# SAFER CROYDON PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

## Overview Report into the death of Emma and Child A

## June 2019

**Independent Chair and Author of Report: James Rowlands**

**Associate, Standing Together Against Domestic Abuse**

**Date of Final Version: August 2022**

"*Emma was my sister. She was full of life, unconditionally loving and always wanting to help no matter the sacrifice. She was kind, adventurous and unique. We don't know how to live without her. From a young age our mother had taught us how to be independent. This shaped Emma into the mother she wanted to be, but also the fierce independent woman she was.*

*Emma was always trying to find her way in the world and had followed many career routes to determine this. After leaving college education, she developed a passion for vehicles. This created a spark in her which formed her love of Motorcycles, and her attraction to Ryan. Emma was a carefree spirit, who wanted to prove that a female's abilities were not limited to the stereotypical views and became educated about Motorcycles and learnt to ride these. This fuelled her and encouraged her to seek a career in driving larger delivery lorries, then becoming a London bus driver, and working as a delivery driver, before finally settling into the Royal Mail where she wanted to thrive.*

*Emma's pregnancy was unexpected but impacted her in a positive way. It allowed her to want to settle down and set her eyes towards the future. I believe this is why Ryan and Emma's relationship came to an end. It was unforeseen and a shock to those around her. But Emma knew what she wanted for her baby. She once referred to Ryan as being a "child", and that she already had one on the way that she now needs to care for. It was stability that she wanted to provide for her child. This did not affect her decision of wanting Ryan in their child's life. Emma encouraged them to put their relationship aside and focus on amicably co-parenting. Which felt promising.*

*Emma grew up in a huge family with many siblings. And would fight the world to care and protect every single one of them. She was loved by many, partially for her ability to walk into a silent room and fill it with joyful smiles and laughter due to her playfulness.*

*One of my most cherished memories of my sister was watching her love and care for my child from day one. She loved them so much. They had their own special bond. It breaks my heart every time I reminisce about this and have to face the reality that they were too young to even remember her. Emma was more of a protector rather than an individual who would lay out her burdens. Which is why no one knew of any issues between Ryan and her.*

*Hours before she died, Emma came into my room where our mother, my child, and I were watching T.V. She brought a packet of cards with her to challenge us to a game, which our mother accepted. We laughed and joked. We sung and smiled. We went to sleep peacefully with so much love in our hearts, only to be awaken by death.*

*What kind of person was my sister? A mother who fought to protect her child until her last breath. A sister who we could always count on through thick and thin. A daughter who loved and cared for her parents. An Aunty, a niece, a cousin, a friend, a colleague. Someone who has touched many lives and will never be forgotten*".

**Pen Portrait by Samantha, Emma's sister**

# 1. Preface

## 1.1 Introduction

1.1.1 The Review Panel firstly expresses its sympathy to the family of Emma for their loss and thanks them for their contributions to and support for this process.

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

1.1.3 This DHR examines agency responses and support given to Emma,[1] a resident of the London Borough of Croydon (hereafter 'Croydon') prior to the point of her being killed at her home in late June 2019. Emma, who was eight months pregnant at the time of her death, was killed by her ex-boyfriend Ryan[2]. Emma had separated from Ryan sometime towards the end of 2018 or early in 2019. In the early summer Emma had started a new relationship with Joseph.[3]

1.1.4 Emma was found with multiple stab wounds by family members in her bedroom on the ground floor of the family home. Despite the efforts of staff from the London Ambulance Service (LAS), tragically Emma died at the scene. Her child, who was named by family members, was delivered by emergency caesarean at the scene before being taken to hospital. Sadly, Child A died a few days later.

1.1.5 Some two weeks later, Ryan was arrested and charged with killing Emma, the manslaughter of Child A, and the possession of an offensive weapon. In July 2020 Ryan was found guilty of murdering Emma, the manslaughter of Child A, and possessing an offensive weapon. He will serve a minimum term of 35 years.

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] Not her real name.

[2] Not his real name.

[3] Not his real name.

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.

## 1.2 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 Croydon Partnership – commissioned this DHR. Having received notification from the Metropolitan Police Service (MPS) in July 2019, a decision was made to conduct a DHR in consultation with CSP partners in the same month. Subsequently, the Home Office was notified of the decision in writing in August 2019.

1.2.2 Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in November 2019. The delay in appointing a chair was a result of restructuring within Croydon Council. This impacted the capacity available to support DHRs within the Violence Reduction Network. This also meant case information was not provided to Standing Together until January 2020.

