career minded and independent. She possessed a heart of gold, loved everyone and was loved by all".

"We are ashamed to laugh or smile and do not know what real happiness is now - Our other children haven't got their big sister to look after them, love them and care for them. Our [grandchild] no longer has a Mother in this world for the rest of [their] life - to love and care for [them], to protect [them], to watch [them] grow up and go to College and University, to watch [them] get married and have children, to laugh, hug and play with, to have family gatherings and go on holidays, to sit by the fireside and watch a movie, family birthdays, Easter, Christmas or to go Church and sing and Pray. Only God's Grace and Mercy, Peace and comfort provides this strength each day".

Extracts from the Victim Impact Statement provided by Charles, Isabel, Elaine's siblings and Child A

"She was a unique, lovely, special and beautiful person Inside & Outside"

"Her life had a great impact on her husband, family and friends".

"We will dearly miss her strong strength of character, seriousness- yet fun person being together who loved her family' immensely & unconditionally!"

"Elaine was very professional in her Job… Her etiquette and mannerism [were] exquisite".

“Our eternal thanks and tremendous sense of Gratitude to all Family, friends, the Church, work colleagues and all who have loved and cared for Elaine.
Thank you”.

Extracts from the Eulogy read by Isabel and Charles at Elaine’s funeral

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This DHR report examines agency responses and support given to Elaine[1], a resident of the London Borough of Lambeth (hereafter 'Lambeth') prior to the point of her death in mid-April 2018. Elaine was killed by her nephew, Aiden[2], in the home she shared with him and a number of other family members. Aiden was convicted of manslaughter by diminished responsibility in March 2019. However, sentencing was delayed for psychiatric reports. In November 2019 Aiden was sentenced to an indefinite period at a secure hospital under Section 37 Mental Health Act 1993 with a section 41 restriction. The murder charge has been left to lie on file.

1.1.3 This DHR considers agencies contact/involvement with Elaine and Aiden from 1st January 2016 (the year Elaine moved to London and began living at the same property as Aiden) to the date of the homicide (in mid-April 2018). In this context, the Review Panel were mindful that the relationship between Elaine and Aiden was familial rather than intimate. The Review Panel has framed its considerations of the contact between Elaine and Aiden in the context of fatal Adult Family Violence (AFV), which is a form of domestic abuse. This is discussed in 1.6 below.

1.1.4 This DHR has also considered contact/involvement with Aiden from 2011. This is because he had repeated contact with a number of different agencies from this year which may have had a bearing on his experiences and actions.

1.1.5 Finally, the DHR has considered contact/involvement with Aiden's mother (Rachel) and former partner (Mia). This is because there were reported incidents of violence and abuse by Aiden involving both. The Review Panel thought it appropriate to consider whether Aiden had a propensity for violence against women. This added an additional layer of complexity to the review process and the Review Panel has sought to understand these contacts in their own right. The Review Panel has framed its considerations of the contact between Rachel and

[1] Not her real name.

[2] Not his real name.

Mia as potential examples of Child to Parent Violence (CPV) and Intimate Partner Violence (IPV) respectively, with these both being forms of domestic abuse. This is discussed in 1.6 below.

1.1.6 In addition to agency involvement, the DHR 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.

1.1.7 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order 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 in order to reduce the risk of such tragedies happening in the future.

1.1.8 This DHR does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.9 The Review Panel expresses its sympathy to the family and friends of Elaine for their loss, and also acknowledges the impact on the wider family network(s) of Elaine and Aiden. The Review Panel would like to thank everyone who contributed to this DHR for their support in this process.

1.2 Timescales

1.2.1 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Lambeth Partnership – commissioned this DHR. Having received notification from the Metropolitan Police Service (MPS) in late April 2018, a decision was made to conduct a DHR in consultation with the Safer Lambeth Partnership Co-Chairs and the Chairs of the Lambeth Safeguarding Adults Board (LSAB) and Lambeth Safeguarding Children Partnership (LSCP). Subsequently, the Home Office was notified of the decision in writing in May 2018.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in June 2018. The completed report was handed to the Safer Lambeth Partnership in November 2019. In February 2020, it was tabled at a meeting of the Safer Lambeth

Executive and signed off, before being submitted to the Home Office Quality Assurance Panel in April 2020. In August 2020, the completed report was considered by the Home Office Quality Assurance Panel. In September 2020, the Safer Lambeth Partnership received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2.3 Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. This timeframe was not met due to:

- The timing of the first panel (held in September 2018 so agencies could attend, and with reference to the commencement of the criminal trial);
- To allow the completion of the criminal trial (Aiden was convicted in March 2019 and sentenced in November 2019);
- To meet with family and friends after the conclusion of the criminal trial, as well as allowing time for the family to feedback on the draft report (from May 2019, see 1.9); and
- To allow time to facilitate an approach to the perpetrator (in September 2019, see 1.10).

1.3 Confidentiality

1.3.1 The findings of this DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers.

1.3.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of any children have been removed (with anonymity further enhanced by Elaine's child being referred to as Child A, and Aiden's child being referred to as Child B). Only the chair and Review Panel members are named.

1.3.3 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members and the perpetrator:

Name	Relationship to Elaine	Relationship to Aiden
Elaine	n/a	Aunt
Aiden	Nephew	n/a

Luke	Husband	Uncle
Isabel	Mother	n/a
Charles	Father	n/a
Hazel	Mother-in-law	Grandmother
Rachel	Former Sister-in-law	Mother
Jacob	Brother-in-law	Father
Mia	n/a	Former partner
Child A	Child	Cousin
Child B	Great nibling	Child

1.3.4 Elaine's family were invited to choose pseudonyms. They selected the pseudonym 'Elaine' for their daughter. The other pseudonyms used in this report were chosen by the chair and agreed with Elaine's family.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel did bear in mind all the Protected Characteristics of Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, and Sexual Orientation during the DHR process.

1.4.2 At the first meeting of the Review Panel, it was identified that the Protected Characteristic of *Sex* required specific consideration. This is because Elaine was female, and Aiden is male. An analysis of DHRs reveals gendered victimisation

across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators[3].

1.4.3 The Review Panel also identified the following Protected Characteristics as requiring specific consideration:

- *Religion and Belief* (Elaine was a Christian and was an active member of a Protestant faith community; Aiden's religion and belief were unknown at the start of the DHR, but it was later reported that he had converted to Islam); and
- *Race* (both Elaine and Aiden were/are Black Caribbean).

1.4.4 Subsequently, the Review Panel identified it would also specifically consider *Age* (Elaine was 38 at the date of the homicide, while Aiden was 21).

1.4.5 These issues are considered throughout the review and analysed in 5.3 below.

1.5 Terms of Reference

1.5.1 The full Terms of Reference is included in **Appendix 1**. This DHR aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from Lambeth, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the DHR, their participation and the need to secure their records.

1.5.3 Additionally, at the start of the DHR, it was established that both the victim and perpetrator had contact with agencies in other parts of the country. This was managed as follows:

- Elaine and her husband (Luke) had previously lived in Buckinghamshire and were also regularly returning to that area, because this was where

[3] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

Elaine's family (and their child, Child A) lived. Agencies in Buckinghamshire were contacted for information and involved in this DHR. This was coordinated through the local CSP, with a representative from the relevant CSP being invited to be part of the Review Panel;

- The perpetrator had previously lived with his mother in the London Borough of Lewisham (hereafter 'Lewisham'), where his former partner (Mia) and child (Child B) also lived. Agencies in Lewisham were contacted for information and involved in this DHR. This was coordinated through the local CSP, with a representative from Lewisham Council being invited to be part of the Review Panel; and
- Surrey Police were also identified as having had contact with the perpetrator. Information was requested as part of the DHR. As their contact with Aiden was historical, it was agreed that a representative from Surrey Police would participate electronically but would attend the final Review Panel meeting.

1.5.4 At the first meeting, the Review Panel shared brief information about agency contact with the subjects of the DHR, and as a result, established that the time period to be reviewed would be from 1st January 2016 (the year Elaine moved to London and began living at the same property as Aiden) to the date of the homicide (in mid-April 2018). The Review Panel also agreed to consider contact/involvement with Aiden from 2011 (when he first came into contact with services). Where there was agency involvement with any subject prior to these dates, agencies were asked to summarise this, and review any issues pertinent to the DHR.

1.5.5 Additionally, because there were reported incidents of domestic violence and abuse by Aiden involving Aiden's mother (Rachel) and former partner (Mia), the Review Panel sought to identify any relevant information about these contacts.

1.5.6 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Elaine and / or Aiden [and wider family];

- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved on domestic abuse issues;
- Specific consideration to the following issues: AFV; Substance Misuse; Mental Health; and Youth Crime and Child Criminal Exploitation[4,5]; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.5.7 While the Review Panel included agencies that could bring expertise in relation to these additional issues, the local Drug and Alcohol Service, Lambeth Addictions (provided by the South London and Maudsley NHS Foundation Trust, SLaM[6]) was also invited, even though they had not been previously aware of the individuals involved. SLaM offers assessment, treatment and advice for people, aged over 18, who have substance misuse (drug and/or alcohol) related problems) and the Review Panel felt it would be useful to have their involvement.

1.5.8 As both Elaine and Aiden were Black Caribbean, the Review Panel also sought to identify appropriate additional expertise. A local partnership – Black Thrive – was invited to act as a 'critical friend' to the DHR[7]. Black Thrive operates in Lambeth and is working to reduce mental health inequalities and improve

[4] At the start of the DHR, the Review Panel identified included 'Youth Crime' in the Terms of Reference because of contact with Aiden in relation to youth offending. During the course of the DHR, the Review Panel agreed to amend this to 'Youth Crime and Child Criminal Exploitation' because there were periods when Aiden was missing from home, as well as contact with the MPS relating to the carrying or supply of drugs, largely when he was under the age of 18. The Review Panel therefore felt was appropriate to consider the potential of Child Criminal Exploitation.

[5] HM Government defines Child Criminal Exploitation as occurring where "*occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology*". For more information, go to the GOV.UK page, Criminal exploitation of children and vulnerable adults: county lines.

[6] For more information, go to: the Slam NHS service finder.

[7] The Safer Lambeth Partnership facilitated the approach to Black Thrive. Given the organisation's capacity and the time commitment associated with Review Panel membership, it was agreed that Black Thrive would act as a 'critical friend' (rather than joining the Review Panel) and provide comment and feedback on the report during drafting.

support for Black communities and service users in relation to mental wellbeing[8].

1.6 Methodology

Some considerations about definition(s)

1.6.1 The Review Panel has faced considerable methodological challenges, particularly around the definition of domestic violence and abuse.

1.6.2 As noted in the preface, the DHR was initiated because of a fatal act of violence by Aiden towards Elaine (his paternal aunt). Elaine's homicide is properly the focus of this DHR.

1.6.3 However, the Review Panel also became aware of historical reports of violence and abuse by Aiden towards Rachel (his mother) and Mia (his former partner). The Review Panel agreed it was important to consider these contacts. In doing so, the Review Panel hoped to better understand Aiden's experiences and behaviour, identify any opportunities for intervention, and consider whether there was a more general pattern of violence by Aiden towards women.

1.6.4 Consequently, throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013. The definition is included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

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

[8] For more information, go to the Black Thrive page, 'What we do'..

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."

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

1.6.5 Using this definition, it is possible to consider both Aiden's fatal act of violence towards Elaine, as well as frame the reported violence and abuse towards Rachel and Mia. However, the Review Panel noted that while it was possible to consider the presence of domestic violence and abuse in these three relationships using the cross-government definition, there are challenges in doing so. Most importantly, there is a risk of conflating three distinct relationships in which, if violence and abuse were present, there may have been different dynamics. Such a concern extends beyond this DHR, with the cross-government definition of domestic violence and abuse being criticised for conflating IPV with family violence (which includes both AFV and CPV)[9].

1.6.6 However, there is also clearly a benefit to looking at the behaviour of Aiden in relation to Elaine, as well as Rachel and Mia. To manage this concern, the Review Panel agreed to frame the approach as follows:

- The homicide of Elaine can be defined as fatal AFV. While there is no single definition of AFV, fatal AFV is generally accepted to involve a homicide between family members aged 16 years and older, albeit (as in this case) the killing of an aunt by a nephew is relatively rare. This is also consistent with the published literature on DHRs which groups homicides of family members together[10,11];
- Although the reported violence and abuse towards Rachel could be considered as an example of AFV, a pattern of violence and abuse from

[9] Kelly, L. and Westmarland, N. (2014) Time for a rethink – why the current government definition of domestic violence is a problem. (Accessed: 6th March 2019).

[10] Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) case analysis. (Accessed: 6th March 2019).

[11] Home Office. (2006) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. (Accessed: 6th March 2019).

a child to a parent is commonly referred to as CPV. There is no single definition of CPV, but the concept is not age specific and recognises that child to parent relationships exist through the life course (i.e. it includes both children and adults abusing parents)[12]. CPV is an appropriate definition through which to explore the reports of changes in Aiden's behaviour, as well as contact with the MPS after he was 18; and

- The reported violence and abuse towards Mia could be considered as IPV.

Process

1.6.7 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.6.8 On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. This included both Elaine and Aiden, but also Aiden's mother (Rachel) and his former partner (Mia) and Child B, given reports of other domestic abuse incidents. A total of 28 agencies were contacted to check for involvement with the parties concerned with this Review. Of these: five agencies had limited contact and submitted a Summary of Engagement; four agencies submitted Short Reports due to the brevity of their involvement; and 10 agencies were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.6.9 *Independence and Quality of IMRs:* The IMRs and Short Reports were written by authors independent of case management or delivery of the service concerned. They were largely of good standard and enabled the Review Panel to analyse the contact with Elaine and/or Aiden, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. The MPS were also asked to produce an addendum to their original IMR, expanding on their contact with Aiden on the 31st March 2019. This was because Aiden's mother (Rachel) told the chair that her family had provided information about Aiden's mental health to the MPS on this date. However, only a brief account of this contact had been included in the original

[12] Home Office. (2013) Information guide: Adolescent to parent violence and abuse (APVA). (Accessed: 10th July 2019).

MPS IMR. (MPS contact is described in the chronology, while Rachel's account is set out in 4.2 below).

1.6.10 Four agencies made recommendations of their own. A number of other IMRs and Short Reports identified learning, but reported changes in practice and policies over time, meaning no recommendations were made. These are described in the analysis (section 5).

1.6.11 *Documents Reviewed:* In addition to the IMRs and Short Reports, other documents reviewed during the DHR process have included information shared by Elaine's family, as well as previous case review learning in Lambeth.

1.6.12 *Interviews Undertaken:* The chair has undertaken a number of interviews in the course of this DHR. This has included face to face meetings with Isabel and Charles (Elaine's parents) and a telephone interview with Rachel (Aiden's mother). The chair is very grateful for the time and assistance given by the family and friends who have contributed to this DHR.

1.7 Contributors to the Review

1.7.1 The following agencies in Lambeth were contacted, but had no recorded involvement:

- SLaM - Addictions;
- Lambeth Council Adult Social Care;
- Lambeth Council Education;
- Lambeth Council Housing Needs;
- Lambeth Council Safer Communities – for the local Multi Agency Risk Assessment Conference (MARAC);
- London Community Rehabilitation Company;
- National Probation Service;
- The Gaia Centre (run by Refuge)[13]; and

[13] The Gaia Centre provides confidential, non-judgmental and independent support services for those living in the London borough of Lambeth who are experiencing gender-based violence. For more information, go to: The Gaia Centre webpage.

- Victim Support.

1.7.2 Agencies in Lewisham and Buckinghamshire were also contacted via the local CSP, but there was no recorded contact other than with the agencies listed in 1.7.4 below.

1.7.3 The following agencies made contributions to this DHR:

Agency	Contribution
Clapham Family Practice (which took over Dr Santamaria's Medical Practice on 1st July 2018) – General Practitioner (GP) for Aiden from August 2016 until April 2018)[14]	IMR and Chronology (with support from the Lambeth Clinical Commissioning Group, CCG)
Guys and St Thomas Hospital NHS Foundation Trust (GSTT) / Evelina London – provider of children's health services	Short Report
Hetherington Group Practice – GP for Aiden prior to August 2016 and from April 2018	IMR and Chronology (with support from the Lambeth CCG)
Kings College Hospital NHS Foundation Trust (KCH)	Short Report
MPS	IMR and Chronology / addendum relating to the 31st March 2019
Refuge[15]	Summary of Engagement
SLaM - Mental Health	IMR and Chronology
Victim Support	Summary of Engagement
Surrey Police	Short Report

1.7.4 Agencies in other areas also contributed to this DHR:

Lewisham

Agency	Contribution

[14] Dr Santamaria's Medical Practice was a comprised of only one GP partner. The practice closed with their Dr Santamaria's retirement prior to this DHR commencing. The patient list (which included Aiden) was transferred to the Clapham Family Practice, which has cooperated with the Lambeth CCG to prepare an IMR. In the chronology itself, reference is made to Dr Santamaria's Medical Practice although the analysis addresses the Clapham Family Practice.

[15] This related to contact with Refuge services provided in areas outside Lambeth.

Harris Academy Beckenham	Summary of Engagement
Lewisham and Greenwich NHS Trust (LGT) – Health visiting services	IMR and Chronology
Lewisham Council – Children's Social Care	IMR and Chronology
Lewisham Council – Youth Offending Service (YOS)[16]	IMR and Chronology
Lewisham Council – Single Homeless Intervention and Prevention (SHIP)[17] Service	IMR and Chronology

Buckinghamshire

Agency	Contribution
Buckinghamshire Children's Social Care	Summary of Engagement
Buckinghamshire Healthcare Trust – Hospital / community nursing	Summary of Engagement
Medical Centre – GP for Elaine[18]	IMR and Chronology
Oxford Health NHS Foundation Trust – Mental Health	IMR and Chronology
Local Authority District Council – Housing[19]	Short Report

1.7.5 Following a proposal from the chair, the Safer Lambeth Partnership agreed that the Review Panel would receive a briefing on AFV. This was to ensure that Review Panel members had a shared understanding of the potential issues in relation to family violence that needed to be considered in the DHR. Consequently, at the second Review Panel meeting, Simon Kerss, a Lecturer in Criminology at Anglia Ruskin University[20], provided an input which addressed:

[16] Works with the community and local agencies such as the police and schools, to help keep young people aged 10-17 out of trouble. For more information, go to the Lewisham Youth Offending Service page.

[17] Responsible for preventing homelessness and placing vulnerable single homeless people with support needs into supported accommodation. For more information, go to the LB Lewisham - Single Homeless Intervention and Prevention Team page.

[18] The Medical Centre is not identified to enhance anonymity.

[19] The local authority is not identified to enhance anonymity.

[20] For more information, go to the Anglia Ruskin University website.

Definition; Prevalence; Impact, Theoretical Perspectives; and Risk Factors. The chair and Review Panel are grateful to Simon for sharing his time and expertise.

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Agency	Role	Agency
Alice Wu	Clinical Adult Safeguarding Lead	Lambeth CCG
Angela Middleton	Patient Safety Lead, Mental Health	NHS England (NHSE)
Charlene Noel	Violence against Women and Girls (VAWG) Programme and Strategy Manager	Lewisham Council Community Safety / Link to local CSP
David Rowley	Adult Safeguarding Lead	Lambeth CCG
Elaine Rumble	Head of Nursing Quality Lambeth	Mental Health (SLaM)
Eleanor Hargadon-Lowe	Child Protection Conference Chair	Lewisham Council Children's Social Care
Ella Pollock	Senior VAWG Project Officer	Lambeth Council Integrated Children's Commissioning and Community Safety
Graeme Gwyn	Review Officer	Metropolitan Police Specialist Crime Review Group (SCRG)
Matthew Edom	Area Manager, South West London	Community Rehabilitation Company
Mick Collins	Borough Lead	Lambeth Addictions (SLaM)
Moira McGrath	Director of Integrated Commissioning	Lambeth CCG
Naeema Sarkar	Assistant Director (Quality Assurance)	Lambeth Council Children's Services
Rachel Nicholas[21]	Head of Service – Domestic Abuse	Victim Support

[21] Succeeded Hannah Norgate on the Review Panel in October 2019.

Richard Sparkes	Assistant Director	Lambeth Council Adult Social Care
Rose Parker[22]	VAWG Programme and Commissioning Manager	Lambeth Council Integrated Children's Commissioning and Community Safety
[redacted]	Community Safety Team Leader	Local Authority District Council in Buckinghamshire / Link to local CSP[23]
Sharon Erdman	Head of Operations	Refuge
Sophie Bartle	Contracts & Partnerships Manager – South West Area	Community Rehabilitation Company

1.8.2 As noted in 1.5.3, Surrey Police participated electronically but a representative (Jane Lord, the manager of the Surrey & Sussex Crime Review Team) attended the final Review Panel meeting.

1.8.3 As noted in 1.5.8, Black Thrive acted as a critical friend and provided comment and feedback on the report during drafting. The chair and Review Panel are grateful for their time and input. Black Thrive has, in particular, provided feedback that has helped shape this report in relation to both the experience of Aiden as a young, Black Caribbean man and his access to mental health services. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge in the course of a DHR.

1.8.4 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.5 The Review Panel met a total of four times, and the first meeting was on the 19th September 2018. There were further meetings on the 19th January 2019, the 5th April 2019 and the 3rd July 2019. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft by email during September and signing off the final report in November 2019. Following feedback from the Home Office

[22] Succeeded Sophie Taylor on the Review Panel in July 2019.
[23] The local authority name, and that of the local representative, are not identified to enhance anonymity.

Quality Assurance Panel, the Review Panel also commented on and then agreed revisions to the final report by email in October and November 2020 (these are discussed in section five).

1.8.6 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and wider community.

Family

Name[24]	Relationship to victim	Means of involvement
Isabel	Mother	Interviewed by chair; reviewed and commented on report
Charles	Father	Interviewed by chair; reviewed and commented on report
Luke	Husband	Invited. No response received

1.9.2 The Safer Lambeth Partnership notified family members of the decision to conduct a DHR in July 2018, with the letter being sent via the MPS Family Liaison Officer (FLO) and being accompanied with information on Advocacy After Fatal Domestic Abuse (AAFDA)[25]. Thereafter the chair wrote to family members in October 2018. This letter was also sent via the FLO and was sent along with the Home Office leaflet for families and further information on AAFDA.

[24] Not their real names.

[25] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: the AAFDA website.

Elaine's parents (Isabel and Charles)

1.9.3 In December 2018, Elaine's parents (Isabel and Charles) confirmed that they wanted to take part in the DHR. While Isabel and Charles were not able to meet with the chair until after the criminal trial had concluded, regular updates were facilitated by a caseworker from AAFDA. The chair met in person with Isabel and Charles in May 2019. A transcript of this meeting was produced, with this being approved by Isabel and Charles. Information and comments by Isabel and Charles have been incorporated into this report (see 4.1 below for a summary).

1.9.4 Subsequently, the chair has maintained contact with Isabel and Charles directly or via their AAFDA case worker. The chair sent a copy of the final draft report to Isabel and Charles in September 2019 and then met with them in October 2019. At this meeting Isabel, Charles and the chair reviewed the report. A number of changes were agreed, reflecting feedback by Isabel and Charles. At this meeting, Isabel and Charles had a number of questions about the format of the report, as well as the scope of the DHR. To manage these issues, in some parts of the report comments by Isabel and Charles have been directly included. Most importantly, Isabel and Charles wanted to encourage all those who read this report to keep Elaine and her life at the centre of their thoughts. To help readers do this, Isabel and Charles have shared a copy of the Witness Impact Statement that they, and other family members, prepared for the trial of Aiden. They also shared a copy of the Eulogy that they read at Elaine's funeral. Extracts from both are included at the beginning of the report to help readers to keep Elaine, who Isabel and Charles described as "*our beautiful gorgeous Princess*", in mind. In November 2019, the chair had a follow up call with Isabel and Charles to discuss final changes to the report before it was completed.

Elaine's husband (Luke)

1.9.5 In December 2018, the chair established contact with a caseworker from the Victim Support Homicide Service (VSHS)[26] who was supporting Elaine's husband (Luke). The chair remained in touch with VSHS, who made several attempts to speak to Luke about the DHR and his potential involvement. VSHS reported that they initially had limited contact with Luke but later were unable to

[26] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to the Victim Support website.

contact him at all. A follow up letter was sent to Luke from the chair by post in August 2019. No response was received.

Elaine and Luke's child (Child A)

1.9.6 Consideration was given to involving Child A in the DHR. This was considered by the maternal family, but they ultimately decided that this was not something that they felt able to take up.

Friends, Work Colleagues, Neighbours and Wider Community

1.9.7 Consideration was initially given to approaching friends, work colleagues, neighbours and wider community. However, as part of the murder enquiry the MPS only took one witness statement. This was from Jacob (Elaine's brother in law) and is discussed below. This has meant that the Review Panel was not able to identify friends, work colleagues, neighbours and wider community using witness statements. In discussion with Elaine's family, it was agreed not to approach friends. Elaine's family wanted the report to reflect that they would have liked to have facilitated this. They would have done so if they had had more time and less pressure from dealing with other things like the trial.

1.10 Involvement of Perpetrator and/or his Family:

The perpetrator

1.10.1 There were considerable challenges in approaching the perpetrator. This was because of his mental ill health, as a result of which he was being detained in a secure unit.

1.10.2 After confirming the MPS Senior Investigating Officer (SIO) was happy for contact to be made before sentencing (Aiden was convicted of manslaughter in March 2019, his sentencing was delayed, with this not taking place until November 2019), the Review Panel representative from NHSE facilitated contact with the Responsible Clinician (RC). An RC has overall responsibility for the care and treatment of a patient. The chair approached the RC in September 2019. The RC advised that Aiden had neither capacity to consent or engage meaningfully in the DHR. He was therefore not invited to participate.

Family and ex-partner

1.10.3 Attempts were also made to engage with Aiden's family and ex-partner:

Name[27]	Relationship to perpetrator	Means of involvement
Rachel	Mother	Interviewed by chair
Jacob	Father	Invited. No response received
Mia	Ex-partner	Invited. No response received
Hazel	Grandmother	Not contacted

1.10.4 After Aiden's conviction in March 2019, attempts were made to contact Aiden's mother (Rachel), father (Jacob) and ex-partner (Mia). In April 2019, the MPS was able to speak directly with Rachel and provide a letter from the chair. In May 2019, the MPS was able to pass on similar letters to Jacob and Mia. These letters were accompanied by the Home Office leaflet for families.

1.10.5 In May 2019 the chair was able to have an initial conversation with Rachel, explaining in person the purpose of the DHR and the ways that she could be involved. Subsequently, Rachel spoke over the phone in August 2019. A note of this call was produced, with this then being approved by Rachel. Information and comments by Rachel have been incorporated into this report (see 4.2 below for a summary).

1.10.6 In relation to Mia, no response was received. This also meant it was not possible to consider the involvement of Child B.

1.10.7 Unfortunately, no response was received from Jacob. This also means it was not possible to ask for an introduction to Hazel.

1.10.8 A follow up letter was sent to both Mia and Jacob in August 2019, again facilitated via the MPS, but no response was received.

1.11 Parallel Reviews

1.11.1 *Criminal trial*: Aiden was charged with murder, which he denied. The MPS SIO was invited to the first meeting of the Review Panel. It was agreed that approaches would not be made to witnesses until after the criminal trial had

[27] Not their real names.

been concluded, with the exception of an introductory letter to Elaine's family as described in 1.9 above.

1.11.2 The trial date was initially set for October 2018 but was subsequently listed in February 2019 to allow time for psychiatric reports. Aiden was convicted in March 2019. After delays, Aiden was sentenced in November 2019.

1.11.3 Elaine's parents, Isabel and Charles, told the chair that they were angry and deeply disappointed with both the police investigation and the criminal trial outcome. In particular, they are distressed that Aiden was only convicted of manslaughter, which they do not feel reflects the gravity of his actions in killing Elaine. They also do not accept that Aiden's mental health offers any mitigation for this act. While these matters are beyond the purview of the DHR, the chair agreed to record Isabel and Charles feelings and views in this report.

1.11.4 *The Coroner's Inquest*: The death of Elaine has been referred to the HM Coroner, and an inquest was opened and adjourned at Southwark Coroner's Court in April 2018.

1.11.5 *Mental Health Investigation:* SLaM commissioned a Mental Health Investigation Report in April 2018. This was shared with the chair in August 2019 and has been integrated into this report.

1.11.6 *Children*: There are no parallel reviews in relation to Child A (who has been in the care of their maternal family since the homicide) or Child B (who remains in the care of Mia).

While the Safer Lambeth Partnership is not responsible for the care of Child A and Child B, it has a responsibility to liaise with the appropriate Children's Social Care departments to ensure that their wellbeing is considered both in relation to the aftermath of Elaine's homicide and the publication of this DHR.

Recommendation 1: The Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and satisfy itself that Child A and Child B (as well as their families) are in receipt of trauma informed support to cope with both the aftermath of the homicide and the publication of the DHR.

Recommendation 2: After publication of this DHR, the Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and ensure that this report is attached to Child A

and Child B's social care records. This is so that, if they wish to read the DHR when they are older, it will be available to them.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The chair and author of the review is James Rowlands, an Associate DHR Chair with STADV. James has received DHR Chair's training from STADV. He has chaired and authored seven previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.12.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.12.4 *Independence:* James has chaired one previous DHR in Lambeth. However, he has no other current connection with the local area or any of the agencies involved. James has had some contact with Lambeth prior to 2013 in a former role, when he was a MARAC Development Officer with SafeLives (then CAADA)[28]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.13 Dissemination

[28] For more information, go to the SafeLives website.

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Lambeth Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.13.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the LSCP and LSAB; be published; and there will be a range of dissemination events to share learning.

1.13.3 The Executive Summary and Overview Report will also be shared with the CSP in Lewisham and the relevant CSP in Buckinghamshire for dissemination, as well as the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

1.13.4 The recommendations will be owned by Safer Lambeth Partnership. The Violence Against Women and Girls Programme and Commissioning Manager will be responsible for monitoring the recommendations and reporting on progress.

1.14 Previous case review learning locally

1.14.1 This is the fourth DHR commissioned by the Safer Lambeth Partnership, with the three previous DHRs having been published[29]. The chair reviewed these DHRs to identify any issues relevant to this case. Relevant considerations included assessment of a perpetrator's mental health (Ms Z) and issues with the timeliness of MPS responses to victim reports (Sophia). These DHRs were considered by the chair and fed into the review process.

1.14.2 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR:

1.14.3 Two Serious Case Reviews (SCRs) were identified by Review Panel members that were relevant: Child L (a joint review between Croydon and Lambeth) and Child K (a joint review between Bromley and Lambeth)[30]. An issue in each SCR related to the challenges of coordination across boroughs. These SCRs were considered by the chair and fed into the review process.

[29] Available at Safer Lambeth: Domestic homicide reviews and reports.

[30] Both SCRs can be accessed from Lambeth Safeguarding Children Partnership website.

1.14.4 No Safeguarding Adult Reviews (SARs) were identified by Review Panel members as relevant.

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to V**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Elaine	n/a	38	Black Caribbean	Christian	UK Citizen	No
Aiden	Nephew	21	Black Caribbean	Muslim[31]	UK Citizen	Unknown
Luke	Husband					
Isabel	Mother					
Charles	Father					
Hazel	Mother-in-Law					
Rachel	Former Sister-in-law					
Jacob	Brother-in-law					
Mia	n/a					
Child A	Child					
Child B	Great niece / nephew					

2.1 The Homicide

2.1.1 *Homicide:* Elaine was killed at her home, which she shared with Aiden and a number of other family members. In mid-April 2018, the London Ambulance Service (LAS) were called to an address in Lambeth. As it had been reported that a female had been stabbed, the LAS also notified the MPS. The LAS waited for Police Officers to arrive before entering the address, where they found Elaine

[31] This has not been confirmed with Aiden and is based on information provided by his mother (Rachel).

in an upstairs bedroom. The LAS provided medical aid, but Elaine died at the scene.

2.1.2 *Post-mortem*: A post-mortem examination was conducted and gave the cause of death as Multiple Incised Wounds. Elaine was stabbed multiple times, and this would meet the definition of 'overkill'. This is term used to describe the use of gratuitous violence that goes further than that which is necessary to cause the victim's death[32].

2.1.3 *Criminal trial outcome:* Aiden was found guilty of manslaughter by diminished responsibility in March 2019. In December 2019 he was sentenced to an indefinite period at a secure hospital under Section 37 Mental Health Act 1993 with a section 41 restriction. The murder charge has been left to lie on file.

2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background Information relating to the Victim:* At the time of her death, Elaine was 38 years old. She was British, Black Caribbean, and had no known disability. She was a Christian and was an active member of a Protestant faith community.

2.2.2 Elaine and Luke had been in a relationship for nearly 20 years and married in 2015. They had one child (Child A), who was born in 2004. They lived in Buckinghamshire for most of their relationship. In Spring 2016 they came to London, moving into a family home which they shared with a number of other family members.

2.2.3 Elaine had qualifications in travel and tourism and had worked in the hospitality industry and financial services.

2.2.4 Elaine and Luke moved to London because Elaine had been offered a job, although this move was intended to be temporary. Meanwhile, Child A remained in the care of family members in Buckinghamshire. Elaine regularly returned home, spending most weekends with her child.

2.2.5 In February 2018, Elaine had secured a new job. This allowed her and Luke to move back to Buckinghamshire. On the weekend of the homicide, Elaine and Luke had travelled back to London to collect some personal possessions.

[32] Long, J., Harper, K., and Harvey, H. (2018) The Femicide Census 2017 Findings: Annual Report on UK Femicides 2017. (Accessed: 31st October 2019).

2.2.6 The family home was owned by Luke and his brother (Jacob). It was split into different, self-contained living areas, with these being occupied by Elaine and Luke (her husband), Aiden and Jacob (Elaine's brother-in-law, and the perpetrator's father), and Hazel (mother-in-law of Elaine, mother of Luke and Jacob, and (paternal) grandmother to Aiden). Based on the account provided by Isabel and Charles, there had been what they described as a "*long standing*" disagreement about whether to sell the family home. However, they believed that a decision had been made to do this in late 2017. It has not been possible to confirm this with Luke or Jacob.

2.2.7 *Background Information relating to Perpetrator:* At the time of the homicide, Aiden was 21 years old. He was British, Black Caribbean, and had no known disability. He had been raised as a Christian. As an adolescent, Aiden is reported to have converted and begun to identify as a Muslim. It is unclear whether he was practicing his faith.

2.2.8 Aiden was one of two children. His mother (Rachel) and father (Jacob) were separated. Aiden had initially lived with Rachel in Lewisham, but from 2011 he was living between Rachel's home and with Jacob in Lambeth. He began living with Jacob full time after 2014, when he could no longer continue to live with Rachel. From 2011, there were periods when Aiden was not staying with either Rachel or Jacob and it is unknown where he was residing. These are described in the chronology.

2.2.9 Aiden had completed a functional skills course at Lambeth College in 2016-2017. Thereafter, he had started a bricklaying course and had been an apprentice at a construction company. He is reported to have been suspended from the bricklaying course in the latter part of 2017 and did not thereafter secure employment. He was not in education or employment at the time of the homicide.

2.2.10 Aiden had been in an intimate relationship with Mia, although this had ended some years before the homicide. Aiden and Mia had a child, Child B, who was born in 2013.

2.2.11 *Synopsis of relationship with the Perpetrator:* Elaine and Aiden were family members, specifically (paternal) aunt and nephew. Based on the account provided by Isabel and Charles, Elaine had known Aiden since he was a young boy. Elaine first met Aiden when her relationship with Luke began, although Isabel and Charles said she and Aiden did not have much contact. The family members who have participated in this DHR were not aware of any tension or conflict between Elaine and Aiden.

2.2.12 *Members of the family and the household:* There were a number of other family members living in the family home, who are described above in 2.2.5. Isabel and Charles said that while Elaine spoke with Hazel, any communication with the rest of the family was via Luke.

3. Chronology

3.1 Background to the Chronology

3.1.1 During the course of the DHR, it became apparent that while there was agency contact with both Elaine and Aiden, this contact was in different parts of the country and at no time did it overlap both. Consequently, it was agreed to present the chronology for Elaine and Aiden separately.

3.1.2 In relation to Aiden, he and his former partner (Mia) were aged under 18 for some of the time period covered by this DHR. To help contextualise this, in each year of the chronology, Aiden's age is noted.

3.2 High level summary relating to Elaine

3.2.1 Requests for information identified that Elaine had contact with a number of agencies in Buckinghamshire, as set out in 1.7.4 above.

3.2.2 Although Elaine's contact with these agencies was at different periods and for different lengths of time, her contact with each had been concluded for some years by the time of her death.

3.2.3 Elaine's contact with these agencies, including the nature of her contact, was considered at length in the second Review Panel meeting. The Review Panel concluded that there was no evidence to indicate that any of these issues, or Elaine's agency contact, had any bearing on the homicide. Additionally, none of this contact related to Aiden. Mindful of Elaine's rights to privacy, even after her death, and the interests of her family, the Review Panel agreed that it was neither appropriate nor proportionate to include specific details of this contact in the DHR.

3.2.4 While Elaine's parents (Isabel and Charles) understood and agreed with this decision, they felt that this might mean it was heard to 'hear' and 'see' Elaine as part of this DHR. To help address this, as noted in 1.9, extracts from both a Victim Impact Statement, as well as the Eulogy that Isabel and Charles read at Elaine's funeral and some lines from a poem included in it, can be found at the beginning of this report. This is in order to help readers to keep Elaine in mind. Additionally, see 4.1 below for a summary of information and comments by Isabel and Charles.

3.3 Contact relating to Aiden

3.3.1 The Review Panel identified that Aiden had contact with a number of agencies, with this including contact in relation to his mother (Rachel) and ex-partner (Mia). Although none of this information was related to Elaine, it has been included in the DHR. This is because the Review Panel felt it provided relevant history and context and, as discussed below, opportunities to engage with Aiden differently.

3.3.2 Some information from health agencies was not included in the chronology. This relates to contact with Aiden regarding health matters. This information has been considered by the Review Panel and determined to not be relevant, specifically:

- Aiden was known historically to GSTT, first as a child and then in 2017; and
- Aiden had some contact with KCH as a child and then in 2017.

3.3.3 Additionally, information was also provided by Aiden's Secondary School, which he attended between 2008 and 2013. This described how his behaviour and attendance to school took a significant decline in year 9 (when Aiden would have been 13/14)[33].

2011 (Aiden was aged 15/16)

3.3.4 Between May and October 2011, Aiden was reported missing by his mother (Rachel) on three occasions. When found, he refused to say where he had been, saying only that he had been "*with friends*".

3.3.5 As a result of being missing, Aiden came to the attention of Lewisham Council – Children's Social Care. Initially, Aiden was allocated to a Social Work Assistant for Missing Children and Young People. After each missing episode, the Social Work Assistant had contact with the MPS. They also wrote to Aiden and his parents offering support after the first occasion he went missing. This offer was not taken up.

3.3.6 The third period when Aiden went missing lasted over 28 days, running from the 22nd October 2011 and the 22nd November 2011[34]. This led to a Strategy

[33] The Review Panel discussed whether to undertake a more extensive exercise looking at Aiden's time in school. It decided that while this may have revealed some important contextual information about his experiences, particular his change in behaviour, it would have also considerably extended the scope of the DHR. The Review Panel therefore agreed it was proportionate to focus on the Police and Children Service response to Aiden.

[34] The Review Panel noted that these periods of missing could have been evidence of the exploitation of Aiden in the context of 'county lines'. This is explored in the analysis.

Discussion between Lewisham Children's Social Care and the MPS Missing Person's Unit[35]. It was agreed that once Aiden returned to his home, an Initial Assessment[36] would be undertaken. The intention was to consider what measures could be put in place to support Aiden to remain safely at home and support his mother.

3.3.7 However, at the end of this third period Aiden was arrested on the 22nd November after a male was stabbed during a drug deal. Aiden was charged with assault (specifically Grievous Bodily Harm (GBH)) and Possession of Class A Drugs[37] with Intent to Supply). He was bailed until the 15th January 2012 to his father's (Jacob) address in Lambeth.

3.3.8 Because Aiden had been bailed to Lambeth, and was therefore no longer a resident of the borough, Lewisham Council – Children's Social Care referred his case to Lambeth Council – Children's Social Care. This meant that the planned Initial Assessment was not completed. A supervision note on the 12th December reflects this determination, recording three actions:

- "*Action 1. Missing Children LO to contact* [Lambeth Council – Children's Social Care] *and advise that Aiden is now in their area and that he was missing for a substantial amount of time and that he may be considered as a [Child in Need] in their area. Lambeth need to decide whether or not they carry out an initial assessment given that Aiden was missing for more months* [sic].
- *Action 2. Missing Children LO to contact Lambeth* [YOS] *to see if Aiden has a worker assigned to his case, so that information can be shared.*
- *Action 3. Notes to be updated and case to be closed*".

3.3.9 Unfortunately, there is:

- No information in the case record to indicate that Lewisham Council – Children's Social Care were aware of, or considered, the length of Aiden's bail in making this decision;

[35] Where information gathered during a referral or an assessment (which may be very brief) results in the social worker suspecting that the child is suffering or likely to suffer significant harm, a strategy discussion meeting should be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989. This would assess whether the child is suffering or likely to suffer significant harm.

[36] Conducted under Section 17 of the Children Action 1989 and to decide whether a child is a child in need.

[37] Class A drugs include: Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth). For more information, go to the GOV.UK drugs penalties page.

- No record of the outcome of these actions; and
- No record of any referral being received by Lambeth Council – Children's Social Care.

2012 (Aiden was aged 16/17)

3.3.10 Aiden was charged on the 16th January. He appeared at Wimbledon Magistrates Court on the 18th January 2012 (relating to the possession charge) and then on the 24th February 2012 (relating to the GBH charge).

3.3.11 Aiden was bailed again and supported on a bail support programme by Lewisham Council – YOS[38].

3.3.12 There were numerous breaches of the electronic tag fitted to Aiden up until a conviction at the end of 2012. Although this information was passed to the MPS Wanted Offender Units, there does not appear to have been any action taken[39].

3.3.13 On 12th October 2012, Aiden appeared at Kingston Crown Court where the GBH charge was discontinued.

3.3.14 On the 15th November 2012, Aiden appeared at the South London Juvenile Court and was sentenced to a 12-month Referral Order[40].

3.3.15 Aiden was stopped and searched by the MPS on six occasions between March and November 2012. No further action was taken on any of these contacts. Aiden also appeared on an intelligence report in October 2012; this related to reports of individuals carrying and supplying drugs.

3.3.16 In June 2012, Aiden had a single appointment with the Hetherington Group Practice, which he attended with his mother (Rachel). A number of minor medical issues were raised, which Rachel felt were due to Aiden's pending court hearing (although he did not think this was the case). Later that year (in November), Aiden did not attend a booked appointment. The reason why is not recorded.

2013 (Aiden was aged 17/18)

[38] This means that, despite Lewisham Council – Children's Social Care's decision to refer Aiden's case to Lambeth, no agency in Lewisham had ongoing contact with Aiden from 2012.

[39] A search of MPS computer systems identified information and no convictions recorded for these breaches or any intelligence reports.

[40] A referral order is the community sentence most often used by the courts when dealing with 10 to 17-year olds, particularly for first time offenders who plead guilty. Referral orders require that an offender must agree a programme of work to address their behaviour. For more information, go to the GOV.UK website community sentences page.

3.3.17 Between the 12th March and the 19th November 2013, Aiden was supervised by Lewisham Council – YOS. He was described as "*very compliant*"[41].