1.2.3 The completed report was handed to the Safer Croydon Partnership in February 2022. In February 2022, it was tabled at a meeting of the Safer Croydon Partnership Board and signed off, before being submitted to the Home Office Quality Assurance Panel in March 2022. In May 2022, the completed report was considered by the Home Office Quality Assurance Panel. In July 2022, the Safer Croydon Partnership received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2.4 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 (originally scheduled for April 2020 but subsequently delayed to July 2020 as a result of the Covid-19 pandemic. This also meant the first panel occurred after the conclusion of the criminal trial);
- The need 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 (see 1.9); and
- The ongoing impact of the Covid-19 pandemic (while the Review Panel was able to continue operating during this period, the availability and capacity of some members of the Review Panel and the transfer of meetings online extended the duration of the DHR).

## 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 the only child related to this DHR being referred to as Child A). 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 Emma |
|---|---|
| Emma | n/a |
| Ryan | Ex-boyfriend |
| Child A | Child |
| Alice | Mother |
| Samantha | Sister |
| Victor | Father |
| Aria | Cousin |
| Hazel | Mother of Ryan |
| Joseph | New Boyfriend of Emma |
| Henry | Manager at Royal Mail |

1.3.4 The family of Emma was offered the opportunity to choose the pseudonyms used in this report and asked the chair to do so on their behalf. The family subsequently had sight of a draft of this report and have agreed the pseudonyms that were chosen.

## 1.4 Equality and Diversity

1.4.1 The chair and the Review Panel considered 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 Emma was female, and Ryan 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.[4]

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

- *Disability*: Emma had no known disability; Ryan had a diagnosis of Autistic Spectrum Disorder (ASD), with this sometimes being recorded by agencies as 'Asperger's'.[5]
- *Pregnancy and maternity*: Emma was pregnant when she was attacked;
- *Race*: Emma was Black British; Ryan was also Black British; and
- *Sexual orientation:* although Emma was killed by Ryan in the context of a heterosexual relationship, she had previously been in a same sex relationship.

1.4.4 The Review applied an intersectional framework to understand the lived experiences of both the victim and perpetrator. This means the Review Panel sought to explore how an individual's characteristics may have combined or intersected to create heightened and persistent forms of inequality, marginalisation, disadvantage, and powerlessness. An intersectional approach to DHRs is vital in identifying and analysing the multiple and overlapping barriers that create vulnerability and risk. These issues are considered throughout this report and summarised in 5.4 below.

## 1.5 Terms of Reference

[4] "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 Standing Together 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.

[5] ASD is the medical name for autism. Being autistic does not mean someone has an illness or disease. It means their brain works in a different way from other people. Autism is a spectrum: Some autistic people need little or no support. Others may need help from a parent or carer every day. For more information, go to: https://www.nhs.uk/conditions/autism/what-is-autism/.

1.5.1 The Terms of Reference are included at **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 was comprised of agencies from Croydon (where Emma lived), as well as Southwark (where Ryan was living). Agencies were contacted as soon as possible to inform them of the DHR, invite their participation and to ask them to secure their records. In relation to Southwark, specific agencies were also asked to participate on the Review Panel.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of January 2014 to the date of the homicide. This date was chosen because Emma and Ryan's relationship was believed to have begun in either 2014 or 2015. It was also agreed that agencies would summarise any relevant contact with either Emma or Ryan before this date if relevant.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered the statutory guidance and identified 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 Emma and/or Ryan [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 in domestic abuse issues;
- Specific consideration to the following issues: the impact of Ryan's reported violence against his mother, his childhood experiences and his ASD diagnosis; and
- Analyse any evidence of help seeking (in particular as Emma had limited contact with services), as well as considering what might have helped or hindered access to help and support.

1.5.5 The Review Panel benefited from the involvement of additional expertise to support its work:

- The Croydon BME Forum[6] nominated a panel representative who acted as a critical friend and brought experience relating to the experience of Black, Asian, Minority Ethnic and Refugee (BAMER) communities;
- The South London and Maudsley NHS Foundation Trust (SLaM) nominated a panel representative with expertise in relation to ASD;[7] and
- The Family Justice Centre (FJC), which provides domestic abuse services locally.[8]

1.5.6 The chair and Review Panel are grateful for their time and input. Their contribution is a reminder of the importance of being able to access local community and/or expertise and knowledge in the course of a DHR.

## 1.6 Methodology

1.6.1 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 and 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 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."*

[6] The Croydon BME Forum is an umbrella organisation for Croydon's Black and Minority Ethnic voluntary and community sector. For more information, go to: https://cbmeforum.org.

[7] Provides NHS mental health, as well as drug and alcohol, services in in South London. For more information, go to: https://www.slam.nhs.uk.

[8] Provides support for people affected by domestic abuse in Croydon. For more information, go to: https://www.croydon.gov.uk/community/dabuse/fjc.

1.6.2 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.