3.3.18 Aiden first came to the attention of Surrey Police on the 3rd March when he was the subject of a drugs street check in the Woking area. This was recorded on an intelligence report. He told police officers that he was staying with his girlfriend[42]. No drugs were found. The details of the girlfriend and her address were thought to be fabricated as they were unconfirmed.

3.3.19 On the 23rd April, Surrey Police received intelligence reports relating to drugs. Aiden was arrested, along with another male and a female. Two mobile phones were seized from Aiden along with a quantity of cash. There were messages relating to drug dealing on the other male's phone, while messages on Aiden's phone were found to have been deleted. Following advice from the Crown Prosecution Service (CPS) that there was insufficient evidence to charge Aiden, no further action was taken. At the time of this arrest, Aiden provided his father's (Jacob) address in Lambeth.

3.3.20 Between this date and September, 20 intelligence reports were recorded by Surrey Police. All of the reports named Aiden as a "*drug dealer*" and noted that he was frequenting an address in Woking. This address was known to be the residence of a male and a female who were associated with the misuse of drugs.

3.3.21 Child B (the child of Aiden and his then partner Mia) was born in September 2013 at St Thomas Hospital, which is part of GSTT[43]. After the birth, Mia had contact with Health Visiting Services in Croydon (provided by Croydon Health Services NHS Trust[44]) as she was living in that area[45].

3.3.22 On the 17th September, Aiden was arrested for a second time in Surrey. During the arrest, Aiden's phone rang constantly. He had £80 on him, which he stated was for food and travel. Aiden was arrested on suspicion of being concerned in the supply of Class A drugs. Aiden was detained for 96 hours. As it was believed that Aiden may have concealed drugs in his body, he was taken to the Royal

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[41] During this period of supervision, the YOS was not aware of any further offences, although as detailed in the chronology Aiden was frequently in contact with Surrey Police.

[42] It is not clear from the information available whether this was Mia or another person.

[43] Mia was aged 18 at the time Child A was born. She was two years older than Aiden.

[44] For more information, go to Croydon Health Services website.

[45] The Review Panel made the decision not to request additional information about Mia's care before and after Child A's birth, from either St Thomas Hospital or Croydon Health Services NHS Trust. This was because the Review Panel felt it would not be proportionate to do so. Additionally, the Review Panel had access to information from the GSTT Health Visiting service, which had received a discharge summary from health visiting services in Croydon, which reported no known safeguarding concerns during their contact with Mia.

Surrey County Hospital[46]. He was subsequently released, and no further action was taken.

3.3.23 Surrey Police completed a 39/24 (child referral form)[47] for Aiden. This was shared with Children Social Care and Health Services in Surrey. This form:

- Outlined the circumstances of Aiden's arrest;
- Included Aiden's parents' details, along with information provided by Aiden's father (Jacob) that Aiden lived at the family home in Lambeth but also stayed out with acquaintances;
- Noted that, in the view of the police officer completing the form, *Aiden's* parents "*lacked control*" and that others were "*taking advantage*" of Aiden and that he may be "*under duress*" in relation to drug misuse; and
- Noted that Aiden had said that he had become a father within the last week and the mother of his child lived in Surrey (no further details recorded).

3.3.24 The 39/24 was also shared with the MPS. This information was then passed onto Lambeth Council – Children's Social Care, which received a Merlin PAC[48] on the 25th September. No further action was taken, and the case was closed.

3.3.25 Aiden turned 18 in September.

3.3.26 Between 1st October 2013 and the 10th June 2015, a further 21 intelligence reports were recorded by Surrey Police. All contained similar information that Aiden was involved in the supply of drugs, the persons he was associating with and the areas around Woking that he was frequenting.

3.3.27 On the 24th October, the MPS received an intelligence request from Surrey Police relating to Aiden and the supply of drugs.

3.3.28 In October, Aiden had a single appointment with the Hetherington Group Practice and raised minor medical issues. Additionally, he asked for a note from the doctor because he had missed an appointment (this was recorded as with

[46] Because Aiden attended hospital, a notification was sent to the Hetherington Group Practice. This is recorded in the health record, although no further action was taken.

[47] This form is no longer in use by Surrey Police. It has been superseded by the Single Combined Assessment of Risk Form (SCARF).

[48] A Merlin PAC should be completed by police officers when they encounter a child in circumstances that cause concern in relation to that child. This information is then shared with the relevant Children Social Services department.

"*probation*" but was presumably Lewisham Council – YOS). He was informed that this would cost £15. He did not take this up.

***2014* (Aiden was aged 18/19)**

3.3.29 On the 12th March 2014, Aiden approached the Lewisham Council – SHIP Service. He said he was living with friends because his mother (Rachel) had excluded him from her home on the 21st January 2014 after an argument. He stated that whilst he maintained a relationship with his mother, she was unwilling to have him at home. Aiden is recorded as describing how he had been "*throwing and breaking household items"* during an argument. Aiden told the worker that he was being financially supported by his father, who lived in Lambeth. Aiden did not provide an address for his father but said he could not live with him either. Aiden is recorded as saying that this was because he had "*problems with some people in Brixton and* [it was] *therefore unsafe*". Aiden provided a summary of his previous contact with the MPS and Lewisham Council – YOS.

3.3.30 Following this contact, Aiden was put forward for a further in-depth assessment with a Youth Homelessness Officer.

3.3.31 On the 20th March, Aiden re-presented to the Lewisham Council – SHIP Service. He confirmed he was still excluded from the family home(s) and that he was staying "*here and there*".

3.3.32 On the 14th April, Aiden's case was passed to a Youth Homelessness Worker. They attempted contact twice. The line was engaged on both occasions[49].

3.3.33 Further contact was attempted with Aiden on the 20th May 2014. This was successful. Aiden advised that whilst he had not returned home, he had made alternative arrangements. As a result of this the case was closed[50].

3.3.34 In September and November, Aiden had appointments with the Hetherington Group Practice and raised minor medical issues.

3.3.35 On the 11th December, Aiden's mother (Rachel) called the MPS. Aiden had refused to leave the house. He left before police officers arrived. Aiden later returned and caused criminal damage to the front door in an attempt to get in. Rachel did not want Aiden arrested and is reported as simply wanting him to

[49] The time elapsed between Aiden's first presentation and these unsuccessful attempts to contact was 24 working days.

[50] The time elapsed between the previous unsuccessful attempts to contact Aiden and this further attempt was 25 working days.

leave. Police officers attended again and arrested Aiden for criminal damage. A report was created on the Crime Recording and Information System (CRIS) and Police Officers also completed a Domestic Abuse, Stalking and Harassment (DASH) risk assessment form. This was assessed as 'standard risk' and also reviewed by a supervisor.

3.3.36 Aiden was interviewed, but denied any offences, stating he "*did not realise how hard he was banging the doo*r". He was served with a Prevention of Harassment Letter[51].

3.3.37 On the 17th December, Aiden presented at University Hospital Lewisham's Accident & Emergency (A&E) Department (run by LGT). He did not wait to be seen. A notification was sent to the Hetherington Group Practice. This is noted in the health record, but no further action was recorded as being required[52].

3.3.38 In this year, Mia and Child B had contact with GSTT Health Visiting Services, after they were referred in from Croydon. The Croydon Health Visitor discharge summary recorded that there were no known safeguarding concerns.

2015 (Aiden was aged 19+)

3.3.39 On the 15th January 2015 Aiden was involved in a civil dispute, unrelated to any of the subjects of this DHR. This came to the attention of the MPS, but no further criminal action could be taken.

3.3.40 On the 21st January 2015, Aiden's mother (Rachel) called the MPS and made a third-party report that Aiden was outside her home, punching the front door and threatening to assault his then partner (Mia).

3.3.41 When police officers attended the property, Aiden was calm. He said he had been kicked out of the house by Rachel and had returned to collect his belongings. Police officers spoke with Mia who said she had been told by Rachel to call the MPS if Aiden turned up. Police officers also spoke to Rachel by phone, who said she wanted the police to be there when Aiden collected his belongings, so she did not have to talk to him. Aiden took his property and left. No criminal allegations were made by Rachel and Mia and no further action was taken. A CRIS report was not created and nor was a DASH risk assessment form completed.

[51] This is known as a 'Form 9993'. These letters are served in a first instance of harassment and help support future prosecutions should the harassment be repeated'.

[52] This information is based on the GP records. During the Review LGT were not able to locate any record of this attendance.

3.3.42 In March 2015 Child B and Mia were seen at their home address by the GSTT Health Visiting Service. Mia was asked by the Health Visitor if she felt safe in her relationship with Aiden. Mia said she felt safe. No domestic violence was disclosed, and Mia reported that she frequently stayed with Aiden in Lewisham[53].

3.3.43 On the 10th June 2015, Aiden was stopped in Surrey by a police officer who recognised him. He was riding a pedal cycle at the time. He refused to provide any information and cycled away. This brief interaction with Aiden was recorded on an intelligence report.

3.3.44 In August, Aiden had a single appointment with the Hetherington Group Practice and raised minor medical issues.

2016

3.3.45 In March 2016, the GSTT Health Visiting Service had contact with Mia and she reported she was now living in Lewisham. The Health Visitor transferred the case to the Lewisham Health Visitors in April 2016.

3.3.46 In June 2016, Lewisham and Greenwich NHS Trust (LGT) received a 'referral in' from the GSTT Health Visiting Service relating to Child B. On the 8th June a telephone call was made to Mia to book in a visit. This was not successful. The case notes indicate that it was not possible to leave a voice message.

3.3.47 Subsequently, contact was made with Mia and she was visited on the 16th June. Mia and Child B were seen at home, with a friend of the mother being present[54]. There were no concerns identified, although no questions were asked about domestic violence and abuse as another person was present. The Health Visitor documented Aiden's details and that the parents (i.e. Mia and Aiden) had separated. Following the visit, Child B was assessed as needing a universal service, meaning there would have been no further contact unless it was requested by another agency or Mia.

3.3.48 On the 14th June, the MPS received a report of a domestic incident between Aiden and Mia. The following information was recorded as a result of this phone call:

[53] This is believed to be the address of Rachel, Aiden's mother, although in the absence of contact with Mia it has not been possible to confirm this.

[54] There was no information on this friend in the case record.

- The previous evening Aiden had stayed at [Mia's] flat. Child B had slept in a cot in the same room;
- At approximately 02:00hrs Aiden argued with Mia and stated they should be married as they had a child together. Mia told Aiden "*they hardly had the good relationship needed for marriage*". Aiden became angry telling her to delete his number from her mobile phone;
- Aiden went to the living room to spend the rest of the night;
- In the morning Aiden again raised the subject of marriage. He "*made some nasty comments*", including saying that he would like to "*stamp on* [Mia's] *head*" and wished he "*never had the child and would like to slit its throat*". Aiden is reported to have asked for a picture of himself and the child prior to this;
- Aiden had "*issues*" and he told her not to tell anyone about what he said and said he knew where her family lived if she did;

3.3.49 Aiden left and later sent a text to say sorry for his behaviour. Later that day, Mia called a friend for advice and decided to make a report to the police as she did not want Child B (who had been awake that morning) exposed to such behaviour.

3.3.50 Police officers later spoke to Mia in person. They confirmed that Child B was well, and they had no concerns about their care. Mia told police officers that she had an "*on-off*" relationship with Aiden, which had been going on for two years[55]. She stated that she had regularly been assaulted in the past by Aiden when they lived together at her mother's address. This included being punched. Mia reported she had previously sustained injuries to her arm, as well as her head. She said she had not sought medical treatment or reported these matters to the MPS.

3.3.51 A DASH risk assessment form was completed by the police officers who spoke with Mia. This was graded 'medium', but it was not updated or supervised on the domestic violence page of the CRIS report which had been created. An arrest Computer Aided Dispatch (CAD)[56] was created but it was not actioned.

[55] Child B was born in September 2013, which means Mia and Aiden had known each other for at least three years by this date.

[56] CAD stands for Computer Aided Dispatch. It is an application used by the MPS to coordinate communication, assignment and tracking in response to calls.

Initially the incident was sent to the Child Abuse Investigation Team (CAIT) before being passed to the Community Safety Unit (CSU).

3.3.52 Mia was not spoken to again until the 7th July[57], when she reported that she and Aiden had decided to attend counselling together. Mia was asked about previous assaults but could not provide any specific details. The Officer in the Case (OIC) noted that the previous report did not provide enough details about previous assault(s), which meant no allegations could be put to Aiden. By this time, Mia was not willing to support the allegations made.

3.3.53 [*The CRIS was reopened on 19th January 2017, when a memo was sent to the OIC by their supervisor asking that they make contact with Mia to let her know the report would be closed unless she wished to support the allegation and that Aiden was no longer circulated as wanted by MPS.*

3.3.54 *Mia was contacted on the 2nd February 2017[58]. When Mia was spoken with by phone, she said she wanted to forget the matter completely.*

3.3.55 *The OIC noted that the six-month time limit for common assault had passed and a report was given to a supervisor for comments prior to closure. A supervisor entry on 7th February 2017 asked for clarity around any fear, further incidents, and whether there was a requirement for assistance from the Domestic Abuse Investigation Team or Non-Molestation Order. The OIC noted the self-referral for counselling and the report was closed. Aiden was never arrested*].

3.3.56 After receiving a Merlin PAC from the MPS, Lewisham Council – Children's Social Care sent a letter to Mia offering advice and information about support agencies for those experiencing domestic abuse, as well as highlighting the impact on children. The Lewisham Council – Children's Social Care IMR included additional information (beyond what was in the information originally shared by the MPS). This additional information was gathered because police officers are based in the local MASH that screened the referral. This reported:

- That historical violence had included regularly punching Mia in the face;
- That the "*issues*" related to mental ill health; and
- Describes Mia as "*refusing*" to marry.

[57] The time elapsed between the report and this second contact with Mia was 17 working days.

[58] This time elapsed between the report and this third contact with Mia was 164 working days.

3.3.57 At the end of June, Aiden had an appointment with the Hetherington Group Practice. He had two further appointments in July, as well as one telephone consultation. These were all routine.

3.3.58 On the 3rd August, Aiden registered as a new patient at Dr Santamaria's Medical Practice. Aiden did not attend appointments on the 8th or 15th August. There is no record of the reasons for the original appointment or the reason for missing the appointment.

3.3.59 On the 22nd August, Aiden attended an appointment at Dr Santamaria's Medical Practice. He raised three issues. Of these, one was for a routine medical issue. Two are of note:

- Aiden reported stuttering when he got angry. When talking about anger, Aiden said that he got angry "*very easily*".
- He reported living with his parents again, "*following time away*", who he said were "*strict*". Aiden said he was not feeling depressed but was smoking cannabis.

3.3.60 As Aiden had asked for counselling he was signposted to local support (by being given information on the local IAPT service[59]). He was advised to stop smoking cannabis.

3.3.61 On the 19th December, Aiden did not attend an appointment at Dr Santamaria's Medical Practice. No reason was given.

3.3.62 On the same day the MPS received a phone call from a male (using the same surname as Aiden but giving a different first name) who reported that their ex-partner Mia was at their address and refusing to leave. They then called back and said that Mia had left. No police officers attended.

3.3.63 Although no police officers attended, a non-crime domestic CRIS was created. The initial risk assessment was graded 'standard' and was supervised as correct. A follow up phone call was made to Aiden by a member of the CSU the following day. In this contact, Aiden explained that the incident was over and did not want assistance. The report was closed with no further action.

2017

[59] IAPT services offer therapies for people experiencing mild to moderate depression, general anxiety and worry, panic attacks, social anxiety, traumatic memories and obsessive-compulsive disorder. In Lambeth, IAPT is provided by the Lambeth Talking Therapies Service, which is led by SLAM. For more information, go to the Slam NHS website.

3.3.64 On the 3rd January 2017, Aiden attended an appointment at Dr Santamaria's Medical Practice. At the appointment, there was a discussion of a number of routine medical issues, one of which led to a referral for a physical health issue. There was no discussion of the anger issues Aiden had raised in August 2016.

3.3.65 On the 10th February, Aiden called the MPS to report that someone had posted a picture of his child (Child B) online. An appointment was scheduled for the next day and, when police officers arrived, they spoke with an unnamed female. The pictures were determined not to be indecent. As no crime had taken place, a CRIS report was not created[60].

3.3.66 On the 17th March, Aiden was sent a letter about the physical health issue he had discussed in January (he had been seen by a specialist, assessed and was being discharged).

3.3.67 On the 26th May, Aiden attended an appointment at Dr Santamaria's Medical Practice. He raised three issues. Of these, two were for a routine medical issue. The third is of note: the record describes Aiden as saying he was "*stressed, anxious, angry and down about things*". He reported having been suspended from a bricklaying course at college, as well as separating from his partner and 3-year-old child. An appropriate referral was made for the routine medical issue.

3.3.68 Additionally, a referral was made to mental health services. This referral was sent to the 'North Lambeth Recovery and Support Service'[61]. It contained a risk assessment, on which Aiden was noted as being 'no risk of harm to others'.

3.3.69 There is no indication in the medical records about any plans for a review by the GP in terms of this referral and whether it had been of benefit for Aiden. Additionally, there is no correspondence from the 'North Lambeth Recovery and Support Service' on the outcome of the referral, and there is no indication that this referral was followed up by Dr Santamaria's Medical Practice[62].

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[60] As a result, the Review Panel has not been able to determine the nature of the image and the identity of the unnamed female.

[61] SLaM informed the Review Panel that there was no 'North Lambeth Recovery and Support Service'. Instead, a referral should have been made to the 'Living Well Network Hub', which is the local 'front door' to mental health services locally. For more information, go to the Lambeth CCG website.

[62] As noted above, the referral should have been sent to the Living Well Network Hub. However, the Review Panel were assured that a referral that was sent in error to another team would have been re-routed. During the course of the DHR, SLaM was asked to check whether there was any evidence of any referral during this time to mental health. No referral could be found. Additionally, the records for Dr Santamaria's Medical Practice were re-checked during the course of the review. It was confirmed a faxed referral was sent on the 26th May 2017 with the fax report stating: "*transmission ok*". It has not been possible to resolve this discrepancy.

3.3.70 On the 20th June and 21st August Aiden had further appointments at Dr Santamaria's Medical Practice for a routine medical issue. At neither of these appointments was there any recorded discussion of the issues raised in August 2016 or May 2017. At the second appointment, he reported that he was not engaged in recreational drug use.

2018

3.3.71 On the 31st March 2018, Aiden was arrested for robbery after pushing a shop keeper who had refused to give him a packet of cigarettes when he admitted he did not have any money. He was also arrested for resisting arrest.

3.3.72 Aiden was booked into police custody at 5.30pm. In line with standard practice, attempts were made to carry out a risk assessment. However, Aiden refused to answer any questions. He was searched and then placed in a cell. A care plan was completed and, in line with this, checks were made on Aiden every 30 minutes. Later that evening (just before 11pm) Aiden was brought out of his cell to carry out a risk assessment. Aiden is reported to have been violent and had to be restrained and returned to his cell. It is at this point the custody sergeant noted there may be some underlying mental health concerns and called a Health Care Practitioner (HCP).

3.3.73 The custody sergeant also called Aiden's father (Jacob) and made the following record of their discussion:

> "*I have spoken to* [Aiden's] *father who informed me that the* [Aiden's] *granddad died about 2 weeks ago and this affected the* [Aiden] *quite badly.* [Aiden] *has also broken up with his long-term girlfriend and is father of a young child. The father felt* [that Aiden] *was going through a lot and appears to be having some form of breakdown. The father stated* [that Aiden] *was depressed and had cried in front of him stating he was worried about his life and the fact he had no formal qualifications. The father also stated* [that Aiden] *smokes skunk and despite telling to stop he continued to smoke skunk. I will relay this to the HCP*".

3.3.74 The custody sergeant said that they could not recall the time of the call with Jacob. However, they said that they had been present with the HCP when they saw Aiden and that they had passed this information on.

3.3.75 The HCP made a record of their examination of Aiden, which includes the comment "*denies he has any diagnosed* [mental health] *conditions*" but "*admits to smoking skunk, and denies all other drug use at this time*". The HCP does not recall being told about the specific concerns about Aiden's mental health raised by Jacob. They stated that they would have explored mental health

further if they had been informed of these concerns and would also have documented this information.

3.3.76 After the examination Aiden was checked on regularly, in line with the custody care plan, and a risk assessment was completed. This noted: "*There was concern over* [Aiden's] *mental health when he came into custody yesterday – believed due to drugs. Appears calm now"*.

3.3.77 Subsequently, on the morning of the 1st April, Aiden was interviewed and later charged.

3.3.78 A pre-release risk assessment was completed at around 4pm which noted the following:

> *"*[Aiden] *has not disclosed any issues relating to either physical or mental health. Reviewed by HCP twice whilst in custody due to odd behaviour upon booking in – running around the custody area – no violence displayed".*

3.3.79 Aiden was later released, having been bailed to appear at Camberwell Green Magistrates on the 1st May 2018.

3.3.80 On the 9th April, Aiden re-registered at the Hetherington Group Practice. Aiden was seen with his father (Jacob), who had persuaded Aiden to attend the appointment. Aiden waited outside of the consultation room while the GP discussed his health with Jacob. Jacob was recorded as being concerned about Aiden's mental health, particularly his "*odd*" behaviour in the past three to four weeks. The patient notes record that Aiden was not sleeping, talking to himself, and that his grandfather had died. They also recorded that since his grandfather's death, his relationship with his girlfriend had broken down.

3.3.81 The General Practitioner (GP) was concerned about the possibility of early onset psychosis. They made a referral[63] to the (SLaM) Lambeth Early Onset (LEO) Community Mental Health Team (CMHT)[64]. As it was out of hours, the referral was highlighted as urgent. A day later, on the 10th April, the GP contacted the LEO Team and was given confirmation that the referral had been received.

3.3.82 The referral was discussed at a LEO CMHT Multi-Disciplinary Team (MDT) meeting and contact was made with Jacob in order to make the assessment

[63] As noted above in relation to the referral from Dr Santamaria's Medical Practice, this referral should have been sent to the Living Well Network Hub.