1.6.3 This definition includes domestic abuse in intimate and familial relationships. In this DHR, while the focus is on Emma as a victim of domestic abuse by her former partner (Ryan), the Review Panel has also considered other information about Ryan's behaviour, including towards his mother (Hazel). This is described in the chronology and discussed further in the section 5.1 of the analysis.

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

1.6.5 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. As there was involvement both in Croydon and Southwark, scoping was completed in both areas. A total of 26 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, four had only limited contact and submitted a Summary of Engagement only. However, 12 had more extensive contact and were asked to submit either a Short Report or an Individual Management Review (IMR). A narrative chronology was also prepared.

1.6.6 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Emma and Ryan.

1.6.7 However, the diversity and equality analysis in the IMRs was weak. Largely, where information was presented, this listed any relevant Protected Characteristics, rather than analysing how these might have come together to affect someone's experiences and the circumstances in which these occurred, including the effect on their needs and risk, as well as barriers to help and support. As a result, all agencies who submitted IMRs were asked to submit revisions to address these issues and the Review Panel had extensive discussions relating to intersectionality. This is a reminder of the importance of integrating an intersectional analysis from the start, with this then being threaded throughout an IMR's analysis (and the DHR itself) rather than treated as an 'add on' when dealing with the section on equality and diversity.

1.6.8 Seven IMRs made recommendations of their own, and in some cases IMRs reported changes in practice and policies over time. These are described in the analysis (section 5).

1.6.9 *Documents Reviewed:* In addition to the above information, a number of other documents have been reviewed. These are referenced in this report.

1.6.10 *Interviews Undertaken:* The chair interviewed both family members and Emma's manager during the course of this DHR. For more information, see 1.9 below.

## 1.7 Contributors to the Review

1.7.1 The following agencies in Croydon were contacted, but recorded no involvement with the victim or perpetrator:

- Croydon Council - Adult Social Care.
- Croydon Council - Children Social Care.
- FJC.
- National Probation Services (NPS).
- Turning Point[9].

1.7.2 The following agencies in Southwark were contacted, but recorded no involvement with the victim or perpetrator:

- Change Grow Live.[10]
- Guy's and St. Thomas' NHS Foundation Trust.
- Solace Women's Aid.[11]
- Southwark Drug and Alcohol Action Team.
- Southwark Multi Agency Risk Assessment Conference (MARAC).

1.7.3 The following agencies made contributions to this DHR:

| Agency | Contribution |
|---|---|
| Croydon Council Housing | Short Report |
| Croydon Health Services NHS Trust (CHS)[12] | IMR and Chronology |
| General Practice (GP) 1 – GP for Ryan (Completed by South East | IMR and Chronology |

[9] Provides the Croydon Recovery Network, a drug and alcohol service. For more information, go to: https://www.turning-point.co.uk/services/croydon.

[10] Provides the Drug and Alcohol Service in Southwark. For more information, go to: https://www.changegrowlive.org/drug-alcohol-service-southwark

[11] Solace Advocacy & Support Service provides support to survivors of domestic abuse in Southwark. For more information, go to: https://www.solacewomensaid.org/service/solace-advocacy-support-service-southwark.

[12] Croydon Health Services provides integrated NHS services to care for people at home, in schools, and health clinics across the borough as well as at Croydon University Hospital and Purley War Memorial Hospital. For more information, go to: https://www.croydonhealthservices.nhs.uk.

| | |
|---|---|
| London Clinical Commissioning Group (CCG) on behalf of the GP) | |
| King's College Hospital NHS Foundation Trust (KCH)[13] | Short Report |
| GP 2 – GP for Emma | IMR and Chronology |
| London Ambulance Service (LAS) | Summary of Engagement |
| London Community Rehabilitation Company (CRC)[14] | IMR and Chronology |
| MPS | Short Report |
| Royal Mail (Emma's employer) | Short Report |
| SLaM | Summary of Engagement |
| Southwark Council – Adult Social Care Services | Summary of Engagement[15] |
| Southwark Council – Community Harm & Exploitation Hub (on behalf of the Southwark Anti-Violence Unit (SAVU)[16] | IMR and Chronology |
| Southwark Council – Children Social Care Services | Summary of Engagement |
| Southwark Council – Housing Solutions | Short Report |
| Southwark Council – Resident Services | Short Report |
| Victim Support[17] | Short Report |

[13] KCH provides a wide range of specialist acute and elective inpatient and outpatient NHS services across a number of hospital and community sites throughout the South East. For more information, go to: https://www.kch.nhs.uk.

[14] In 2014, the probation sector was separated into a public sector organisation that managed high-risk criminals (the NPS) and 21 private companies that supervised low- to medium-risk offenders (CRCs). This arrangement has been brought to end, meaning all probation work will, once again, be the responsibility of the NPS. In London, this transfer will happen from June 2021. This means the NPS will be responsible for the implementation of any recommendations for the London CRC.

[15] As will be discussed in the chronology, despite reports of referrals being made by the MPS, Adult Social Care had no records relating to incidents in 2013 and 2014.

[16] Set up in 2012, the SAVU was a multi-agency team tackling serious youth violence, gang involvement and its associated criminality. It was made of a number of statutory and voluntary sector agencies. The SAVU no longer exists. In July 2019, the SAVU was absorbed/transferred into a new Community Harm & Exploitation Hub Operations Group. For further information, see the discussion in the analysis (section 5).

[17] Victim Support deliver the London Victims and Witness Service, which offers offer initial support and information to anyone affected by crime. For more information, go to: https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/london.

1.7.4 Additionally, information was also provided by LAS, who provided medical care to both Emma and Child A after Emma was stabbed in late June. LAS otherwise had not had any contact with Emma or Ryan.

## 1.8 The Review Panel Members

1.8.1 The Review Panel members were:

| Name | Job Title | Agency |
|---|---|---|
| Alison Eley | Named Nurse for Safeguarding Children and Domestic Violence and Abuse Lead | South London and Maudsley NHS Foundation Trust (SLaM) |
| Alison Kennedy | Operations Manager | FJC |
| Bethan West | Head of Community Harm and Exploitation Hub (CHEH) (representing the former SAVU) | Southwark Council |
| Ciara Goodwin | Domestic Abuse & Sexual Violence Coordinator | Violence Reduction Network, Place Department, Croydon Council |
| Clare Capito | Deputy Regional Maternity Lead for London | NHS England and NHS Improvement |
| Clare Tebbutt | Independent Casework Manager | Royal Mail |
| David Lynch | Trust Safeguarding Adults/Prevent Lead | SLaM |
| Dawn Mountier | Safeguarding Officer, Quality and Assurance Directorate | London Ambulance Service (LAS) |
| Dr Dene Robertson | Autism Spectrum Disorder (ASD) expert | SLaM |
| Estelene Klaasen | Designated Nurse Safeguarding Adults | South West London CCG (including Croydon) |
| Dr Fazia Mehdi[18] | Named GP Safeguarding Adults | South East London CCG (including Southwark) |
| Felisha Dussard | Critical Friend | Croydon BME Forum |

[18] Towards the end of the DHR, the CCG was represented by Dr Megan Morris.

| | | |
|---|---|---|
| Florence Acquah | Designate Nurse Safeguarding Adults | South East London CCG |
| Hannah Edwards | Southwark Safeguarding Children Partnership and Southwark Safeguarding Adults Board manager – Southwark CSP link | London Borough of Southwark |
| Heather Payne | Head of Adult Safeguarding | KCH |
| Helen Rendell | Detective Sergeant – Specialist Crime Review Group | MPS |
| Jenny Moran | Quality Assurance Officer | Adult Social Care, Croydon Council |
| Jo Joannou | Operational Manager, Council Homes Districts and Regeneration | Housing Services, Croydon Council |
| Lucien Spencer | Area Manager – London South East Area | CRC |
| Paulin Sullivan | Young People's Team Manager | Turning Point |
| Rachel Nicholas | Head of Services | Victim Support |
| Rebecca Harding | Safeguarding Children and Adult Lead (Croydon) | SLaM |
| Ricky Bellot | Housing Choice and Supply Manager | London Borough of Southwark – Housing (Housing Options) |
| Robertson Egueye | Area Manager | London Borough of Southwark – Housing (Resident Services) |
| Sarah Hayward | Director, Violence Reduction Network | Place Department, Croydon Council |
| Selene Grandison | Head of Service Delivery – Croydon, Sutton and Merton | NPS |
| Dr Shade Alu | Director of Safeguarding | CHS |
| Shaun Hanks | Head of Quality Assurance & Safeguarding | Children Social Care Service, Croydon Council |
| Valentine Nweze | Head of Adult Mental Health Substance Misuse, Operations | Adult Social Care, Croydon Council |

| | | |
|---|---|---|
| Yvonne Wright | Safeguarding Specialist | LAS |

1.8.2 *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.

1.8.3 The Review Panel met a total of four times, and the first meeting was on the 28th July 2020. There were further meetings on the 25th November 2020, the 24th February 2021 and the 10th May 2021. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft in July and August 2021. The Overview Report was circulated in November 2021 and then in January 2022 for sign off once family members had provided feedback

1.8.4 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 the wider community.