[64] The LEO Team a specialist team to help people living in Lambeth who are experiencing psychosis for the first time. For more information, go to the Slam NHS website.

appointment. To ensure that Aiden was assessed, staff also made plans to conduct a home visit if he did not attend the appointment.

3.3.83 A few days before Elaine was killed, a joint assessment was carried out by SLaM OASIS[65] and the LEO CMHT. The assessment was completed by two members of staff. Aiden was observed to be "*agitated, not wanting to engage… stared intensely without break eye contact… irritable and hostile in his approach being abrupt with his response*s" and he terminated the assessment after 40 minutes, stating he did not want help.

3.3.84 There was an attempt to have a conversation with Jacob during the assessment (although this was in front of Aiden). Jacob said that Aiden had severe depression due to the pressures of life, observing his son to be feeling hopeless and lacking self-confidence, experiencing poor sleep and mood changeability, as well as lacking trust in others. He reported that Aiden had a stammer when he was younger.

3.3.85 No care plan documentation (including crisis contacts) was given to Jacob after the assessment. Additionally, a limited social history was taken, there was no contemporaneous documentation of the assessment, and there was no clarity as to which team would be taking over the care of Aiden (i.e. LEO CMHT or OASIS). The LEO CMHT MDT that took place after the assessment did not discuss Aiden's case.

3.3.86 On the day Elaine was killed, Jacob and Aiden had spent the day together. Jacob told the MPS during the murder enquiry that Aiden had "*appeared quite stable*". Jacob and Aiden returned to the family home, and Jacob went out.

3.3.87 Hazel (Aiden's grandmother) said that shortly after Jacob had left, Aiden had gone out into the garden. At the time she was downstairs in her kitchen with a friend and Aiden had walked past her.

3.3.88 Soon after, Elaine and Luke arrived at the property, having travelled to London to collect some personal possessions as they finalised their move back to Buckinghamshire. Luke went into the house and spoke with his mother (Hazel), who told him that Aiden was behaving oddly. He then went to unpack the car. Meanwhile, Elaine went to the bedroom in their part of the family home.

[65] OASIS is a health service for young people aged 14-35, who are experiencing psychological distress. For more information, go to the Slam NHS website.

3.3.89 Aiden was seen by Hazel with a screwdriver, then a knife and shortly after, gloves. Hazel asked Aiden, "*What's wrong with you*?", "*Why do you have a knife*?" Aiden did not respond. Hazel rang Jacob and said that Aiden was "*acting strangely*" and asked him to come home.

3.3.90 At some point, Aiden locked Hazel in the kitchen, and also locked the front door so that Luke could not get in the home.

3.3.91 Shortly thereafter, Elaine was killed by Aiden.

4. Overview

4.1 Summary of Information from Family

4.1.1 Elaine's parents (Isabel and Charles) shared the following information:

4.1.2 Isabel and Charles described Elaine as "*very friendly, outgoing, ambitious, and adventurous*". As well as being "*very much a family person"*, they described Elaine as hard working saying: "[she] *was very quiet, ambitious, career-minded and acted very professional in her career*". Elaine had originally qualified in travel and tourism, before working in the hospitality industry and then having some roles in finance.

4.1.3 Isabel and Charles said that Elaine moved to London in Spring 2016 with Luke for work, having secured a job that allowed her to return to the hospitality industry. In their eulogy, they described this decision as: "*True to her strong strength of character, determination and grit*". This had come after a difficult period in her life. However, moving to London had been hard decision because: "[Child A] *meant everything to her,* [they were] *her number one*". While living in London, Elaine spent most weekends in Buckinghamshire so she could see Child A. in February 2018, Elaine got a new a job closer to home, which meant she could move back to Buckinghamshire. Elaine and Luke were planning to buy a house, and Child A would have returned to live with them.

4.1.4 Isabel and Charles said that Elaine had known Aiden for many years. She first met him when he was a young boy when her relationship with Luke started. Isabel and Charles were not aware of any tension or conflict between Elaine and Aiden. They thought that Elaine and Aiden had limited contact with each other, saying "*they were never in each other's way"* because the flats in the family home were self-contained.

4.1.5 The only cause of any tension Isabel and Charles could identify was the possibility of the family home being sold. They said that there had been a disagreement about whether to sell the family home. Elaine and Luke are reported to have talked about this, but Isabel and Charles said that Luke and his brother (Jacob) had not been able to agree on a sale for some time. They felt that this had caused some "*friction*". Isabel and Charles believe that a decision to sell the family home had been made in late 2017. They are of the view that the possibility that the family home was going to be sold was the reason why Aiden targeted Elaine. They also believe that his actions on the day were premeditated.

4.1.6 Isabel and Charles told the chair that they felt that Elaine had been targeted by Aiden. They were sceptical about reports of his previous mental health, feeling that this was not an explanation for his actions. Isabel and Charles also said that they thought Aiden had used cannabis "*regularly*".

4.2 Summary of Information from Perpetrator and/or his Family

4.2.1 For the reasons explained in 1.10, Aiden was not invited to participate in this DHR.

4.2.2 Aiden's mother (Rachel) shared the following information:

4.2.3 Rachel described Aiden as having been a "*good boy*" but that his behaviour changed from the age of 13 when he began to have "*a lot of issues with attitude*" and started running away from home. From the age of 15, Aiden started to refuse to go to school. Rachel recalled trying to seek help, including accessing a club for young boys, but Aiden refused to go.

4.2.4 Rachel acknowledged that Aiden had been involved in criminality in the past, although she said that this had not been the case for at least a year before the homicide. Rachel talked about reading a report about Aiden which she said claimed that "*Aiden ran away to join a gang*". Rachel felt that this was an assumption and thought that at most Aiden had been involved "*on the periphery*".

4.2.5 The chair asked Rachel about whether she had experienced violence and abuse from Aiden. Rachel said, "*Aiden was never violent towards me*" and "*there was never any threat to me…",* although she did acknowledge some "*misbehaving*" including a broken gate. Rachel said that she later asked Aiden to move out because he was being "*disrespectful*". However, while Aiden moved to live with Jacob, Rachel had an ongoing relationship with him. When asked about the occasions she called the MPS, Rachel said: "*The police were a means to an end in terms of stopping an immediate situation*".

4.2.6 Talking about his relationship with his former girlfriend (Mia), Rachel said that Aiden and Mia had been "*very close*" but "*things didn't work out*" and their relationship become "*dysfunctional*". Rachel said that Aiden treated Mia "*terribly*". She said: "*He was going for her. I was not going to have that in my house. For me, it was protection of her. She was living with me at the time. Even when I chucked him out, she was still there*".

4.2.7 In terms of help-seeking, Rachel said her focus was on supporting Mia, including letting her continue to live with her even after Aiden had been asked to leave, and telling Aiden that "*you cannot treat people in this way*".

4.2.8 Talking about Aiden's mental health, Rachel said she became increasingly concerned sometime after he moved to live with his father (Jacob). Rachel felt that the death of her father (Aiden's grandfather) was significant, saying: "*So, issues with work, end of his relationship: The icing on the cake was my dad passing away. There were obvious signs that he was suffering some kind of breakdown*". Rachel also said: "*There was loads going on. A lot to take on for someone that age. Admitting he was struggling was not something that comes easy for Aiden*".

4.2.9 Rachel was aware of Aiden's contact with the MPS in March or April 2019 (it was later confirmed this was the incident on the 31st March 2019. This is described in the chronology above).

4.2.10 Specifically, Rachel said that she had spoken to a police officer after the arrest and they had asked her whether Aiden had mental health problems. She noted: "*as I don't particularly trust the police or their motivations where black people, particularly young black, are concerned I asked why they were asking me about his mental health … I was told* [they were asking] *because of how he was acting, pacing up and down and appearing agitated*". Rachel also said that Jacob had spoken to the police as well during this incident about Aiden's mental health.

4.2.11 Rachel reported feeling relief that Aiden's mental health had been identified as an issue[66]: "*We felt the arrest was a positive thing".* Yet Rachel noted: "*But nothing happened*". Rachel felt that the MPS's decision to release Aiden, without any mental health follow up, was a missed opportunity.

4.2.12 Talking more generally about Aiden and his mental health, Rachel was aware that Jacob had been trying to get Aiden to get help, saying that Jacob "*managed to get him* [Aiden] *to mental health services*" shortly before the homicide. The catalyst for this approach to mental health services was Aiden's behaviour in the home, including throwing "*throwing everything out* [of the house]" and being "*very paranoid*".

4.2.13 Rachel was also aware of Aiden's contact with SLaM. She said that Jacob had told her about the assessment that he and Aiden attended a few days before Elaine was killed. While acknowledging that the feedback was second-hand, she noted: "*one of the things that Jacob did say …was about relatable doctors.*

[66] There is no record of any contact by the MPS with LP, although as described in the chronology, there is a record of the custody sergeant speaking with Jacob.

What he said to me, Aiden was seen by, a very mature white male that didn't seem to connect with [him]".

4.2.14 Rachel thought that Elaine "*kept to herself*" and was unaware of any issues between her and Aiden.

4.3 Summary of Information known to the Agencies and Professionals Involved

Elaine

4.3.1 Elaine had contact with a number of agencies in Buckinghamshire between 2014 and 2016. Her contact with all of these agencies had been concluded for some years by the time of her death. The Review Panel concluded that there was no evidence to indicate that any of this contact had any bearing on the homicide.

Aiden

4.3.2 Aiden had contact with a range of agencies. This included contact with the police because of periods when he was missing from home, and later in relation to reports of carrying and supplying drugs. This contact was with both the MPS and, from 2013, Surrey Police. These reports began in 2011 (when he was 15/16) and continued until 2014 (when he was aged 18/19).

4.3.3 From 2011, Aiden also came to the attention of Lewisham Council – Children's Social Care in relation to concerns about the periods he was missing from home, as well as charges relating to drug supply and assault. In 2011, because Aiden had been bailed to Lambeth, Lewisham Council – Children's Social Care referred his case to Lambeth Council - Children's Social Care. There is no evidence that there was any consideration of the length of Aiden's bail or record of the outcomes of the referral. Furthermore, Lambeth Council – Children's Social Care has no records of a referral being received.

4.3.4 Although the assault charge was discontinued, Aiden was sentenced in relation to drug supply. He was ordered to engage with Lewisham Council – YOS and, during this time, he was deemed to be compliant and no issues were identified with his engagement. However, at the same time, Aiden was frequently coming to the attention of the police. Because there were no processes in place to share this information (as he was not charged with any new offences), this information was not known to YOS.

4.3.5 In 2013, Lambeth Council – Children's Social Care received a police notification relating to Aiden but took no further action.

4.3.6 Aiden also presented to the Lewisham Council – SHIP Service. He said he was living with friends because his mother (Rachel) had excluded him from her home after an argument. Although SHIP identified that an assessment was required, a considerable delay meant that by the time Aiden's application was processed, he had made alternative arrangements. During this time, it is unknown where he was staying.

4.3.7 The MPS, Surrey Police, both Children Social Care departments, YOS and SHIP have all acknowledged that their practice with Aiden was not joined up and was insufficient. Since the period when Aiden was in contact with services (during which he was for the most part under 18 and therefore still a child), there is an acknowledgement that there should have been a more robust assessment of his risks and needs. This should have included considering whether he was at risk of Child Criminal Exploitation. All of these agencies have described changes to policy and practice since this contact which would have enabled more robust information sharing and assessment of need. As a result, the Review Panel did not make further recommendations.

4.3.8 Aiden also came to the attention of the MPS in relation to reports of violence and abuse, including incidents involving his mother (Rachel) and then partner (Mia). These contacts are discussed below with reference to Rachel and Mia respectively.

4.3.9 Aiden had a range of contact with health services, including two different general practices. This contact was often related to other physical issues, but significantly some contacts involved disclosures relating to his anger, relationship and use of cannabis, as well as his mental health. Broadly, these issues were addressed appropriately in individual consultations. However, each response was specific to a particular consultation and there was not any broader consideration which brought these issues together, particularly in relation to the possible risk of domestic violence and abuse. The Review Panel has not made recommendations in relation to these issues as the local CCG is already progressing actions in relation to GP awareness and response as a result of a previous DHR.

4.3.10 In relation to Aiden's mental health, Aiden had contact with GPs, the MPS and SLaM.

4.3.11 Considering GP contact, the Review Panel has identified that there is a lack of awareness of mental health referral pathways in Lambeth, with two different GPs making referrals outside of the recommended route. One of these referrals was 'lost' and the GP in question did not follow up with Aiden about whether he

had accessed mental health services. While the second referral was mis-directed, it did trigger an assessment by SLaM. Recommendations have been made to the CCG to ensure professionals are aware of the local mental health referral pathway.

4.3.12 The MPS also had contact with Aiden in March 2018, shortly before Elaine's homicide. Significantly, during this contact, his family shared their concerns about Aiden's mental health. Aiden was seen by a Health Care Practitioner (HCP) when he was in custody, but it is unclear whether his family's concerns weere shared. As a result, a vulnerability assessment was not completed. Although a recommendation has not been made, this issue is discussed further in the analysis.

4.3.13 Concerning Aiden's contact with the police, the Review Panel has recognised that as a young, Black Caribbean man, he may have faced personal and / or structural barriers or discrimination. This possibility is evident given his mother's expressed distrust of the police, as well as his early experiences of being stopped and searched, and during his last contact with the MPS in March 2018. However, the Review Panel did not feel it was able to make any specific finding(s) or recommendation(s) about these considerations (the rationale for this is set out in section five). Instead, it endorsed a single agency recommendation made by the Safer Lambeth Partnership, which will use the learning from this DHR to work with the MPS to identify how to improve relationships between Black communities and the police.

4.3.14 Finally, Aiden attended an assessment with SLaM before the homicide. While the assessment was arranged promptly, the Review Panel (and to its credit, SLaM) has identified significant weaknesses in the response. This included issues relating to Aiden and his family (there was a limited family history taken, his father was asked about possible risk in front of Aiden and there was no information provided to Aiden's father about care) and with the assessment itself (this was not recorded properly, and it was not clear which team in SLaM was responsible for Aiden's case). SLaM has made a number of recommendations to address these issues, which the Review Panel has accepted. The Review Panel has also considered Aiden's experience of this assessment, including with reference to wider health inequalities experienced by people of Black Caribbean descent. A recommendation has been made to consider the learning from this case as a result.

Rachel

4.3.15 Rachel reported two incidents to the MPS but told the chair that she called the police to manage a specific issue at the time and did not experience any violence and abuse from Aiden. During the course of the DHR, the Review Panel determined that it was not able to reach a conclusion on this matter and could therefore not consider it further.

4.3.16 However, Rachel did identify the significance of the contact by the MPS with Aiden relating to mental health shortly before the homicide. This has been discussed above.

Mia

4.3.17 Mia was Aiden's former partner. They have a child together. During their relationship, Mia had contact with GSTT Health Visiting and LGT. It is positive that GSTT was able to demonstrate that they undertook routine enquiry about domestic violence and abuse with Mia (who did not make any disclosures). However, while LGT considered making an enquiry, they did not do so. While this was a reasonable decision (Mia was in the company of a friend), practice at the time meant there was no follow up and therefore no way to ask at a future date. Since this time the clinical supervision form in LGT has been changed to monitor how incidents like this are followed up. That would mean that, in similar circumstances, a further contact attempt would be made in order to safely enquire about domestic abuse. The Review Panel accepted this and made no further recommendations.

4.3.18 There were a number of other contacts where the response from the MPS was inadequate. This included issues with the quality of risk assessment in contact with Mia, as well as the timeliness of the MPS response both to Mia as a victim and in pursuing Aiden as an alleged perpetrator. Recommendations have been made to address these issues.

4.3.19 Lewisham Council – Children's Social Care has also acknowledged that its contact with Mia (when it received information about a serious incident of domestic violence and abuse) should have triggered an assessment. Lewisham Council – Children's Social Care have described changes to policy and practice since this contact which would have enabled more robust information sharing and assessment of need. This includes having an Independent Domestic Violence Advisor (IDVA) in the boroughs Multi-Agency Safeguarding Hub (MASH)[67]. This is good practice, as it ensures there is specialist, independent

[67] For more information, visit the Lewisham Council website.

expertise around domestic violence and abuse during this process. As a result, the Review Panel did not make further recommendations.

4.4 Any other Relevant Facts or Information

4.4.1 During the DHR, Aiden's name was checked against the MPS Gangs Matrix[68]. The Review Panel felt it was appropriate to request that a check was made against the Gangs Matrix given the information about the possible Child Criminal Exploitation of Aiden. Aiden was not known in either Lambeth or Lewisham[69].

[68] The MPS describes the Gangs Matrix as an intelligence tool to 'identify and risk-assess gang members across London who are involved in gang violence'. It also seeks to identify those at risk of victimisation. For more information, visit the Met Police website.

[69] While it requested checks against the Gangs Matrix, the Review Panel noted that there has been considerable criticism of this mechanism, including by Amnesty International. A review of the Gangs Matrix was published by MOPAC in December 2018. This made a number of recommendations, including an investigation into whether the disproportionate number of young black men included is legitimate.

5. Analysis

5.1 Domestic Violence and Abuse

5.1.1 Elaine was the victim of a fatal act of domestic homicide, with this perpetrated by her nephew, Aiden. It occurred when Elaine (in the company of her husband, Luke) had returned briefly to London, where they had been living before returning to Buckinghamshire. In this context, Elaine's homicide can be understood as a fatal case of AFV. However, beyond this fatal act, this DHR has not identified any previous history of domestic violence and abuse by Aiden towards Elaine.

5.1.2 Prior to 2016, Elaine had some contact with a number of agencies in Buckinghamshire. This related to specific issues in her own life and had concluded some years earlier. The Review Panel has not identified any information that might suggest that these contacts included any reference to, or indicators of, domestic violence and abuse by Aiden.

5.1.3 Between 2016 and 2018, Elaine and Aiden lived in the same house. There are no reports of any ongoing violence, abuse or coercive control by Aiden towards Elaine. Indeed, as noted previously, the house was split into different, self-contained living areas. Isabel and Charles told the chair that they believed Elaine had relatively little direct contact with Aiden. They also said that Elaine did not share any concerns with them about tensions or conflict with Aiden, although they noted there were tensions about whether the house would be sold (although these tensions are reported to have been between other family members rather than between Elaine and Aiden). Aiden's mother, Rachel, also said that she was unaware of any tensions or conflict between Elaine and Aiden.

5.1.4 It does not appear therefore that any professional or agency had grounds to suspect that Elaine was at risk from Aiden. However, the Review Panel felt it was appropriate to consider whether existing processes would have identified and considered the potential for risk to Elaine, particularly as she shared a home with Aiden.

5.1.5 There was explicit consideration of 'risk to others' on two occasions. These were when Aiden presented at Dr Santamaria's Medical Practice in May 2017, and during Aiden's contact with SLaM in April 2018. However, in both these contacts the consideration of 'risk to others' was limited. The mental health referral

completed by Dr Santamaria's Medical Practice contained a risk assessment, where Aiden was assessed as 'no risk of harm to others', but this did not indicate what information had been considered in making this assessment. During Aiden's contact with SLaM, only a limited social history was taken and the discussion around risk was focused on his father (Jacob).

5.1.6 This is a reminder that mental health services must be able to routinely enquire about risk to others. This must be supported by tools (a tick box process is not sufficient), procedure to manage any disclosures, as well as staff training.

5.1.7 The Review Panel also considered whether, assuming there is a robust process around enquiry relating to risk to others, professionals were likely to consider AFV.

5.1.8 The Review Panel felt that, because AFV is less well understood than IPV, this means that the *potential* for risk to the wider family (including Elaine) was also less likely to have been considered. As noted above, it is not clear to whom the assessment of 'risk to others' by Dr Santamaria's Medical Practice was directed, while the professionals who had contact with Aiden in SLaM probably did not know that Elaine existed because a limited social history was taken.

5.1.9 The NHSE panel representative informed the Review Panel that the NHSE London region had recently hosted a multi-agency conference on risk assessment and is currently considering how to improve risk assessment in the London region. The next stage is to present the learning from this conference to the London Mental Health Transformation Board. Given this work is in progress, and the active participation of NHSE in this DHR, the Review Panel decided not to make additional recommendations.

5.1.10 As discussed in 1.6, AFV (and CPV, which is explored specifically in relation to Rachel below) are not always clearly defined or well understood. This means that in assessing 'risk to others' in future cases, professionals may continue to focus on a smaller number of immediate family members rather than considering the broader family context. The implications for this in terms of policy, procedure and training locally are explored further below. However, regarding the issue of definition, the Review Panel made the following recommendation:

Without a clear definition, it can be challenging for policy makers and practitioners to address specific social issues. This is the case with AFV (and CPV).

Recommendation 3: The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV. This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance.

5.1.11 The fact that Elaine was targeted by Aiden was a question that Isabel and Charles wanted answered, as they are unsatisfied with the explanation that Aiden's fatal act was a consequence of his mental health. As noted previously, Isabel and Charles are of the view that the possibility of the family home being sold was the reason why Aiden targeted Elaine. Regrettably the DHR is unable to answer this question, having found no evidence either way. Moreover, in the absence of an interview with Aiden, it is also not possible to ask him why he targeted Elaine. Ultimately, it is beyond the purview of the Review Panel to account for Aiden's actions on the day, or why he killed Elaine. Nonetheless, the Review Panel noted two things. First, for whatever reason, Aiden locked his uncle (Luke) out of the house and his grandmother (Hazel) in the kitchen and did not target them in the attack. Second, regardless of whether Aiden's act can be accounted for by a sudden deterioration in his mental health, there are reports of Aiden being previously violent towards women.