*Family*

| Name[19] | Relationship to victim | Means of involvement |
|---|---|---|
| Alice | Mother | Ongoing contact and reviewed the draft Overview Report. |
| Samantha | Sister | Provided a Pen Portrait and other information via email. Reviewed the draft Overview Report. |
| Victor | Father | Reviewed the draft Overview Report |
| Aria | Cousin | Reviewed the draft Overview Report |

1.9.2 The Safer Croydon Partnership notified Emma's mother and father respectively of the decision to conduct a DHR by letter in October 2019. This was a delay of 4 months, despite the statutory guidance requiring notification within 1 month. This was because of the capacity issues as detailed in 1.2.2. In response, and

[19] Not their real names.

to ensure that this is not repeated, Croydon Council have put systems in place to prevent this from happening including an internal DHR flowchart specifically outlining timeframes to be adhered to. Given action has been taken to address this issue, the Review Panel felt it was important to acknowledge this delay but have decided not to make a recommendation.

1.9.3 Standing Together were appointed to chair the DHR in November 2019 but did not receive case information until January 2020. Thereafter, in February 2020, the chair wrote to Emma's mother (Alice) and father (Victor) respectively. The letters provided information about the DHR process and how family could participate. The letters were shared with the MPS Family Liaison Officer (FLO) as they were in contact with both Alice and Victor.

*Alice (Emma's mother)*

1.9.4 As Alice had been referred to the Victim Support Homicide Service (VSHS)[20], the chair liaised with her caseworker. With Alice's consent, this liaison continued throughout the DHR.

1.9.5 Initially, Alice indicated she did not feel able to take part in the DHR and that she would contact the chair when she was ready. In October 2020, Alice approached her caseworker and said she was now ready to participate. As a result, in that same month, Alice and the chair spoke for the first time. In a subsequent call, Alice (who spoke with the chair alongside her daughter, Samantha) identified three key issues, each of which has been considered by the Review Panel and which are addressed in this report:

- Health contact with Emma relating to her pregnancy, and how the pregnancy related to the end of the relationship with Ryan;
- Which agencies were involved with Emma and Ryan; and
- Why information was not shared between agencies in Southwark and Croydon.

1.9.6 A meeting was arranged with Alice in February 2021 but did not go ahead, however Alice has been involved with the DHR, communicating with the chair directly and/or via her caseworker.

1.9.7 Alice also introduced the chair to Samantha (Emma's sister). Subsequently, Samantha also participated in the DHR, providing a Pen Portrait (included at the front of this report) and responding to questions from the chair by email (summarised in section 4). Samantha was also provided with information on both VSHS and Advocacy After Fatal Domestic Abuse (AAFDA)[21].

---

[20] VSHS supports families bereaved by homicide. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

[21] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

1.9.8 At the start of September 2021, the chair met with Alice and Samantha to discuss and share the Overview Report. Having had time to read and comment on the Overview Report in that month, they provided feedback to the chair. Overall, they were content with the Overview Report, saying "*although it is very difficult to read, it has helped us to see a bigger picture of the situation*". They were also able to help provide some additional information to ensure the report was accurate. Alice and Samantha were thereafter kept up-to-date with the progress of the DHR.

*Victor (Emma's father)*

1.9.9 As Victor was not being supported by any agency providing specialist advocacy support, the letter sent to him by the chair in February 2020 provided information on both VSHS and AAFDA.

1.9.10 After the first DHR panel meeting, as the chair had not been contacted by Victor, the MPS were asked – via the FLO – to make a further approach. In August 2020, Victor told the FLO he had not received the letter from the chair but wanted to know more about the DHR. The letter was re-sent via the FLO.

1.9.11 As a Serious Further Offence (SFO) Review – see 1.11 below – was also being completed, it was identified that the London Community Rehabilitation Company (CRC)[22] was in contact with Victor. As contact had not been established with Victor by the chair, the London CRC was asked to provide Victor with information on the DHR process. This was completed December 2020.

1.9.12 There were further attempts to contact Victor in March and August 2021. After the last attempt Victor contacted the chair. He and a cousin of Emma (Aria) met with the chair and subsequently received a copy of the draft report. In November 2021, Victor and Aria provided written feedback and Victor and Aria were thereafter kept up-to-date with the progress of the DHR.

*New Partner, Friends, Neighbours and Wider Community*

1.9.13 Consideration was initially given to approaching Emma's new partner, Joseph, as well as friends, neighbours and wider community.

1.9.14 Emma's new partner also worked at the Royal Mail. Information on the DHR was provided to the Royal Mail to share with Joseph, but ultimately the Royal Mail felt that it was not appropriate to invite Joseph to contribute because of concerns about his well-being. The Review Panel accepted this advice from the Royal Mail.

[22] The London CRC is a private-sector provider that delivers probation services to offenders who are assessed as being at low or medium risk of re-offending. For more information, go to: https://www.mtcgroup.org.uk/our-services/probation/london-community-rehabilitation-company/.

1.9.15 In relation to friends, neighbours, and wider community, all the witnesses known to the MPS as part of the murder enquiry where either family members or otherwise professionals involved in the incident. Consequently, the Review Panel did not identify any friends, neighbours, and wider community who could be invited to be part of the review.

*Employers*

1.9.16 Emma was employed by the Royal Mail and her manager, Henry, was interviewed. As part of this process Henry was provided with the relevant Home Office leaflet and, although willing to be interviewed, declined further involvement or support. Information from Henry is summarised in section 4.

## 1.10 Involvement of Perpetrator, Family, Friends, Work Colleagues, Neighbours and Wider Community

*The Perpetrator*

1.10.1 The Review Panel has limited additional information about Ryan.

1.10.2 Ryan chose not to participate in the DHR. When a letter was sent to Ryan in prison, no response was received. Subsequently, Ryan's Prison Offender Manager was approached and spoke with Ryan. He confirmed that Ryan did not want to participate.

*The Perpetrator's Family, Friends, Work Colleagues, Neighbours and Wider Community*

1.10.3 In March 2021, the chair wrote to Hazel, Ryan's mother, to invite her to participate in the DHR. In March 2021, Hazel contacted the chair and declined to take part.

## 1.11 Parallel Reviews

1.11.1 *Criminal trial*: Ryan was charged with murder in July 2019 and, in December 2019, pleaded not guilty to charges of killing Emma, the manslaughter of Child A, and the possession of an offensive weapon. Following a trial in June 2020, Ryan was convicted of all three offences.

1.11.2 Although the first meeting of the Review Panel took place after the conclusion of the trial, a member of the MPS murder inquiry was invited to the first meeting to provide a briefing on the case.

1.11.3 *The Coroner's Inquest*: The death of Emma was referred to the HM Coroner. An inquest was opened and then discontinued after the conviction of Ryan.

1.11.4 *Serious Further Offence (SFO) Review:* A SFO Review is undertaken when an individual who is being supervised by either the National Probation Service (NPS) or a CRC commits a specified serious offence. In undertaking an SFO, the NPS or CRC must transparently and rigorously review their work and

provide an understanding of what happened. The SFO Review was disclosed to the chair as part of the DHR process, with the CRC summarising the learning in its IMR.

## 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 Standing Together. James has received DHR Chair's training from Standing Together. He has chaired and authored 13 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 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. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.

1.12.3 *Independence:* James has no connection with the local area or any of the agencies involved, although he is concurrently chairing another DHR in the borough.

## 1.13 Dissemination

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Croydon 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 local partners, and also published. 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 Safer Southwark Partnership in Newham for dissemination to partners in that borough, 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 the Safer Croydon Partnership, with Croydon Council's Violence Reduction Network being responsible for monitoring the recommendations and reporting on progress.

## 1.14 Previous case review learning locally

1.14.1 As of May 2021, this is the 9th DHR commissioned locally. The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations that were specifically relevant to this case.

1.14.2 Published DHRs can be found at https://www.croydon.gov.uk/community/dabuse/homicide-review.

# 2. Background Information (The Facts)

| The Principal People Referred to in this report | | | | | | |
|---|---|---|---|---|---|---|
| **Referred to in report as** | **Relationship to Emma** | **Age at time of Emma's death** | **Ethnic Origin** | **Faith** | **Immigration Status** | **Disability** |
| Emma | n/a | 26 | Black British | Christian | UK Citizen | No |
| Ryan | Ex-boyfriend | 25 | Black British | Unknown | UK Citizen | No |
| Child A | Child | Born by emergency caesarean | Black British | - | UK Citizen | No |
| Alice | Mother | - | - | - | - | - |
| Samantha | Sister | - | - | - | - | - |
| Victor | Father | - | - | - | - | - |
| Aria | Cousin | | | | | |
| Hazel | Mother of Ryan | - | - | - | - | - |
| Joseph | New Boyfriend of Emma | - | - | - | - | - |
| Henry | Manager at Royal Mail | - | - | - | - | - |

## 2.1 The Homicide

2.1.1 Homicide: On a day in late June 2019, family members of Emma were woken by her screams. Emma, who had been in her bedroom on the ground floor of the family home, was found unconscious by family members. She had multiple stab wounds. A family member called the emergency services but, despite the efforts of paramedics, tragically Emma died at the scene. At the time of her death, Emma was eight months pregnant. Child A was named by family members after being delivered by emergency caesarean at the scene. They were then taken to Croydon University Hospital and then to St. Georges Hospital. Sadly, Child A died a few days later.

2.1.2 At the time, no assailant was identified although it subsequently became apparent that Ryan had gained access to the property through an open patio door in Emma's bedroom. (Family members told the MPS during the murder enquiry that Emma was unable to open the door from inside herself. This suggests the door was opened from the outside, but it was not possible to determine if force was used).