5.1.12 With reference to these previous reports, the Review Panel considered Aiden's reported behaviour towards Rachel, including:

- Aiden's self-report to Lewisham Council – SHIP in March 2014 that he had been "*throwing and breaking household items"* during an argument with his mother (Rachel), who was reported to be unwilling to have him at home; and
- Rachel contacted the MPS in December 2014 after Aiden refused to leave her home, leading to Aiden's arrest for criminal damage. There was also a contact in January 2015, relating to the collection of Aiden's belongings.

5.1.13 As noted previously, the Review Panel considered whether these may have been evidence of CPV. However, during the course of the DHR, the Review Panel determined that it was not able to reach a conclusion on this matter and could therefore not consider it further. This was because of the small number of reports noted above, and because it was not possible to explore these with

Aiden as he did not participate in the DHR. Additionally, Rachel has stated categorically that "*Aiden was never violent towards me*". She also said that, when she reported the incidents in December 2014 and January 2015, "*the police were a means to an end in terms of stopping an immediate situation*".

5.1.14 In contrast, Aiden appears to have been responsible for IPV towards Mia. Although Mia (Aiden's former partner) has not participated in this DHR, this behaviour is reported to have included:

- As part of the January 2015 incident, Rachel told the MPS that Aiden was threatening to punch Aiden's then partner Mia (although Mia did not herself report this);
- In June 2016, Mia called the MPS. During this contact, Mia reported that Aiden regularly assaulted her, although she later withdrew her allegations. In this incident, Aiden is also reported to have made threats towards Child B; and
- Rachel also confirmed that Mia and Aiden's relationship become "*dysfunctional*" and that Aiden "…*was going for her*".

5.1.15 As noted in 1.6, there is a risk of conflating these three distinct relationships. It is therefore important to note that the Review Panel has the benefit of hindsight. Nonetheless, different agencies had different contacts with Aiden, Rachel and Mia over this period and, at some points, these could have been considered together. Reflecting the Terms of Reference, the Review Panel discussed these contacts at some length. The specific issues relating to each are discussed in the analysis of agency involvement below.

5.2 Analysis of Agency Involvement

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference. Given the complexity of this case, the analysis is presented with reference to each subject of the DHR.

The communication, procedures and discussions, which took place within and between agencies.

Elaine

5.2.2 There is no information to indicate that there were any issues in relation to communications, procedures and discussions within and between agencies relating to Elaine that are relevant to the homicide.

Aiden

5.2.3 There was extensive contact with Aiden relating to allegations of domestic abuse, as well as Youth Crime and (possible) Child Criminal Exploitation. These matters are discussed further from 5.2.91 below.

5.2.4 The only other communications, procedures and discussions within and between agencies specifically relating to Aiden was in relation to his mental health.

5.2.5 With regard to Primary Care, neither Dr Santamaria's Medical Practice nor the Hetherington Group Practice made a referral directly to the Living Well Network Hub. Dr Santamaria's Medical Practice made a referral to the SLaM via the 'North Lambeth Recovery and Support Service', while the Hetherington Group Practice made a referral directly to the SLaM LEO Team. In both cases, a referral should have been made to Living Well Network Hub as this is the 'front door' for mental health services locally.

5.2.6 Moreover:

- In the case of Dr Santamaria's Medical Practice, it has not been possible to establish what happened to the referral that was sent to SLaM because there is no record of this referral being received. This may be because it was sent in error to the (non-existent) 'North Lambeth Recovery and Support Service'. There is also no indication that there was a further discussion with Aiden about this referral; such a discussion would have been an opportunity to identify that he had not been contacted by SLaM. This is discussed further in the mental health section of this report (from 5.2.64 below); and
- While the Hetherington Group Practice incorrectly referred directly to the SLaM LEO Team, this was a prompt referral and they followed it up to ensure it had been received. This ultimately led to an assessment of Aiden.

5.2.7 The Review Panel did not feel that the issues identified regarding health professional's awareness of the Living Well Network Hub had any bearing on the homicide of Elaine. However, as a DHR process is about learning, a recommendation was made to drive improvement locally. In this case, this

recommendation relates to ensuring clear and consistent communication about local referral pathways.

While the Review Panel felt it was positive that the Living Well Network Hub is in place, it noted that neither of the GPs in this case used this route. A front door to mental health services can only be effective if professionals are aware of the referral pathway and access it.

Recommendation 4: The Lambeth CCG to further promote the Living Well Network Hub to ensure that all GPs are aware that mental health referrals should be made via this route.

5.2.8 The Review Panel noted a broader issue in relation to the referral sent by Dr Santamaria's Medical Practice in that it was sent by fax. This matter has not been considered further by the Review Panel. While it may be surprising to some that the NHS is still using fax machines, the Review Panel has not considered this further. This is because the substantive issue was not the method of transmission but the fact that the referral was sent to the wrong place. This is addressed by the recommendation above.

5.2.9 With regard to Secondary Care, there were significant issues in relation to internal communication within SLaM between OASIS and LEO CMHT, with these being the two teams that undertook a joint assessment of Aiden in the company of his father (Jacob) in April 2018. This is discussed further in the mental health section of this report (from 5.2.64 below).

5.2.10 Finally, after Aiden's arrest on the 31st March 2018, he was detained in custody. During his detention, a care plan was completed and implemented. This was in line with MPS policy and no issues have been identified in relation to the care he received. The exception relates to the contact with the HCP and the response made to the concerns by Aiden's family relating to mental health issues. This is discussed further in the mental health section of this report (from 5.2.64 below).

The co-operation between different agencies involved with Elaine and / or Aiden [and wider family].

5.2.11 This is discussed elsewhere in the analysis.

The opportunity for agencies to identify and assess domestic abuse risk.

Elaine

5.2.12 There is no information to indicate there were specific opportunities for agencies to identify and assess the domestic abuse risk to Elaine.

Aiden, Rachel and Mia

5.2.13 On several occasions the MPS responded to domestic abuse incidents involving Aiden and his behaviour towards his mother (Rachel) and his then partner (Mia).

5.2.14 In relation to Rachel, the MPS response to the identification of domestic abuse is discussed from 5.2.21 below.

5.2.15 On several occasions domestic abuse risk in relation to Mia was identified, including by the MPS. The response to this identification is discussed from 5 5.2.26 below.

5.2.16 Based on the information available to the Review Panel, there were also two opportunities where Mia could have been asked about domestic abuse by health services, potentially providing an opportunity to identify any concerns. The first was taken, the second was not.

5.2.17 The first was when Mia was in the care of GSTT Health Visiting services, after she gave birth to Child B in Autumn 2013. Although Mia was staying in Croydon, and initially had contact with Health Visiting services there, GSTT was responsible for her care because her home address was in Lambeth at this point. In March 2015 Child B and Mia were seen at their home address by a health visitor. Mia was asked if she felt safe in her relationship with Aiden and she reported that she did. There was no disclosure of domestic abuse. The GSTT Short Report did not identify any issues around the quality of care provided and the Review Panel accepted this assessment.

5.2.18 LGT also had an opportunity to enquire about domestic abuse as part of their contact with Mia in 2016. This arose after GSTT transferred the case to LGT, as a result of Mia moving to Lewisham.

5.2.19 At an assessment in June 2016, Mia was seen in the presence of a friend. There were no concerns about her parenting, and it was appropriate that the health visitor did not make an enquiry because another person was present. However, because no concerns were identified during the assessment, Mia was deemed to require a 'universal' service. As a result, there was no planned further contact with Mia, and such contact would only have happened if it had been triggered by another referral. This meant that there was no planned follow up and therefore no further opportunity to ask about domestic violence and abuse. This

was a missed opportunity. The LGT IMR addresses this point, noting that since this time the clinical supervision form has been changed to monitor how incidents like this are followed up. That would mean that, in similar circumstances, a further contact attempt would be made. The Review Panel accepted this and made no further recommendations.

Agency responses to any identification of domestic abuse issues.

Elaine

5.2.20 There is no information to indicate there were specific opportunities for agencies to respond to the domestic abuse risk to Elaine.

MPS: response to Rachel

5.2.21 In relation to Rachel, if she had concerns, the decision to report and / or support any subsequent criminal justice interventions in relation to Aiden would likely have been a challenging one. However, as noted elsewhere, Rachel has said she did not experience any violence or abuse from Aiden. She said that, on the two occasions she called the MPS, this was a way to manage an immediate situation.

5.2.22 In December 2014, Rachel contacted the MPS after Aiden had refused to leave her house. Aiden was arrested for criminal damage, but no further action was taken because Rachel did not want to support a prosecution. A CRIS report was created, as was a DASH risk assessment form. This was graded as standard risk. This appears to have been treated as a harassment case, as Aiden was served with a 'Prevention of Harassment Letter'. The CRIS report records that Rachel was offered information on support services but declined this.

5.2.23 A month later, in January 2015, the MPS was again called to Rachel's address. Rachel was not present, although Mia was and spoke to Police Officers. Shortly thereafter, Police Officers spoke to Rachel by phone. The Review Panel discussed this contact and were informed that Police Officers would have treated the call from Rachel as a 'third party report', as she was not at the address. When they attended the address and spoke with Mia, and then again with Rachel by phone, no allegations were made. Following this contact, Police Officers did not complete a CRIS report.

5.2.24 The Police IMR acknowledges that a CRIS report should have been created in line with Standard Operating Procedures (SOP). If a CRIS report had been

completed, this would have meant a DASH risk assessment form could have been completed, meaning support from domestic abuse services may have been offered or signposted.

5.2.25 During the course of the DHR, the MPS was asked whether police officers receive any training on violence and abuse on CPV (or, relating to the above discussion to Elaine, in relation to AFV). There is no specific training provided. The Review Panel identified this as a significant gap in terms of skills and competence.

There were two opportunities to provide Rachel with information about help and support in relation to Aiden, although she was only offered information on one occasion. Although the Review Panel has not been able to consider the possibility of CPV, this is an important reminder that the MPS is likely to respond to incidents reported between children and parents that could be violence and abuse. The MPS will also be called to incidents that could involve violence and abuse in other familial contexts like AFV.

Recommendation 5: The MPS to undertake a training needs assessment to identify the skills and training that police officers require to respond to AFV/CPV.

MPS response: response to Mia

5.2.26 Mia contacted the MPS in June 2016 and reported domestic abuse by Aiden. There were a number of issues with the MPS response:

- Initially the incident was sent to the CAIT, before being passed to the local CSU. This was down to the report being very poorly worded, but it did not substantively slow down the transfer of information (with this dealt with in under an hour);
- The DASH risk assessment form that was completed was graded 'medium'. However, it was not updated or supervised on the domestic violence page of the CRIS report;
- An arrest CAD was created but was not actioned; and
- The CRIS was later closed without further action.

5.2.27 The MPS IMR identified a number of consequences that arose from this poor response, specifically that there was both a missed opportunity to arrest and

interview Aiden as an alleged perpetrator but also to offer support to Mia as a victim. In offering supporting to Mia, this could have included considering whether a Domestic Violence Prevention Notice (DVPN) was an option or giving advice relating to a Non-Molestation Order (NMO). It is also unclear whether Mia was offered any information about, or referred to, specialist support services.

5.2.28 The MPS included one recommendation, which was accepted by the Review Panel. This recommendation addresses the issue above about the failure to action the arrest CAD:

"It is recommended that South East Basic Command Unit (BCU) Senior Leadership Team (SLT) review systems in place for offender management and the Emerald Warrants Management System (EWMS) as the new BCU forms and goes forward."

5.2.29 However, the Review Panel additionally noted a number of further issues that were not addressed in the MPS IMR.

5.2.30 In relation to risk, a DASH risk assessment form was completed and was graded as medium risk. However, Mia had disclosed that Aiden had said:

- He would like to stamp on her head;
- He wished he had never had Child B and would like to slit their throat;
- That she should not tell anyone about what he said (about his "*issues"*) and said he knew where her family lived if she did; and
- Mia said that Aiden regularly assaulted her in the past.

5.2.31 Police officers were also aware that the relationship status was variable, and the incident as reported might indicate separation because:

- Mia and Aiden had an "*on-off*" relationship and this had been going on for the previous two years; and
- Mia had just declined Aiden's marriage proposal and, in response, that JH had told her to delete his number.

5.2.32 The Review Panel felt that police officers did not take into account all the information available and that the risk to Mia was not therefore accurately assessed. Furthermore, the Review Panel felt that, based on a combination of

the information available and an understanding of the dynamics of domestic abuse, the risk should have been assessed as high. A high-risk assessment should have then triggered a multi-agency response including a referral to the local MARAC.

5.2.33 The Review Panel also noted that the DASH risk assessment form which had been completed was not updated or supervised on the domestic violence page of the CRIS report. The Review Panel was informed that this is not uncommon, with most assessments being revised by a police officer's immediate supervisor rather than a domestic abuse specialist.

5.2.34 Sadly, these inconsistencies are not surprising. In 2016, her Majesty's Inspectorate of Constabulary (HMIC) commissioned a research project to investigate risk-led policing of domestic abuse across England and Wales. Of relevance to this case were the findings that noted:

- The DASH risk tool was not applied consistently at the frontline;
- Police officers and staff appeared to prioritise criminal offences and especially physical violence and injury at the current incident at both the initial and secondary stages of risk assessment; and
- A more thorough risk/needs assessment is best undertaken by those with specialist training[70].

5.2.35 Given the distance between this incident and Elaine's homicide, it is clearly not possible to say if a different response to this incident could have prevented Elaine's death. However, there was a missed opportunity to take a more robust response to Aiden as a perpetrator of IPV.

5.2.36 In light of this, the Review Panel considered whether to make a recommendation in relation to the issue of secondary supervision.

5.2.37 The Review Panel were informed by the MPS Review Panel representative that:

- In 2017 the MPS started a programme called 'Strengthening Local Policing' (SLP) as they started to approach a restructuring of the policing of the 32 London boroughs into 12 BCUs;

[70] Robinson, A., Myhill, A., Wire, J., Roberts, J., and Tilley, N. (2015) Risk-led policing of domestic abuse and the DASH RIC model. (Accessed: 26th April 2019).

- As part of the final go live date from June 2019 uniform response officers (Police Constables) received training to own and investigate end to end the simple crimes, thereby reducing handovers and the number of different officers a victim has to deal with. The intention is to put Victim Care at the heart of the investigation;
- This is called 'Mi' investigation and part of this overall investigative process now includes 'Focused Supervision'. This is part of the improvement plan laid out in 'Leading Investigation Programme' which came about as a result of HMIC inspection reports in 2015. This places responsibility on first line managers to communicate with their staff to go through investigations and is a move away from the 'tick box' approach;
- Safeguarding training has been rolled out to all Detective Constables and Trainee Detective Constables on the newly formed Safeguarding teams on BCU's; and
- This approach will see Police Constables on response teams investigating low level crimes and DC's will have more time to focus on the more serious and complex crimes.

5.2.38 It is beyond the remit of the DHR to assess the MPS 'Strengthening Local Policing' programme but a consistent response to domestic violence and abuse should be embedded within it as part of its role out.

Secondary supervision, by appropriately trained staff, is critical to ensure that domestic abuse risk is appropriately identified. In this case, the incident was not appropriately assessed. Additionally, the absence of supervision means that the risk grading was not signed off and there was also no opportunity to identify and respond to the outstanding issues (like the failure to update the CRIS report or ensure that the CAD was actioned). Lessons learnt must be used to shape the delivery of the 'Strengthening Local Policing' programme.

Recommendation 6: The MPS to audit the 'Strengthening Local Policing' programme' to ensure it enables a consistent and robust process for the supervision all of domestic abuse incidents / crimes.

5.2.39 Furthermore, the Review Panel was concerned about the extended period of time between Mia's report and subsequent contact with the MPS:

- In the first instance, 17 working days passed between Mia's report and a follow up contact. By the time this contact was made Mia reported that she and Aiden had spoken and attended counselling together. During this contact, Mia was asked about previous assaults but was unable to provide specific details about these; and
- In relation to the follow up contact, which lead to the final case closure, there were 164 working days between Mia's report and this contact.

5.2.40 The Review Panel noted that a similar issue was identified in the case of Sophia, a DHR that has recently been published in Lambeth (DHR 003[71]). In Sophia's case, there were disputes between MPS teams about the ownership of a report. These disputes led to significant delays in contact and potentially meant that Sophia lost confidence in the police response. Regarding Mia's contact with the MPS, this delay is even more extreme. The Review Panel were informed that the longer delay was likely the result of how Police Officers used various MPS Information Technology (IT) systems.

5.2.41 The Review Panel did not feel it had the technical or process knowledge to reach a judgement about the operation and use of these IT systems. However, whatever the reason for the delay, this delay is unacceptable and runs counter to the Code of Practice for Victims of Crime[72]. Moreover, it can have a significant impact on victim confidence. There has been consistent feedback from consultations with victims and survivors that the sooner the police speak to a victim, the more likely they are to support a criminal justice intervention[73].

5.2.42 The Review Panel were informed by the MPS Review Panel representative that the MPS has an IT 'Changes Project', which aims to ensure that BCUs have the IT they need to be able to operate efficiently and effectively. The two main areas of changes are applications and site-based IT systems:

[71] Access a copy of the DHR.

[72] Ministry of Justice. (2015) *Code of Practice for Victims of Crime* (Accessed: 26th April 2019).

[73] STADV (2013) *Turning Points: Exploring survivors' experiences of the coordinated community response to domestic violence in the London Borough of Hammersmith and Fulham*.

- For applications, the MPS are making sure the new BCUs are set up as units on key IT systems and ensuring individuals within a BCU have access to what they need across the Boroughs that form part of a BCU; and
- For site-based IT, there will be a number of site-based IT changes in BCUs, supporting moves of IT equipment within sites or between sites, and hardware / infrastructure.

5.2.43 It is beyond the remit of the DHR to assess the MPS IT 'Changes Project', but clearly it is important that the root cause of the delays identified in this case are addressed as part of this work.

This is the second DHR in Lambeth where an issue was identified with the timeliness of the MPS response. In this case, there was an initial disagreement between two teams, but thereafter an issue with how Police Officers used various MPS IT systems. Action is required to identify the root cause and appropriate mitigating actions.

Recommendation 7: The MPS to identify the root cause of the delay in the response to Mia's report and ensure that this is addressed in its IT 'Changes Project' in order that such excessive delays cannot occur in the future.

5.2.44 The Review Panel also considered two additional contacts by Aiden with the MPS.

5.2.45 The first was the incident in December 2016, when the MPS received a phone call from a male (using the same surname as Aiden but giving a different first name). The male reported that their ex-partner Mia was at their address and refusing to leave (they provided the same street name as for Aiden's address but a different house number).

5.2.46 The Initial Investigating Officer (IIO) created a CRIS report and completed intelligence checks. They identified the previous reports concerning a female named Mia. The IIO noted there was insufficient information to confirm that the subject of the incident, Mia, was identical to the person named on the previous reports. A DASH risk assessment was completed, and the incident was graded as standard risk. The report was then passed to the local CSU. A police officer at the CSU rang Aiden the next day and, because Aiden explained that the

incident was over and that he did not want further assistance, no further action was taken. No connection was made to Aiden being wanted by the MPS.

5.2.47 In the subsequent Review Panel discussion, the MPS representative felt that the IIO's initial response was thorough, noting that they would have been hampered by the fact that the caller gave both a different first name and a different house number. They also appropriately created a CRIS report and identified the possible link to Mia. The Review Panel accepted this assessment. However, the Review Panel felt that the response - once the case had been passed to the CSU - was lacking. At the CSU, further research could have identified a link between Mia and Aiden. This would have removed any confusion around the different first name being provided by Aiden, not least because the police officer had spoken directly with Aiden.

5.2.48 On the 10th February 2017 Aiden called the MPS to report that someone had posted a picture of Child B online. Police officers attended for a scheduled appointment the following day at Aiden's home address. They spoke to a female (not named) and confirmed that the photos were not indecent. The attending police officers advised they would contact the person who had posted the picture and ask for it to be removed.

5.2.49 The MPS IMR recognises that both a CRIS, and thereafter a Merlin PAC, should have been created in accordance with its SOP. This is because a child had come to notice. In the absence of this it is not clear who the police officers spoke with or who was the alleged sender of the images. The Review Panel identified a further issue in relation to the MPS response. Specifically, CRIS reports were not created both in relation to two incidents (in January 2015, in relation to the incident first reported by Rachel, and also in the incident in February 2017 reported by Aiden).

5.2.50 The Review Panel has not made recommendations in relation to these incidents because the changes outlined above in the MPS 'Strengthening Local Policing' programme (and the associated recommendation) should address these issues.

Lewisham Council – Children's Social Care: response to Mia

5.2.51 Following Mia's report to the MPS in June 2016, the MPS notified Lewisham Council – Children's Social Care. A letter was sent to Mia offering advice and information in relation to support agencies for those experiencing domestic

abuse, as well as highlighting the impact on children of experiencing the same. This was on the basis that Mia was considered to have acted protectively by calling the MPS.

5.2.52 The Lewisham Council – Children's Social Care IMR recognised that an assessment should have been completed at the time based on the information provided by the MPS. This was because of the nature of the incident, including the report that Aiden had threatened his child and Aiden's previous history.

5.2.53 The Lewisham Council – Children's Social Care IMR highlighted significant changes to local practice since the contact with Mia within the borough's MASH. Within the MASH, there is an IDVA. The IDVA can speak with victims of domestic violence and abuse and work with them to consider what further support they may need to access to safeguard themselves and the children (with consent from parents). Furthermore, the MPS are now using the Social Care Continuum of Need[74] when assessing risk as part of the MASH process. This should mean that, even if a child is not present during an incident of violence, information is sent through to Children's Social Care to be considered. In light of these changes, the Review Panel has made no further recommendations.

Organisations' access to specialist domestic abuse agencies.

5.2.54 As there was no contact with Elaine relating to domestic abuse, there is no information to suggest that this was specifically an issue. The MPS contact with Rachel and the consideration of help and support in relation to CPV has been discussed above. In addition, the Review Panel agreed to look more broadly and consider the local awareness of and support available to victim/survivors of AFV and CPV. This is discussed from 5.2.57 below.

5.2.55 In relation to Mia it has been noted that no referrals were triggered to domestic abuse services, as discussed above.

The policies, procedures and training available to the agencies involved on domestic abuse issues.

5.2.56 As necessary, agencies have submitted information on policies, procedures and training relating to domestic abuse. This is discussed in relation to specific

[74] The Lewisham Continuum of Need document is a guide to assessing and meeting the needs of children and their families.

agency contact. However, the substantive issue identified by the Review Panel relates to AFV and policies, procedures and training. This is little considered and is discussed in the following section.

Specific consideration to the following issues:

a) AFV / CPV

5.2.57 The specific issues relating to AFV and CPV in this case are discussed in 5.1 above.

5.2.58 The Review Panel considered existing provision in relation to AFV and CPV in Lambeth. Among Review Panel representatives, there was a consensus that the awareness of, and the response to, these forms of violence and abuse was underdeveloped. Potential issues include the knowledge and skills of staff, the extent to which AFV and CPV are reflected in policy and procedures, as well as how awareness raising is conducted in relation to this issue.

5.2.59 In relation to training, the Review Panel noted the VAWG Training Programme provided by Lambeth Council[75]. This is good practice. However, AFV/CPV are not explicitly identified as learning outcomes in any training.

5.2.60 Balancing these concerns was a recognition that much of the response to AFV / CPV takes place in the context of the wider response to VAWG. Lambeth Council has a VAWG strategy[76] in place and its commissioned specialist service, the Gaia Centre, provides support to all survivors of domestic violence, including those experiencing abuse from family members. This provides a firm foundation on which to further develop responses to CPV and AFV.

The CCR is based on the principle that no single agency or professional can respond to domestic abuse, but all agencies and professionals can offer insight that are crucial to the safety of victims and survivors. This is the core of the CCR. It aims to take the strategic ambition of responding effectively and turn that ambition into operational outcomes. It is important that the CCR is able to support a robust response to AFV / CPV.

[75] London Borough of Lambeth (2019) *Violence Against Women and Girls (VAWG) Training Programme*. (Accessed: 5th October 2019).

[76] London Borough of Lambeth (2017) *Safer Lambeth Violence Against Women and Girls Strategy*. (Accessed: 6th March 2019).

Recommendation 8: The Safer Lambeth Partnership to work with local partners to review the findings from this DHR and develop the response to AFV / CPV locally. This should include identifying the actions that agencies can take individually and collectively, as well as completing a training needs assessment to identify the skills and training that professionals require to respond.

b) Substance Misuse

5.2.61 There is no information to indicate that substance misuse was an issue for Elaine, Rachel or Mia.

5.2.62 There are reports that Aiden was smoking cannabis (and Elaine's parents Isabel and Charles feel this was a significant issue). However, while Aiden had disclosed cannabis use to his GP, in August 2017 he reported that he was not engaged in recreational drug use. There is no information that Aiden was using other drugs and, while he was suspected of drug dealing, he had received only a single conviction for drug offences (as discussed above).

5.2.63 In relation to Aiden's use of cannabis, the Review Panel noted that there are links between cannabis use and mental health issues. However, while epidemiologic studies provide evidence to support the public health message that cannabis use increases the risk of psychotic disorders, in some populations increased cannabis use is not associated with an increase in the incidence of psychotic disorder[77]. A possible explanation is that patterns of cannabis use are implicated in the variations in incidence of psychotic disorder. In one London study participants who used high-potency cannabis on a daily basis had five times the odds of developing psychosis compared to those who had never used cannabis[78]. The Review Panel has included this information for reference but felt that it was not in a position to make any further recommendations.

c) Mental Health

[77] Gage SH, Hickman M, Zammit S. (2016) 'Association between cannabis and psychosis: epidemiologic evidence', *Biological Psychiatry*, 79 (7), pp. 549–56.

[78] Di Forti M, Quattrone D, Freeman T P, Tripoli G, Gayer-Anderson C, Quigley H et al. (2019) 'The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study', *The Lancet*, 6 (5), pp. 427-36.

Contact with GPs

5.2.64 In relation to Aiden's contact with Dr Santamaria's Medical Practice in 2016 and 2017, the support and advice provided was medically appropriate. However, there were a number of missed opportunities:

Practice	Comment
When Aiden attended the practice in August 2016, he talked about his anger. He was signposted to the local IAPT service	• During a subsequent appointment (in January 2017 for a routine physical health matter) there does not appear to have been any further exploration of Aiden's earlier disclosure and / or whether he had self-referred to the IAPT service
At a further appointment in May 2017, Aiden reported feeling stressed, angry and down about work and family matters. The family matters appeared to be in relation to separation from his partner and young child	• During this appointment, there is no evidence that the potential risk of domestic violence was considered • A referral was made for another health matter (unrelated to this DHR) • A mental health referral was also completed. • This contained a risk assessment, where Aiden was assessed as 'no risk of harm to others', although there is no information recorded as to how this determination was made or to whom it related • The medical records record no plans for a review relating to referral, including whether Aiden had attended an appointment and whether it was of benefit[79] • As discussed above, the mental health referral was incorrectly sent to the 'North Lambeth Recovery and Support Service' 5.2.65

5.2.66 In his contact with Dr Santamaria's Medical Practice, Aiden saw a different GP each time he had a face to face consultation. This may have presented additional challenges in reviewing his mental health and domestic situation (for example, whether he felt able to disclose to a new GP, or if the GP had reviewed the medical record and asked about any previous disclosures). The issue of

[79] Arranging such a review is not routine practice but given the nature of this presentation, and previous other contact where Aiden stated he was angry, it might have been advantageous to follow this up.

continuity of care was also identified in the recently completed DHR 003 (the case of Sophia).

5.2.67 Additionally, Dr Santamaria's Medical Practice did not have a Domestic Abuse Policy, and no information is available on the training accessed by staff. As noted previously, the Clapham Family Practice took over responsibility for patients following Dr Santamaria's retirement. The Clapham Family Practice has a domestic abuse policy and reported that, at the point their IMR was submitted, this was being refreshed. (This policy has not been reviewed as part of this DHR). As a result, the Review Panel did not make a recommendation.

5.2.68 In relation to Aiden's contact with the Hetherington Group Practice, Aiden had historically been seen by the practice periodically between 2012 and 2016. As noted previously, the medical care provided in that time was appropriate and timely.

5.2.69 Shortly before the homicide, Aiden re-registered and was seen once on the 9th April 2018. He was seen on the day, assessed and referred urgently to SLaM, with the GP following up this referral to ensure it had been received. This is good practice (although, as discussed above, the referral should have been sent to Living Well Network Hub rather than directly to the SLaM LEO Team).

5.2.70 The Hetherington Group Practice domestic abuse policy does not state how the practice will respond if a perpetrator discloses or is registered with the practice, nor does it provide details of the practice's domestic abuse lead, the local referral pathway or training resources.

5.2.71 The Hetherington Group Practice IMR made the following recommendation, which was accepted by the Review Panel:

"The Practice Domestic Abuse policy needs to be amended to include how the practice will respond if a perpetrator discloses or is registered with the practice, as well as clarifying details of the Practice Domestic Abuse Lead, the local referral pathway and Domestic Abuse training resources".

5.2.72 In relation to the collective learning from both Dr Santamaria's Medical Practice and the Hetherington Group Practice, the Review Panel noted that in Lambeth, the recently completed DHR 003 (the case of Sophia) made the following recommendations:

Recommendation 13: The Lambeth CCG to work with general practices in the borough to incorporate the RCGP domestic abuse guidance for general practitioners into policies and practice.

Recommendation 14: The Lambeth CCG to develop a programme for general practices in the borough providing access to: training (including reflective practice) and a referral pathway (including specialist advocacy) to enable a consistent response to domestic violence and abuse.

5.2.73 The CCG informed the Review Panel that a template GP Practice Adult Safeguarding Policies and Procedures document, which includes local information about responding to domestic violence and abuse, will be available from October / November 2019 to all practices in Lambeth including Clapham Family Practice and the Hetherington Group Practice. (This document has not been reviewed as part of this DHR).

5.2.74 In light of this, the Review Panel felt that the CCG was clearly taking action in response to DHR 003 and therefore did not make a recommendation. It was agreed that the CCG would instead ensure that learning from this case would be integrated into the existing action plan. This should include confirming that both the Clapham Family Practice and the Hetherington Group Practice adopt the above GP Practice Adult Safeguarding Policies and Procedures document.

Contact with the MPS

5.2.75 Aiden had contact with the MPS when he was arrested on the 31st March 2018. During his detention, a HCP was called because of concerns about his mental health. The decision to call an HCP was made by the custody sergeant because of Aiden's behaviour (when he was brought out of the cells) and contact with his family (who had raised concerns about his mental health[80]). From the records that are available, the HCP explored Aiden's mental health, but this was specifically in relation to his detention. The HCP's enquiries do not appear to have been informed by any consideration of the concerns raised by Aiden's family.

[80] As noted previously, there is no record of any contact by the MPS with LP, although as described in the chronology, there is a record of the custody sergeant speaking with Jacob. Regardless of this discrepancy, it is clear that family concerns about Aiden's mental health had been shared with the MPS.

5.2.76 If there are concerns about someone in custody, police officers and staff follow a four stage Vulnerability Assessment Framework (VAF). The VAF is a checklist that helps officers and staff recognise vulnerability and mental health. Within the VAF there is an 'ABCDE tool' that can be used to identify vulnerability. This considers the following factors: Appearance; Behaviour; Communication capacity; Danger; and Environment circumstances. See **Appendix 2** for a fuller description of the VAF.

5.2.77 In this case, stage one was triggered when the Custody Sergeant identified that Aiden may have been vulnerable and called the HCP. However, Stage two (carrying out a vulnerability assessment) was not triggered during or after the contact by HCP.

5.2.78 If stage two had been triggered, the HCP would have used the ABCDE tool to complete the vulnerability assessment. Following this, if they had identified more than 3 factors (or the HCP had a concern regardless of the number of factors), a Merlin ACN (Adult Come to Notice)[81] should be completed. If the second stage is triggered and a vulnerability is identified, stage three allows for a more in-depth consideration of mental health or safeguarding issues, while stage four concerns escalation if there has been a critical incident, serious abuse or death. Regardless of whether these latter stages are relevant, once a Merlin ACN has been completed at stage two, it should be shared with the relevant Adult Social Care department.

5.2.79 In relation to this contact, the MPS IMR notes that consideration could have been given to completing a Merlin CAN. However, given his presentation, it was felt by staff that this was not appropriate.

5.2.80 The Review Panel considered the nature of this contact and the observation in the MPS IMR. It noted:

- The concerns expressed by Aiden's father (Jacob) were documented by the Custody Sergeant;
- There is no record of the conversation that Rachel reported having with police officers in the Police IMR(s);

[81] A Merlin ACN should be completed by police officers when they encounter a vulnerable adult AND there is a concern of vulnerability AND There is a risk of harm to that person or another person.

- There are differences in the recollection of Custody Sergeant and the HCP about whether information about Aiden's mental health was passed on from the former to the latter. Reflecting this, while the information from Aidan's father was recorded by the Custody Sergeant, it is not present in the HCP's records; and
- Regardless of whether this information was or was not shared, it was not taken into account during the HCP assessment.

5.2.81 The Review Panel concluded that while the VAF provides a framework to identify vulnerability, in this case it was not followed. The Review Panel is unable to reach a view as to why it was not followed because of the differences in recollection between the Custody Sergeant and the HCP. It is also possible that at the time the HCP met with Aiden they felt that he was not vulnerable.

5.2.82 Regardless of what did or did not happen, the Review Panel felt that given Aiden's family had shared concerns about his mental health, and based on his presentation in custody, there was a missed opportunity to consider a stage two vulnerability assessment. It is not possible to say whether a vulnerability assessment would have averted the homicide of Elaine, but it should have triggered a Merlin ACN which may have led to earlier contact by mental health services.

5.2.83 The Review Panel considered making a recommendation in relation to this missed opportunity but chose not to do so on the basis that there is a policy and procedure in place. Nonetheless, the Review Panel has been clear in its view that this was a missed opportunity and the MPS should consider the learning from this case.

5.2.84 Looking more broadly, the Review Panel has also considered the potential impact of discrimination. The Review Panel was mindful of this potential given Rachel's (Aiden's mother) comment, when talking about her contact with the MPS after Aiden's arrest on the 31st March 2019, that '…*I don't particularly trust the police or their motivations where black people, particularly young black, are concerned*". This raises an important point around how distrust in the police due to concerns about racial discrimination can affect people's confidence to engage with the criminal justice process. Unfortunately, the Review Panel has not been able to speak with Aiden. As a result, it has not been possible to explore Aiden's perception of his contact with the police (either with the MPS in this incident, or previously, including being the subject of stop and search).

5.2.85 Nonetheless, the Review Panel noted that it was possible that Aiden, as a young, Black Caribbean man, may have faced personal and / or structural barriers or discrimination in his contact with the police. As an example, the Review Panel noted the well documented concerns in relation to the use of stop and search and whether this power is used disproportionality in relation to Black communities. A report released by the Equality and Human Rights Commission the year before Aiden's first police contact included information that some police forces had conducted stops on the basis of stereotypical assumptions, with Black people being at least six times as likely to be stopped as white people[82].

5.2.86 The Review Panel considered whether it could make findings(s) or recommendation(s) in relation to this issue. These might have, for example, explored issues like the disproportionate use of stop and search against Black people, how discrimination may translate into barriers to accessing support from the MPS, or whether the MPS needs to commit to build better relationships with Black communities, including in the context of domestic violence and abuse[83]. However, while Aiden's mother attested to her concerns about the police, as Aiden did not participate in the DHR, it has not been possible to ask him about his experiences and perceptions. Combined with the scope of the DHR, this means the Review Panel did not feel it could conduct a meaningful examination of these issues, particularly as Aiden had previously lived in other boroughs. Nonetheless, the Review Panel has identified possible learning in relation to these issues and made a recommendation to this effect (see 5.2.115 – 5.2.122 and recommendation 10).

5.2.87 Additionally, the Safer Lambeth Partnership – which was represented on the Review Panel – proposed a single agency recommendation, reflecting its wider ambition to address structural inequality, including institutional racism, which would allow it to take the learning from this DHR and use it to inform this wider work:

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[82] Equality and Human Rights Commission (2010) '*Stop and Think: A critical review of the use of stop and search powers in England and Wales*'. (Accessed: 26th April 2019).

[83] The Review Panel was asked to consider these specific points in feedback from the Home Office Quality Assurance Panel in September 2020. While the Review Panel considered the Home Office feedback, the Review Panel felt it could not make finding(s) or recommendation(s). However, the report was revised to consolidate and strengthen the discussion relating to how racial discrimination and structural barriers may have impacted Aidan and his family in their interaction with the police, including the Review Panel's rationale for why it felt it could not make finding(s) or recommendation(s).

The Safer Lambeth Partnership to use the learning from this DHR, as well as other local and national research, to work with the MPS to identify how to improve relationships between Black communities and the police.

5.2.88 The Review Panel endorsed the single agency recommendation. Additionally, it welcomed the Safer Lambeth Partnership's commitment to share these considerations in its response to the forthcoming Mayor's Action plan for improving trust and confidence, transparency and accountability in policing and its ongoing work with MOPAC.

Contact with SLaM

5.2.89 Aiden was assessed by SLaM in April 2018, three days before the homicide. Aiden was in the company of his father (Jacob). While it is positive that this assessment occurred shortly after the referral was received from the Hetherington Group Practice, and a plan for a home visit was made if Aiden did not attend, the SLaM IMR (and Mental Health Investigation Report) identified a number of significant issues.

5.2.90 In relation to Aiden and his family:

- First, in the assessment the social history taken was unclear and, following a review of the available records, there was little sense of who the family members were. Additionally, the assessment of Aiden's risk to his family, child and other members of his family was lacking;
- Second, assessing clinicians did not see Jacob on his own. While they did ask Jacob if he felt at risk, this was done in front of the Aiden. The SLaM IMR noted that it may have been useful for the assessing clinicians to have seen Aiden's father on his own so that he could discuss Aiden's recent behaviour (i.e. recently throwing family property including his father's tools out into the garden); and
- Third, Jacob was not given any care plan documentation (including crisis contacts) after the assessment.

5.2.91 In relation to the assessment itself, Aiden was reported to be "*guarded*" and the assessment was cut short when he left the room. Additionally:

- There was no contemporaneous documentation of the assessment and a risk assessment was not commenced;

- It was unclear which team would be taking over the care of Aiden (i.e. LEO CMHT or OASIS); and
- The LEO CMHT MDT that took place after the assessment did not discuss Aiden's case, because the assessing clinician was not present.

5.2.92 The SLaM IMR identified a number of recommendations, for both the LEO CMHT and the Trust as a whole. These were accepted by the Review Panel:

Local recommendations

"LEO CMHT to develop a local protocol to state that once an initial assessment has been done, the outcome of the assessment should be discussed at the next MDT meeting and any plans put in place to address the key issues relevant to risk"

"LEO CMHT to develop a protocol to state that relatives and patients are to be given a copy of the treatment care plan on the day of the assessment including crisis contact details"

"The LEO CMHT induction package to highlight how to access medical members of the team for advice"

"LEO CMHT to develop a consistent approach and framework for conducting assessments including consideration of collateral sources of information"

Trust wide recommendations

"A Trust-wide piece of work to be done to share the learning from other domestic homicide cases that have taken place in the Trust"

"The Trust should assure itself that all practitioners are sufficiently aware of the need for domestic abuse routine enquiry as part of full needs and risk assessment. The Think Family approach demonstrates that this should not solely focus on service user's vulnerability, but also carers and other family members, if relevant. Staff should also consider the needs of male victims of domestic abuse"

"The Trust should assure itself that staff are aware of the MARAC referral processes, local borough arrangements and the standards expected when there are high risk domestic abuse concerns".

5.2.93 It is clear from the SLaM IMR that, from the perspective of the professionals involved, the assessment with Aiden was challenging, not least because he was

described as "*guarded*". The Review Panel has no reason to doubt the accuracy of this description, but it is worth considering why Aiden behaved in this way.

5.2.94 One explanation for Aiden's guardedness may have been for reasons of ill-health. Another is that the professionals conducting the assessment were unable to establish a rapport with him. This may have reflected the specific circumstances of the assessment. Engaging with someone and establishing a therapeutic relationship takes time. It would have been challenging for any clinician to gain Aiden's trust immediately, particularly given the short time that he was present in the assessment.

5.2.95 Unfortunately, the Review Panel has not been able to speak with Aiden. As a result, it has not been possible to explore Aiden's perception of his contact with SLaM. However, it is of note that Aiden's father (Jacob) told Rachel that "Aiden *was seen by, a very mature white male that didn't seem to connect with* [him]". Given this account, another possible explanation for Aiden's guardedness may have been that he did not feel safe or trust the professionals he encountered. This could have reflected his perception of staff or the service.

5.2.96 While all these possible explanations are speculative and may have all been in play to a greater or lesser extent, the latter explanation has some resonance with what is known locally about access to mental health services. This is because a 2014 report by the Black Health and Wellbeing Commission in Lambeth ('From Surviving to Thriving'[84]) noted that, particularly for people of Caribbean descent, there are local inequalities in mental health and wellbeing. Some of the reasons given for these inequalities include a lack of trust in and / or fear of mental health services; a lack of representation; and the ability of services and those who work in them to provide culturally appropriate support for their clients. The report made a number of recommendations to address these issues. It is beyond the remit of this DHR to investigate the progress made in relation to these recommendations. However, the Review Panel felt it was possible that Aiden, as a young, Black Caribbean man, faced personal and / or structural barriers to accessing mental health services. Moreover, if this was the case, his experience may not be uncommon in light of some of the known challenges locally in relation to health inequalities.

[84] Lambeth Black Health and Wellbeing Commission (2014) '*From Surviving to Thriving*'. [Accessed: 26th April 2019].

This DHR has identified a possible issue in terms of Aiden's experience in accessing mental health services. While it has not been possible to explore this further with Aiden, this finding is significant given the previously identified health inequalities for people of Black Caribbean descent locally.

Recommendation 9: Lambeth Together[85] to consider the learning from this DHR in relation to meeting the needs of local communities, including the provision of culturally appropriate services, a diverse workforce and creating opportunities to build trust with communities.

d) Youth Crime and Child Criminal Exploitation

5.2.97 Aiden had a range of contact with the MPS and Surrey Police. This was related to suspicions about Aiden carrying and / or supplying drugs, as well as some incidents of violence. This was also associated with periods when Aiden was missing from home. Almost all of this latter contact occurred before Aiden turned 18 in late 2014, which is particularly significant given the concern around the potential of Aiden being a victim of Child Criminal Exploitation.

5.2.98 The Lewisham Council – Children's Social Care IMR recognised that there were missed opportunities to engage with Aiden as a young person in relation to both the 'missing episodes' and the potential that he was the victim of Child Criminal Exploitation.

5.2.99 It is striking that, in Lewisham Council – Children's Social Care's contact with Aiden in 2011, while there was a Strategy Meeting, the planned Initial Assessment was not completed. This was because Aiden had been bailed to Lambeth, and therefore the decision was made to refer the case to that borough. This was despite the bail period being only two months. There is also no indication that staff at the time sought information on the length of bail, or indeed that a referral was made by Lewisham Council – Children's Social Care's to their counterparts in Lambeth (the latter have no record of a referral).

5.2.100 Similarly, Lambeth Council – Children's Social Care noted that a later report they had received in September 2013, which was closed because Aiden was not arrested and therefore not seen as at risk of harm, did not recognise

[85] Lambeth Together is run by a single management group called the Strategic Alliance. The Strategic Alliance leads, coordinates and manages health and social care in Lambeth as a single joined-up system with one budget. For more information, go to the Lambeth Together website.

contextual harm. Lambeth Council – Children's Social Care IMR recognised that practice has changed significantly since this contact. It stated that now, if a child from Lambeth is found outside of London and there are indications of criminal activity, they would be considered at risk of harm.