2.1.3 During the murder enquiry, the police identified Closed Circuit Television (CCTV) footage of a man walking to, and shortly after, away from Emma's home. Another man was initially arrested and interviewed but then released.

2.1.4 Initially, Ryan was treated as a family member. When spoken to by Police Officers he showed no emotion and said he had lost his phone, providing an old one to the MPS. Some two weeks later, Ryan was arrested and charged with killing Emma, the manslaughter of Child A, and the possession of an offensive weapon. At first, Ryan denied any involvement in Emma's murder, claiming he was at his mother's address at the time, before producing a prepared statement in which he admitted murdering Emma.

2.1.5 Prior to his arrest, Ryan had spent time with Emma's family and visited Child A in hospital. In a discussion with the chair, Alice talked of the additional distress that Ryan's duplicity had caused. Ryan had, for example, told her at the time that, *"we will get him".* Victor and Aria also talked about feeling distraught when Ryan was arrested, saying of his behaviour, "*This has left the family feeling quite traumatised as we were welcoming a murderer into our home*".

2.1.6 *Post mortem*: A Post Mortem was conducted and gave the cause of death as (multiple) stab wounds to Emma's chest. This meets the definition of 'overkill'. This is the term used to describe the use of gratuitous violence that goes further than that which is necessary to cause the victim's death.[23]

2.1.7 *Criminal trial outcome*: Despite admitting to murdering Emma after his arrest, Ryan subsequently pleaded not guilty to the charges against him. Ryan claimed that another male, a friend who he said was a local drug dealer, had confessed he was responsible. Ryan's trial was initially delayed for a mental health assessment. Subsequently, he was found fit to stand trial and in July 2020 he was found guilty. Ryan received a life sentence (35 years) for murdering Emma, as well as 20 years for the manslaughter of Child A, and 3 years for possessing an offensive weapon. The sentences will run concurrently, meaning he will serve a minimum term of 35 years.

2.1.8 The Judge said: "*It's clear from all the evidence this was the most vicious and deliberate killing*," adding that the attack was a "*cowardly*" response to Emma saying she wanted nothing more to do with Ryan.

[23] Long, J., Harper, K., and Harvey, H. (2018) *The Femicide Census 2017 Findings: Annual Report on UK Femicides 2017.* Available at: https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/ (Accessed: 22nd February 2020).

## 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, Emma was 26 years old and was Black British. Her family had moved to the UK from Mauritius and Emma was born in England.

2.2.2 In terms of her intimate relationships, Emma's family described her as a private person. However, they were aware that prior to Emma's relationship with Ryan, Emma had been in two same sex relationships.

2.2.3 Emma had no known disability and, although she had received a Christian baptism as a teenager, she did not practice a faith as an adult. Emma was eight months pregnant when she was killed.

2.2.4 Most recently, Emma worked for the Royal Mail, having joined the company in 2018. She lived within her family's home, which was privately rented.

2.2.5 *Background Information relating to the Perpetrator:* At the time of the homicide, Ryan was 25 years old. He is Black British. Ryan had been in a heterosexual relationship with Emma.

2.2.6 Ryan had been diagnosed with an Autistic Spectrum Disorder (ASD) at the age of 13. Ryan had experienced significant behavioural issues as a child and young person, as well as one period where there was a concern about serious and concerning paranoid thoughts and behaviours. Ultimately, he was diagnosed as having ASD but no learning disability. It is not known if Ryan had a particular faith.

2.2.7 There is limited information available on Ryan's employment. It appears he had left school at 16 and then completed a pre-apprenticeship with a transport company. He left this job when he was 18 and worked and undertook training in the construction industry. This work was often casual and/or short term and involved travel across the South East of England.

2.2.8 Ryan was recorded as living in Southwark (with his mother, Hazel), up to 2017 by some agencies, although it is likely he was sofa surfing during this period. He was placed in accommodation in Hackney between February and May 2015 as part of his support from SAVU, before disengaging from the service in March 2017 and leaving his placement. From June 2017, Ryan was in Croydon, with agency records showing Ryan as resident at both Emma's home address and another address in the borough after 2017.

2.2.9 *Synopsis of relationship with the Perpetrator:* Emma and Ryan are believed to have begun their relationship in 2014 or 2015 and had separated at some point between December 2018 and early 2019.

2.2.10 Early in the summer of 2019, Emma had started a new relationship with Joseph. It is likely that Ryan was aware that Emma had started to see Joseph.[24]

[24] Based on the account of Emma's manager. See section 4.

2.2.11 *Members of the family and the household:* At the time of the homicide, Emma was living in the family home, which she shared with her mother, two brothers, sister and her sister's baby.

# 3. Chronology

3.1.1 The chronology has revealed that Emma had relatively limited contact with agencies. Moreover, with reference to their relationship, little was known to agencies.