5.2.101 The Review Panel also noted that, if the 2011 referral from Lewisham had been made and then considered by Lambeth Council – Children's Social Care, this may have influenced the decision made in 2013.

5.2.102 The Short Report submitted by Surrey Police also noted that if the information available to them about Aiden was reported now, Aiden would be considered at risk of harm.

5.2.103 Collectively, all three agencies indicated that, if Aiden came to attention now, it is likely that professionals would consider whether Aiden was at risk of Child Criminal Exploitation. Agencies would also have considered, given the contact in both London and Surrey, whether this was associated with 'county lines'. HM Government defines county lines as:

"A term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons[86]."

5.2.104 The Review Panel were assured that, in both Lewisham and Lambeth Children's Social Care, there have been significant changes. In each area, referrals are triaged with multi-agency partners, in respectively a MASH or an Integrated Referral Hub[87]. In both areas, concerns about possible risk of harm (including from Child Criminal Exploitation, county lines or as a result of other issues) would trigger further assessment[88].

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[86] Home Office (2018) Criminal Exploitation of children and vulnerable adults: County Lines guidance. (Accessed: 6th March 2019).

[87] For more information, go to the Lambeth Safeguarding Children Board website.

[88] The Review Panel noted that it is important that, in this case, while there were indicators of potential Child Criminal Exploitation there is specific evidence that this was in the context of county lines. If Aiden was exploited, this could have been for other reasons.

5.2.105 As an example, in 2018/19 there were 37 young people referred by Lambeth's multi-agency Gang Violence Reduction Unit to 'Rescue and Response', a three-year MOPAC funded project working with young Londoner's affected by county lines activity[89].

5.2.106 Surrey Police also noted that all 39/24s (now called 'SCARFs') are submitted to the local MASH[90], where staff would triage the referrals and share accordingly including to neighbouring areas.

5.2.107 In light of the length of time since contact with Aiden, and changed information sharing arrangements in place in Lambeth, Lewisham, and Surrey, the Review Panel did not make any further recommendations.

5.2.108 The Lewisham Council – YOS prepared a Pre-Sentence Report (PSR) for Aiden in 2012, and later worked with him as part of a Referral Order between March and then November 2013. This contact appears to have been appropriate and no issues were identified in relation to Aiden's compliance in this period. However, it is of note that Lewisham Council – YOS was not aware of the extensive contact that Surrey Police was having with Aiden during this same time.

5.2.109 The Review Panel were informed that there have been significant changes in local practice since Aiden was on an Order in 2012/13. At that time, the YOS would not have necessarily been informed by the MPS or Surrey Police that an individual had come to attention unless they had been arrested and charged with new matters. This is no longer the case, with a number of multi-agency meetings now in place where this information would have been made available and shared with the YOS. As a result of these multi-agency meetings YOS are more aware of young people who may be involved in county lines and other forms of Child Criminal Exploitation.

5.2.110 In light of the length of time since contact with Aiden, and these changes, the Review Panel did not make any further recommendations.

5.2.111 The Lewisham Council – SHIP IMR noted that Aiden was appropriately identified as being in housing need and, given his age (17 at the time) and his

[89] For more information, go to the The St Giles Trust website.

[90] For more information, go to the Surrey County Council website.

history of offending, put forward for an in-depth assessment with a Youth Homelessness Officer.

5.2.112 However, the IMR identifies issues with the case management of Aiden's case, in particular that no attempt was made to discuss this with Lewisham Council – YOS.

5.2.113 Additionally, the Review Panel noted the extended periods of time between Aiden's approach allocation and then initial (24 working days) and subsequent (25 working days) contact attempts

5.2.114 The Review Panel were informed that there have been significant changes in local practice since the contact with Aiden. A Children's Social Worker is now permanently attached to the team and there is a joint working protocol in place. There are also two Young Persons Officers. This means that all under 18s presenting as homeless are now the subject of a joint assessment. Finally, a Young Person Supported Person Housing Pathway can provide emergency spaces while an assessment is being carried out.

5.2.115 In light of the length of time since contact with Aiden, and these changes, the Review Panel did not make any further recommendations.

Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

5.2.116 In relation to Elaine, there is no information to suggest any barriers to help seeking as there is no indication that she (or any others) thought that Aiden posed a risk.

5.2.117 In relation to Rachel and Mia, issues around help seeking are discussed elsewhere in the report, particularly in relation to contact with the MPS.

5.2.118 The Review Panel also considered what might have helped or hindered access to help and support in relation to Aiden. In considering this, the Review Panel was mindful that Aiden was the perpetrator of this homicide and has been found guilty of Elaine's manslaughter.

5.2.119 Nonetheless, and without seeking to minimise Aiden's actions, the Review Panel also felt it appropriate to note that, as a child, he had periods of going missing, was potentially at risk of Child Criminal Exploitation, and had contact with YOS and was known to Children Social Care departments and two different police forces. During these periods, Aiden had contact with the police. The

Review Panel has recognised that as a young, Black Caribbean man, Aiden may have faced personal and / or structural barriers or discrimination in this contact. Additionally, in relation to much of this contact, the Review Panel felt that Aiden was seen and treated as an adult, despite being under the age of 18 and therefore still a child until 2014.

5.2.120 While this DHR has sought to better understand Aiden's contact with services from 2011, a more extensive review of his experiences is beyond its scope, not least because the focus of the DHR is properly Elaine[91].

It is beyond the scope of this DHR to review the totality of potential harm to Aiden, including possible Child Criminal Exploitation. As a result, although the agency information considered has highlighted a number of issues, this is at best a partial account, particularly in the absence of Aiden's participation in this DHR. There remain a number of questions that are unanswered in relation to his potential experiences: Was Aiden subject to Child Criminal Exploitation? If so, what specific forms of exploitation took place? Was he coerced by adult(s) and, if so, what type of coercion was used? What were his experiences of the police? How did his age, race and sex affect how he was perceived and / or his interactions with services? The answers to these questions would be significant given the impact that being the victim of Child Criminal Exploitation could have had on Aiden's subsequent mental health, outlook, and decisions. At the same time, the Review Panel has recognised that practice has substantially changed since agencies had contact in this context with Aiden.

Recommendation 10: The Safer Lambeth Partnership to share this DHR with the Lambeth and Lewisham LSCPs with the expectation that they consider the findings in relation to contact with Aiden.

5.2.121 Lastly, as an adult, Aiden himself had sought help, in particular from his GP. Issues with this contact have been explored above.

5.2.122 It is not possible to know if a different response to Aiden during, either before or after he was 18, might have avoided the tragedy of Elaine's death, however the information presented in this report has identified multiple opportunities for agencies to have responded differently to Aiden over the years.

[91] For further information on the scope of this DHR, please see 1.6.

5.2.123 Upon reading the final draft of this report, Elaine's parents, Isabel and Charles, wanted to express their view that opportunities to intervene with Aiden were missed, both before and after he was 18. They accepted that the DHR could not say what, if anything, may have changed if agencies had responded differently over the years, including whether that might have averted Elaine's homicide. However, Isabel and Charles wanted it noted that they felt these missed opportunities were significant and that, as Elaine's parents, they cannot help but imagine how things might have been different.

5.3 Equality and Diversity

5.3.1 At the outset of this DHR, the Review Panel identified the following protected characteristics of Elaine and Aiden as requiring specific consideration for this case; Sex, Religion and Belief and Race.

5.3.2 Additionally, during the DHR the Review Panel felt it was also important to comment specifically on Age.

5.3.3 *Age:* Elaine was 38 at the date of the homicide, while Aiden was 21. A generational age gap is consistent with cases of fatal AFV, albeit (as in this case) the killing of an aunt by a nephew is relatively rare[92,93].

5.3.4 *Race:* Elaine was Black Caribbean. It likely that her wider social and cultural context affected both her perception of her experiences, and also the help and support she felt she could access. Indeed, if Elaine had accessed help and support, as a Black woman she may have experienced direct or indirect discrimination. Isabel and Charles did not feel that Elaine had experienced any form of discrimination that would have prevented her from seeking help. However, given there is no information that anyone was aware of any potential risk from Aiden towards Elaine, it is not possible to know.

5.3.5 Aiden was also Black Caribbean. Aiden had extensive contact with the police, including being the subject of stop and search. However, it has not been possible to explore Aiden's experience of the police, not least because Aiden did not participate in this DHR, while neither the MPS nor Surrey Police identified specific concerns in relation to their contact with him. Additionally,

[92] Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) case analysis. (Accessed: 6th March 2019).

[93] Home Office. (2006) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. (Accessed: 6th March 2019).

while there was intelligence to indicate that Aiden had been a person of interest in the past, as noted above, he was not on the MPS Gangs Matrix. Reflecting Aiden's contact with the police, both at the end of March 2018, as well as historically, the Review Panel has noted Rachel's (Aiden's mother) expression of distrust in the MPS, as well as the possibility that, as a young, Black Caribbean man, Aiden may have faced personal and / or structural barriers or discrimination in his contact with the police,

5.3.6 Aiden accessed local health provision, with regards to his mental health or other issues, and often with the support of his mother (Rachel) or father (Jacob). As discussed above, there were issues with his contact with services, relating to referral, assessment and follow-up. The Review Panel has considered this contact and noted the wider context of the health inequalities locally, which were identified by Lambeth's Black Health and Wellbeing Commission. The Review Panel has had a recommendation in response to this.

5.3.7 *Religion or belief*: SC was a person of faith and, like her family, was an active member of a Protestant faith community. In their interview with the chair, Isabel and Charles described their (and Elaine's) faith as a source of strength.

5.3.8 In the absence of an interview with Aiden, or other members of his family bar his mother, it has not been possible to explore matters relating to his faith further.

5.3.9 *Sex*: As discussed above (see 1.4), sex is a risk factor in domestic violence, with disproportionate numbers of female victims and male perpetrators. The sex of Elaine and Aiden are consistent with cases of familial homicide, which most commonly involve a female victim and a male perpetrator[94,95].

5.3.10 No information was presented that raised any issues regarding other Protected Characteristics, including; *Marriage and Civil Partnership*; *Sexual Orientation; Gender Reassignment; or Pregnancy and Maternity*. The Review Panel noted in relation to *Disability* that a mental health condition is considered a disability if it has a long-term effect (i.e. if it lasts, or is likely to last, 12 months) on someone's normal day-to-day activity. This may have been relevant for Aiden if

[94] Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) case analysis. (Accessed: 6th March 2019).

[95] Home Office. (2006) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. (Accessed: 6th March 2019).

he had received a diagnosis of early onset psychosis, but an assessment had not been completed before the homicide.

5.3.11 In relation to the reported violence and abuse towards Rachel and Mia, the Review Panel agreed it was not able to reach a conclusion on reports of violence and abuse towards Rachel. The Review Panel did however conclude that Aiden appears to have been responsible for IPV towards Mia.

5.3.12 Consequently, while Elaine is rightly the focus of this DHR, the Review Panel would be remiss if it did not note the significance of Protected Characteristics in relation to Mia. In particular her *Age* (16-24 year olds are the most at risk age group for IPV) and *Sex* (most IPV involves a female victim and a male perpetrator)[96]. In relation *to Marriage and Civil Partnership*, while Mia was not married to Aiden, he responded with significant violence and abuse when Mia did not accept his proposal. In the absence of contact with Mia, it has not been possible to explore other protected characteristics.

[96] Office for National Statistics. (2018) Domestic abuse in England and Wales year ending March 2018.

6. Conclusions and Lessons To Be Learnt

6.1 Conclusions and key issues arising from this DHR

6.1.1 This DHR was triggered by the homicide of Elaine, an action for which Aiden has been convicted of manslaughter. Elaine's death was a tragedy. The extracts from the Witness Impact Statement and Eulogy, re-produced with the permission of her family at the start of this report, are testament to her both her life and the impact her death. Yet the same extracts also offer an account of Elaine as a person: someone described by her family as "*responsible, generous, ambitious career minded and independent*", as having a beautiful smile and whose child "*meant everything to her*". Her commitment to her child is evidenced by her determination to get a job closer to home after having to move from Buckinghamshire to London for work. That she had secured such a role shortly before her death, enabling her to return to Buckinghamshire as she had hoped, is heart-breaking.

6.1.2 In undertaking this DHR, the Review Panel has looked beyond contact with Elaine alone and has also considered the experience of Rachel and Mia. This has broadened the scope of the DHR and has drawn attention to some of Aiden's other behaviours, and in doing so has brought the role of different agencies into focus. The Review Panel feels this broadened scope is in keeping with the spirit of the DHR process, which is about learning and prevention. At the same time, the Review Panel would like to acknowledge the challenges this has presented, including the difficulties of defining different types of domestic violence and abuse and ensuring that Elaine remained central to the DHR when most contact related to Rachel, Mia, or Aiden.

6.1.3 While the Review Panel agreed to broaden the scope of the DHR, and has considered Aiden's history, it is beyond its purview to address in full his experiences. However, this DHR has noted that during Aiden's adolescence possible Child Criminal Exploitation was not considered and, despite being a child, agencies appeared to have often treated him as an adult. This is not to suggest that these experiences caused his subsequent actions, nor to minimise his responsibility for the killing of Elaine. However, recognising Aiden's experiences is a salutary reminder of the importance and opportunity of early intervention, as well as our shared responsibilities to children and young people.

6.1.4 More broadly, during this DHR, there has been significant learning identified that the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.

6.1.5 The Review Panel would like to acknowledge that some of the questions that Elaine's family have asked, such as why Elaine was targeted by Aiden, remain unanswered. The Review Panel also recognises that Elaine's family have expressed their deep disappointment about the police investigation and the criminal trial outcome. When they reviewed the final report, Elaine's parents (Isabel and Charles) wanted to reiterate their feelings. They have felt, and continue to feel, "*hurt, anger, concern, shock and trauma*". While the Review Panel can neither resolve nor comment on these matters, it can at least provide witness to them and the ongoing impact on Elaine's family.

6.1.6 Finally, the Review Panel is mindful of impact of his homicide on both Child A and Child B. Child A will tragically grow up without their mother, while Child B's father has been convicted of manslaughter. The Review Panel sadly is unable itself to address this impact, but it has made recommendations for the Safer Lambeth Partnership to take appropriate steps to ensure that Child A and B (and their families) have access to support, including in relation to the publication of this DHR.

6.1.7 The Review Panel extends its sympathy to all those affected by Elaine's death and thanks all those who have participated in the DHR for their contribution.

6.2 Lessons to be learnt

6.2.1 In describing the lessons to be learnt from this DHR, it important to note that it appears that no single agency's contact could have prevented Elaine's homicide. Nonetheless, this DHR has identified learning that can be grouped across four areas:

6.2.2 The first area relates to health responses. In relation to GPs this concerns the identification of domestic violence and abuse and risk to others. While GP practice was medically appropriate in relation to specific issues, contacts were often approached in isolation. As a result, Aiden's disclosure of anger issues was not explored across appointments, and connections were not made between this disclosure and other issues that might have triggered consideration of domestic violence and abuse. Similarly, while risk to others was considered in some contacts, this was often done in a narrow fashion. Indeed, it is likely that the question of whether there might have been risk to Elaine may

not have even been explored if professionals had identified concerns about risks to others. The Review Panel felt that this was because professional understanding is more likely to consider IPV than other forms of domestic violence and abuse like AFV (or CPV).

6.2.3 With reference to mental health, there has been a range of learning.

6.2.4 In terms of local pathways, the local CCG must take note of the lack of awareness of referral routes to its local front door for mental health (the 'Living Well Network Hub'). A front door is meant to simplify referral routes and increase consistency of response. It clearly cannot do this if professionals do not know it exists.

6.2.5 The Review Panel has also identified that there was a missed opportunity by the MPS to consider a vulnerability assessment during contact with Aiden on the 31st March 2019. It is not possible to say whether this would have averted the homicide of Elaine, but it could have triggered a Merlin ACN which may have led to earlier contact by mental health services.

6.2.6 More significantly, there has been substantive learning for SLaM around the conduct and recording of its single interaction with Aiden a few days before the homicide. While there were positives around this contact (including timeliness once the referral had been made, and a plan for a home visit), its actual conduct was lacking. It is welcome therefore that SLaM has identified a range of local and trust wide recommendations as a result. The Review Panel has also considered Aiden's encounter with SLaM and noted the wider context of inequalities in relation to mental health and wellbeing for people of Caribbean descent locally. A recommendation has been made in relation to this issue.

6.2.7 The second area relates to the MPS and their response to domestic violence and abuse. There were a number of contacts where the response from the MPS was inadequate. This included issues with the quality of risk assessment in contact with Mia, as well as the timeliness of the MPS response to both Mia as a victim and in pursing Aiden as an alleged perpetrator. The Review Panel has been made aware of a number of significant change programmes in the MPS that will hopefully prevent these issues occurring in the future, nonetheless recommendations have been made to seek assurance that this is so. In this context, the Review Panel also considered whether Aiden may have faced personal and / or structural barriers or discrimination in his contact with the police. This reflected Aidan's mother's expression of distrust in the police in their treatment of young Black men, as well as the broader context (e.g., the well documented concerns about the disproportionate use of Stop and Search

against Black People). While the Review Panel felt it could not make any specific finding(s) or recommendation(s), for reasons explained in section five, it endorsed a single agency recommendation made by the Safer Lambeth Partnership. This means the Safer Lambeth Partnership will use the learning from this DHR to work with the MPS to identify how to improve relationships between Black communities and the police.

6.2.8 The third area relates to the identification and response to concerns about young people, particularly where there are issues around them being missing, as well as possible Child Criminal Exploitation. Without seeking to minimise Aiden's actions, the Review Panel also felt it appropriate to note that, as a child, he had periods of going missing, was potentially at risk of Child Criminal Exploitation, and had extensive contact with a number of different agencies. In relation to much of this contact, the Review Panel felt that Aiden was seen and treated as an adult, despite being under the age of 18 and therefore still a child until 2014.

6.2.9 The Review Panel has received assurances that practice across a range of agencies has significantly changed since the contact with Aiden in this context. While accepting these assurances, the Review Panel has made a recommendation that Lambeth and Lewisham LSCPs receive this report and consider its findings.

6.2.10 Finally, the Review Panel has – as discussed in the conclusion above – wrestled with issues of definition, particularly around different types of domestic violence and abuse including IPV, AFV and CPV. The Review Panel felt its own struggles with definition and understanding were likely reflective of wider professional understanding in this area. As a result, while there is work ongoing in Lambeth, recommendations have been made for the wider partnership to look at the local response to these issues and develop it for the future. The Review Panel has also recommended HM Government plays its part in supporting learning in this area.

6.2.11 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Fortunately, Lambeth has a well-developed VAWG strategy. Many of the recommendations made in this review will build on, or add to, the initiatives that are already underway to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared

responsibility as it really is everybody's business to make the future safer for others.

7. Recommendations

7.1 Single Agency Recommendations

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section three following the analysis of contact by each agency and are also presented collectively in **Appendix 3**. These are as follows:

MPS

7.1.2 It is recommended that South East Basic Command Unit (BCU) Senior Leadership Team (SLT) review systems in place for offender management and the Emerald Warrants Management System (EWMS) as the new BCU forms and goes forward.

Hetherington Group Practice

7.1.3 The Practice Domestic Abuse policy needs to be amended to include how the practice will respond if a perpetrator discloses or is registered with the practice, as well as clarifying details of the Practice Domestic Abuse Lead, the local referral pathway and Domestic Abuse training resources.

Safer Lambeth Partnership

7.1.4 To use the learning from this DHR, as well as other local and national research, to work with the MPS to identify how to improve relationships between Black communities and the police.

SLaM

Local recommendations

7.1.5 LEO CMHT to develop a local protocol to state that once an initial assessment has been done, the outcome of the assessment should be discussed at the next MDT meeting and any plans put in place to address the key issues relevant to risk.

7.1.6 LEO CMHT to develop a protocol to state that relatives and patients are to be given a copy of the treatment care plan on the day of the assessment including crisis contact details.

7.1.7 The LEO CMHT induction package to highlight how to access medical members of the team for advice.

7.1.8 LEO CMHT to develop a consistent approach and framework for conducting assessments including consideration of collateral sources of information.

Trust wide recommendations

7.1.9 A Trust-wide piece of work to be done to share the learning from other domestic homicide cases that have taken place in the Trust.

7.1.10 The Trust should assure itself that all practitioners are sufficiently aware of the need for domestic abuse routine enquiry as part of full needs and risk assessment. The Think Family approach demonstrates that this should not solely focus on service user's vulnerability, but also carers and other family members, if relevant. Staff should also consider the needs of male victims of domestic abuse.

7.1.11 The Trust should assure itself that staff are aware of the MARAC referral processes, local borough arrangements and the standards expected when there are high risk domestic abuse concerns.

7.2 Multi Agency Recommendations

7.2.1 The Review Panel has made the following recommendations as part of the DHR. These are described in section three as part of the analysis and are also presented collectively in **Appendix 4**.

7.2.2 These recommendations should be acted on through the development of an action plan, with progress reported on to the Safer Lambeth Partnership within six months of the review being approved.

7.2.3 **Recommendation 1:** The Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and satisfy itself that Child A and Child B (as well as their families) are in receipt of trauma informed support to cope with both the aftermath of the homicide and the publication of the DHR.

7.2.4 **Recommendation 2:** After publication of this DHR, the Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and ensure that this report is attached to Child A and Child B's records. This is so that, if they wish to read the DHR when they are older, it will be available to them.

7.2.5 **Recommendation 3:** The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV. This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance.

7.2.6 **Recommendation 4:** The Lambeth CCG to further promote the Living Well Network Hub to ensure that all GPs are aware that mental health referrals should be made via this route.

7.2.7 **Recommendation 5:** The MPS to undertake a training needs assessment to identify the skills and training that police officers require to respond to AFV/CPV.

7.2.8 **Recommendation 6:** The MPS to audit the 'Strengthening Local Policing' programme' to ensure it enables a consistent and robust process for the supervision all of domestic abuse incidents / crimes.

7.2.9 **Recommendation 7:** The MPS to identify the root cause of the delay in the response to Mia's report and ensure that this is addressed in its IT 'Changes Project' in order that such excessive delays cannot occur in the future.

7.2.10 **Recommendation 8:** The Safer Lambeth Partnership to work with local partners to review the findings from this DHR and develop the response to AFV / CPV locally. This should include identifying the actions that agencies can take individually and collectively, as well as completing a training needs assessment to identify the skills and training that professionals require to respond.

7.2.11 **Recommendation 9:** Lambeth Together to consider the learning from this DHR in relation to meeting the needs of local communities, including the provision of culturally appropriate services, a diverse workforce and creating opportunities to build trust with communities.

7.2.12 **Recommendation 10:** The Safer Lambeth Partnership to share this DHR with the Lambeth and Lewisham LSCPs with the expectation that they consider the findings in relation to contact with Aiden.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Elaine and Aiden following the death of Elaine in April 2018. The DHR is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Elaine and Aiden who are believed to have begun to live together at the same property in London from approximately 01/01/2016 to the date of the homicide (April 2018) (inclusive).
2. The timeframes for review are as follows:
   - Aiden - from the 01/01/2011 (when he first came into contact with services)
   - Elaine) - from 01/01/2016 (when she moved to London. Agencies should provide a summary of any previous contact where it is relevant).
3. Additionally, to review the involvement of each individual agency, statutory and non-statutory with two other subjects, focusing on any contact relating to domestic violence and abuse and summarising any other contact where this is relevant:
   - Rachel - Aiden's mother
   - Mia - Aiden's ex-partner.
4. 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.
5. To 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.
6. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
7. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency

approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

8. To contribute to a better understanding of the nature of domestic violence and abuse.
9. To highlight good practice.

Role of the Independent Chair, the Review Panel and the Safer Lambeth Partnership

10. The Independent Chair of the DHR will:

a) Chair the DHR Review Panel.
b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

11. The Review Panel:

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;

- The report provides an accurate description of the circumstances surrounding the case; and
- The analysis builds on the work of the IMRs and the findings can be substantiated.

h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

i) On completion present the full report to the Safer Lambeth Partnership.

j) Implement your agency's actions from the Overview Report Action Plan.

The Safer Lambeth Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan.

b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.

c) Forward Home Office feedback to the family, Review Panel and STADV.

d) Agree publication date and method of the Executive Summary and Overview Report.

e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

12. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that domestic violence and abuse is:

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

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

13. In using this definition, the Review Panel will be mindful that this case relates to Adult Family Violence.

Equality and Diversity

14. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Elaine and Aiden (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
15. The Review Panel identified the following protected characteristics of Elaine and Aiden as requiring specific consideration for this case:
    - Religion and belief (Elaine was a Christian and was an active member of a Protestant faith community; Aiden's religion and belief are unknown at the start of the DHR)
    - Race (both Elaine and Aiden were/are Black Caribbean)
    - Sex (Elaine was female, Aiden is male)
16. The following issues have also been identified as particularly pertinent to this homicide:
    - Adult Family Violence
    - Substance Misuse (Aiden had contact with services in relation to this issue)
    - Mental Health (Aiden had contact with mental health services)
    - Youth Crime (Aiden had contact with both the Police and Youth Offending Services).
17. Consideration will be given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

If it is the case that any party is an adult at risk, the Review Panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

18. *Expertise:* The Review Panel will secure representation from a Black, Asian and Minority Ethnic (BAME) organisation to act as an expert/advisory panel member to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide. The Review Panel will also secure representation from an appropriately qualified advisor in relation to Adult Family Violence.
19. If Elaine and Aiden have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
20. The Review Panel agrees it is important to have an intersectional framework to review Elaine and Aiden's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

21. There is an inquest into the death Elaine and the Review Panel will ensure the DHR process dovetails with the Coroner Inquest.
22. There is a mental health investigation reviewing the care and treatment provided to Aiden led by South London and Maudsley NHS Foundation Trust in line with the Serious Incident Framework, 2015. It was agreed that a link will be made to this parallel review.

23. It will be the responsibility of the Independent Chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

[Criminal trial disclosure dealt with in disclosure paragraph below]

Membership

24. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
25. The following agencies are to be on the Review Panel:
    a) Gaia Centre (provided by Refuge)
    b) Guy's and St Thomas' NHS Foundation Trust
    c) Kings College Hospital NHS Foundation Trust
    d) Lambeth Clinical Commissioning Group
    e) Lambeth Council Adult Social Care
    f) Lambeth Council Children's Social Care
    g) Lambeth Council Housing Services
    h) Lambeth Council Neighbourhoods and Growth (Violence against Women and Girls Programme Team)[97]
    i) Metropolitan Police Service (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and Specialist Crime Review Group)
    j) National Probation Service and Community Rehabilitation Company
    k) NHS England
    l) South London and Maudsley NHS Foundation Trust - Mental Health
    m) South London and Maudsley NHS Foundation Trust - Substance Misuse
    n) Victim Support
26. Elaine or Aiden had contact with two other local authority areas (in Buckinghamshire and the London Borough of Lewisham). The Review Panel considered this and a Community

[97] Renamed as the 'Integrated Children's Commissioning and Community Safety' during the course of the DHR.

Safety Partnership representative from each area will sit on the Review Panel to facilitate agency contact, information sharing and the development of any recommendations. As appropriate, any other agency representative from that area will be invited to attend the Review Panel.

27. The involvement of General Practices will be facilitated by the relevant Clinical Commissioning Group.
28. As set out in paragraph 18 the following will contribute to the review as experts:
    a) *Adult Family Violence* - Simon Kerrs, Lecturer in Criminology, Anglia Ruskin University
    b) *BAME communities*: Black Thrive and the SAFE Communities Project, Standing Together[98].
29. The South London and Maudsley NHS Foundation Trust and NHS England will be the panel members to ensure good cross communication with parallel mental health investigation review (see paragraph 22).

Role of Standing Together Against Domestic Violence (Standing Together) and the Review Panel

30. Standing Together have been commissioned by the Safer Lambeth Partnership to independently chair this DHR. Standing Together have in turn appointed their DHR Associate James Rowlands to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Support Officer (Helene Berhane) is the primary point of contact for the DHR and the DHR Team Manager (Gemma Snowball) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

31. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

[98] Subsequently unable to participate.

32. **Chronologies and Individual Management Review (IMRs)** will be completed by the following organisations known to have had contact with Elaine and Aiden during the relevant time period:
    - Metropolitan Police Service
    - General Practice - Hetherington Group Practice and Dr Santamaria's Medical Practice (patient list taken on by Clapham Family Practice) (GPs for Aiden)
    - South London and Maudsley NHS Foundation Trust - Mental Health Trust (in regard to Aiden)

Lewisham

- Lewisham Council - Youth Offending Service (in regard to Aiden)
- Lewisham Council - Children's Social Care Services (in regard to the risk associated with Aiden, his ex-partner Mia and Child A)
- Single Homeless Intervention and Prevention (SHIP) (in regard to Aiden)

Buckinghamshire

- Oxford Health NHS Foundation Trust, Mental Health Services (in regard to Elaine)
- Medical Centre (GP for Elaine)

Other

- Surrey Police (in regard to Aiden)

33. **Short reports**, addressing contact, agency policy / procedures and any learning, will be completed by the following organisations known to have had contact with Elaine and Aiden during the relevant time period:
    - Guys and St Thomas Hospital NHS Foundation Trust/ Evelina London
    - Kings College Hospital NHS Foundation Trust

Lewisham

- Lewisham and Greenwich NHS Trust – Health visiting services (in regard to the risk associated with Aiden, his ex-partner Mia and their Child A)

Buckinghamshire

- Local Authority District Council – Housing
- Buckinghamshire Healthcare Trust - Hospital / community nursing (in regard to the contact with Elaine and her child)

34. As a number of additional requests for information were agreed at the first panel meeting, further agencies may be asked to completed chronologies and IMRs if their involvement with Elaine and Aiden becomes apparent through the information received as part of the review.
35. Each IMR / short report will:
    - Set out the facts of their involvement with Elaine and/or Aiden;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.
36. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Elaine and Aiden in contact with their agency.

Key Lines of Inquiry

37. In order to critically analyse the incident and the agencies' responses to Elaine and/or Aiden, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Elaine and / or Aiden [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Specific consideration to the following issues:

- Adult Family Violence
- Substance Misuse
- Mental Health
- Youth Crime

h) Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

38. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Lambeth Partnership on their action plans within six months of the Review being completed.
39. The Lambeth Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

40. The review will sensitively attempt to involve the family(s) of Elaine and Aiden in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Metropolitan Police Service Family Liaison Officer (FLO) and thereafter specialist support where relevant (e.g. Victim Support Homicide Service or Advocacy After Fatal Domestic Abuse). In seeking this involvement, the review will be mindful of the additional sensitivities that arise in the context of Adult Family Violence.
41. The Review Panel discussed the involvement of children in the DHR at the 1st panel meeting and have decided it is inappropriate for this review given their ages. Consideration to any issues with the children has been addressed through specific requests for Individual Management Reviews from the relevant agencies.

42. Aiden will be invited to participate in the review, following the completion of the criminal trial.
43. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
44. The Review Panel discussed involvement of other informal networks of the Elaine/Aiden and agreed it was proportionate to the DHR to seek to identify following persons (neighbour, colleagues, members of church/religious organisation) to be involved as the DHR progresses.

Media handling

45. Any enquiries from the media and family should be forwarded to the Safer Lambeth Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Lambeth Partnership will make no comment apart from stating that a review is underway and will report in due course.
46. The Safer Lambeth Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

47. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
48. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
49. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
50. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the

password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.

51. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a Gmail / Hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
52. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

53. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.
54. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with DHRs and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full

disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

- The review team should be informed about the existence of information relevant to an inquiry in all cases; and
- The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
- partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:

i) It is needed to prevent serious crime

ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

55. If there is a police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.
56. The DHR Chair will discuss the issues of disclosure in this case with the police Disclosure Officer.
57. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 2: MPS Vulnerability Assessment Framework and quick guide tool

Stage 1 - understand the Met definition for vulnerability

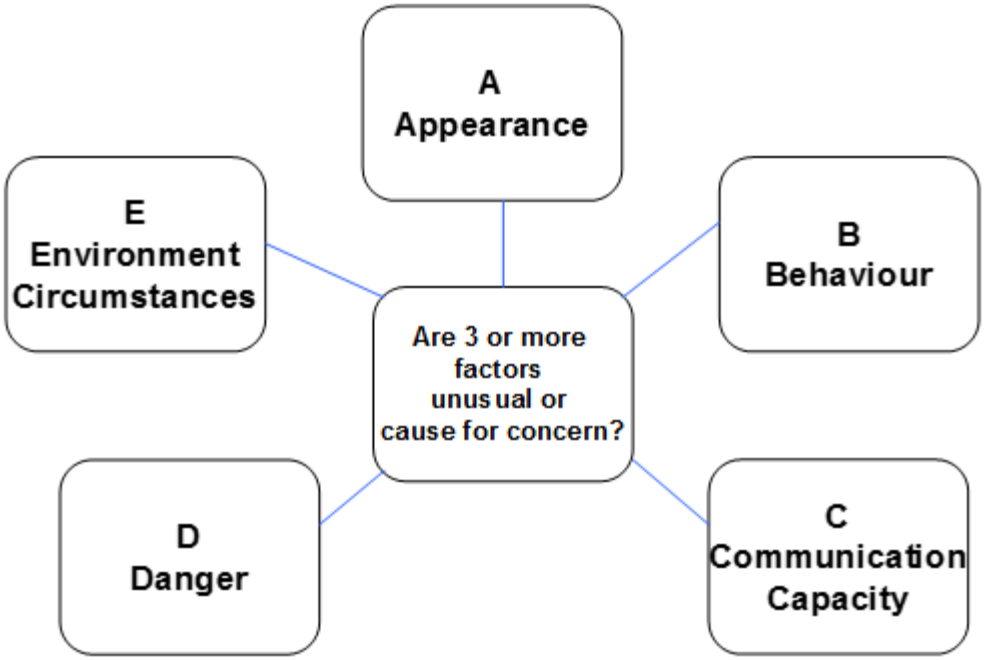
Vulnerability may result from an environmental or an individual's circumstance or a person's behaviour indicating that there may be a risk to that person or another.

Those who come to the notice of the police as vulnerable will require and appropriate response. This may include a multi-agency intervention, if required especially if this is a repeat victim. Additionally one's vulnerability may be linked to their current mental health, or their disability, age or a physical illness.

Stage 2 - carry out the vulnerability assessment using the ABCDE tool

When coming in contact with a member of the public - from victims and witnesses to suspects - all Met personnel must carry out the VAF to identify any vulnerability. The use of Vulnerability Assessment Framework (VAF) at the earliest stage possible will maximise any early intervention opportunities and may help prevent victimisation (see figure 1).

Figure 1: Vulnerability Assessment Framework (VAF)



A - Appearance

- Is there something about their appearance that is unusual or gives rise for concern? Do they look ill, injured, unsettled, anxious?
- What can be observed immediately about the person in distress?
- What is the demeanour of the person?
- Is there a physical problem e.g. bleeding, panic attack?

B - Behaviour

- Is there something about their behaviour that is unusual or gives rise for concern? Are they excitable, irrational, manic, slow, furtive?
- What are they doing and is it in keeping with the situation?

C - Communication/ Capacity

- Is there something about the way that they communicate that is unusual or gives rise for concern?
- Is their speech slurred, slow, fast?
- Are their eyes glazed, staring, dilated/ What is their body language and are they displaying any subtle signs of stress or fear?
- Do they understand your questions?

D - Danger

- Is there a risk of danger / harm to themselves or another?

E - Environment/ Circumstances

- Is there something about the environment that is unusual or gives rise for concern?
- What is the time of day?
- Where do they live? Can they get home?
- Has the incident that they are involved in significantly affected their circumstances?
- What are the circumstances? Are they unusual or out of the ordinary.
- Does anything give rise to concern? (This could include a hunch or intuition).
- Has there been a significant change in the person's circumstances?

Points worth considering when dealing with a member of the public

- Has the subject been identified as being vulnerable using the VAF framework?
- Is this person an Adult at Risk as defined by the Care Act 2014 definition (care and support needs)? -
- Are there concerns regarding their mental health or subject to current Mental Health legislation?

Create a Merlin when 3 or more of the 5 VAF areas are identified, and a CRIS record if a crime is alleged.

Create an ACN only if there are fewer than 3 VAF areas identified and there is a cause for concern for the adult. Ensure the reason for the creation of an ACN is given in all cases together with the person's views regarding any consent for referral. This is a mandatory field in MERLIN.

The VAF must be recorded as a narrative on the circumstances section on MERLIN reports by the reporting officer.

Appendix 3: Single Agency Recommendations and Template Action Plan

MPS

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
It is recommended that South East Basic Command Unit (BCU) Senior Leadership Team (SLT) review systems in place for offender management and the Emerald Warrants Management System (EWMS) as the new BCU forms and goes forward	Regional	*How exactly is the relevant agency going to make this happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*

Hetherington Group Practice

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
The Practice Domestic Abuse policy needs to be amended to include how the practice will respond if a perpetrator	Local	*How exactly is the relevant*	*Which agency is responsible*	*Have there been key steps that have allowed the*	*When should this be completed by?*	*When is the recommendation and*

discloses or is registered with the practice, as well as clarifying details of the Practice Domestic Abuse Lead, the local referral pathway and Domestic Abuse training resources		*agency going to make this happen?* *What actions need to occur?*	*for monitoring progress of the actions and ensuring enactment of the recommendation?*	*recommendation to be enacted?*		*actually completed?* *What does the outcome look like?*

Safer Lambeth Partnership

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
To use the learning from this DHR, as well as other local and national research, to work with the MPS to identify how to improve relationships between Black communities and the police.	Local / Regional	*How exactly is the relevant agency going to make this happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*

SLaM

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
LEO CMHT to develop a local protocol to state that once an initial assessment has been done, the outcome of the	Local	*How exactly is the relevant*	*Which agency is responsible*	*Have there been key steps that have allowed the*	*When should this be completed by?*	*When is the recommendation and*

assessment should be discussed at the next MDT meeting and any plans put in place to address the key issues relevant to risk		*agency going to make this happen?* *What actions need to occur?*	*for monitoring progress of the actions and ensuring enactment of the recommendation?*	*recommendation to be enacted?*		*actually completed?* *What does the outcome look like?*
LEO CMHT to develop a protocol to state that relatives and patients are to be given a copy of the treatment care plan on the day of the assessment including crisis contact details	Local	-	-	-	-	-
The LEO CMHT induction package to highlight how to access medical members of the team for advice	Local	-	-	-	-	-
LEO CMHT to develop a consistent approach and framework for conducting assessments including consideration of collateral sources of information	Local	-	-	-	-	-
A Trust-wide piece of work to be done to share the learning from other domestic homicide cases that have taken place in the Trust	Trust wide	-	-	-	-	-
The Trust should assure itself that all practitioners are sufficiently aware of the need for domestic abuse routine enquiry	Trust wide	-	-	-	-	-

as part of full needs and risk assessment. The Think Family approach demonstrates that this should not solely focus on service user's vulnerability, but also carers and other family members, if relevant. Staff should also consider the needs of male victims of domestic abuse						
The Trust should assure itself that staff are aware of the MARAC referral processes, local borough arrangements and the standards expected when there are high risk domestic abuse concerns	Trust wide	-	-	-	-	-

Appendix 4: Multi Agency Recommendations and Template Action Plan

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1: The Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and satisfy itself that Child A and Child B (as well as their families) are in receipt of trauma informed support to cope with both the aftermath of the homicide and the publication of the DHR	Cross borough	*How exactly is the relevant agency going to make this happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress and ensuring enactment?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
2: After publication of this DHR, the Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and ensure that this report is attached to Child A and Child B's records. This is so that, if they wish to read the DHR when they are older, it will be available to them	Local	-	-	-	-	-
3: The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV.	National	-	-	-	-	-

This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance						
4: The Lambeth CCG to further promote the Living Well Network Hub to ensure that all GPs are aware that mental health referrals should be made via this route	Local	-	-	-	-	-
5: The MPS to undertake a training needs assessment to identify the skills and training that police officers require to respond to AFV/CPV	Regional	-	-	-	-	-
6: The MPS to audit the 'Strengthening Local Policing' programme' to ensure it enables a consistent and robust process for the supervision all of domestic abuse incidents / crimes	Regional	-	-	-	-	-
7: The MPS to identify the root cause of the delay in the response to Mia's report and ensure that this is addressed in its IT 'Changes Project' in order that such excessive delays cannot occur in the future	Regional	-	-	-	-	-
8: The Safer Lambeth Partnership to work with local partners to review the findings from this DHR and develop the response to AFV / CPV locally. This should include identifying the actions that agencies can take individually and	Local	-	-	-	-	-

collectively, as well as completing a training needs assessment to identify the skills and training that professionals require to respond						
9: Lambeth Together to consider the learning from this DHR in relation to meeting the needs of local communities, including the provision of culturally appropriate services, a diverse workforce and creating opportunities to build trust with communities	Local	-	-	-	-	-
10: The Safer Lambeth Partnership to share this DHR with the Lambeth and Lewisham LSCPs with the expectation that they consider the findings in relation to contact with Aiden	Local	-	-	-	-	-

Appendix 5: Glossary of Terms

124D	(MPS) document that supports the gathering of evidence and acts as an aide memoir for police officers attending an incident
39/24	(Surrey Police) Child Referral Form
A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
AFV	Adult Family Violence
BCU	(MPS) Borough Command Unit
CAD	Computer Aided Dispatch
CAIT	(MPS) Child Abuse Investigation Team
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CMHT	(SLAM) Community Mental Health Team
CPS	Crown Prosecution Service
CPV	Child to Parent Violence
CRIS	(MPS) Crime Recording and Information System
CSC	(Lambeth) Children's Social Care
CSP	Community Safety Partnership
CSU	(MPS) Community Safety Unit
DASH	Domestic Abuse Stalking and Harassment
DHR	Domestic Homicide Review
DVPN	Domestic Violence Prevention Notice
EWMS	Emerald Warrants Management System
FLO	(MPS) Family Liaison Officer
GBH	Grievous Bodily Harm
GP	General Practitioner
GSTT	Guys and St Thomas' NHS Foundation Trust
HCP	(MPS) Health Care Practitioner
HMIC	Majesty's Inspectorate of Constabulary
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
IIO	(MPS) Initial Investigating Officer
IMR	Individual Management Review
IPV	Intimate Partner Violence
IT	Information Technology
LAS	London Ambulance Service
LEO	(SLAM) Lambeth Early Onset Team
LGT	Lewisham and Greenwich NHS Trust
LSAB	Local Safeguarding Adults Board
LSCP	Lambeth Safeguarding Children Partnership
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multi-Disciplinary Team

MERLIN CAN	(MPS) report completed by police officer when they encounter an adult in circumstances that cause a concern
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
NHSE	National Health Service (England)
NMO	Non-Molestation Order
OIC	(MPS) Officer in the Case
RC	Responsible Clinician
SAFE	(STADV) Safety Across Faith and Ethnic (Communities Project)
SAFE	Safety Across Faith and Ethnic Communities Project
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SCARF	(Surrey Police) Single Combined Assessment of Risk Form (replaced the 39/24)
SCRG	(MPS) Specialist Crime Review Group
SHIP	(Lewisham Council) Single Homeless Intervention and Prevention
SIO	(MPS) Senior Investigating Officer
SLaM	South London and Maudsley NHS Foundation Trust
SLT	Senior Leadership Team
SOP	(MPS) Standard Operating Procedures
STADV	Standing Together Against Domestic Violence
VSHS	Victim Support Homicide Service
VAF	Vulnerability assessment framework
VAWG	Violence against Women and Girls
YOS	Youth Offending Service