3.1.2 In contrast, Ryan had an extensive history of contact with agencies. This spans the timescales prior to and under review (i.e., before and after 2014). The Review Panel felt that Ryan's previous contact was potentially relevant, particularly in so far as it may inform an understanding of his behaviour, including violence and abuse in other relationships.

3.1.3 As a result, the Review Panel agreed to divide the chronology into two sections. While recognising that this posed some challenges in terms of readability, the Review Panel felt this was the best way to present the available information. This was principally out of concern that further integrating the chronologies would mean the DHR would lose sight of Emma, given most of the agency contact was with Ryan. Consequently, the chronology is divided into two parts:

- Addressing contact with Emma by agencies during the timescales under review, integrating any associated contact with Ryan; and
- Summarising relevant contact with Ryan only by agencies before and after the timescales under review.

### Chronology from year to year (timescales under review relating to Emma)

***2014***

3.1.4 On the 15th April 2014 Emma was seen by a GP at Ackerman Health Centre for medical issues (she had been registered at the practice as a child).

***2015***

3.1.5 On the 7th March 2015, a friend of Emma called the MPS. They reported that Emma had been assaulted by her ex-girlfriend, to whom she had been returning property to after a separation. Emma's ex-girlfriend reportedly poured cold water over Emma's head and then pushed her to the floor causing Emma to bang her head. When police officers spoke with Emma, she said that she would not support an investigation and was no longer in contact with her ex-girlfriend. As a result, while a Domestic Abuse, Stalking and Harassment (DASH) Risk Indicator Checklist (RIC)[25] was completed, (with the incident assessed as being standard risk) the case was closed.

3.1.6 As a result of the MPS contact with Emma, she was automatically referred to Victim Support, with this referral being made on the 9th March. There is no record to indicate that information on this being a same sex relationship was included in the referral (i.e., it would have been basic information on the offence). A first attempt to contact Emma on the 12th

[25] The DASH RIC to a tool to provide a uniform understanding of risk across professions. There is a specific police version of the risk checklist, which is used by most police forces in England and Wales. For more information, go to: For http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face.

March was unsuccessful, although she was contacted the next day. Emma spoke to a Victim Contact Officer and said she was fine and did not want any support although she did agree to have contact detail information sent by text. Subsequently, the case was closed although the MPS was not informed of this outcome.

3.1.7 On the 6th August 2015 Emma was seen by her GP for a review relating to abdominal pain. This was a result of a pre-existing condition, which was chronic and therefore led to intermittent contact with health providers. At this appointment, Emma also talked about stress at work. She was given information on the local Improving Access to Psychological Therapies (IAPT) service.[26] [27]

3.1.8 It is not clear when Emma started to see Ryan, but by the end of 2015 they were in a relationship.

***2016***

3.1.9 On the 31st August 2016 Emma attended CHS's Emergency Department (ED) with a cough and ankle pain. Emma said that she had been in a road traffic accident on the 28th August, involving a collision between a car and a motorbike. It is not recorded which vehicle Emma was travelling in. Emma said she had come into the ED on the day of the accident and had been treated but no record of this could be found. Emma was assessed but she left before having any treatment.

3.1.10 On the 14th October, Emma and Ryan were stopped and searched by police officers (this was the first time there was reference to Emma and Ryan together known to agencies). A bag of herbal cannabis was found the in the foot well of the car and Ryan was given a Fixed Penalty Notice for possession. This is the only contact that the MPS had with Emma and Ryan and there were no indications or disclosures of domestic abuse during this incident.

***2017***

3.1.11 No information recorded for Emma.

***2018***

3.1.12 In August 2018, Emma began working at the Royal Mail. There were no concerns about her attendance or issues noted on her personnel record (with the exception being absences relating to her pregnancy which was confirmed towards the end of the year).

3.1.13 In the same month, Emma re-registered at the GP 2. In October 2018, Emma was seen by the GP 2 for treatment relating to a minor injury arising from an animal bite (she had originally contacted NHS 111,[28] was given advice to manage the injury and directed to her GP).

---

[26] IAPT services provide evidence-based psychological therapies to people with anxiety disorders and depression.

[27] IAPT services in Croydon are provided by SLaM, for more information go to: https://slam-iapt.nhs.uk. SLaM has no record of Emma accessing its services.

[28] Given this was a single contact, and Emma had been treated at the practice, the Review Panel did not seek further information on this contact with NHS 111.

3.1.14 Emma attended the CHS's Emergency Department on four separate occasions with abdominal pain as a result of a pre-existing condition, with these being unrelated to her subsequent pregnancy. On all these occasions Emma was discharged home with medication, except one where she left before being seen. On each occasion, discharge summaries were sent to Emma's GP (GP 2).

3.1.15 Of these attendances, two are of note:

- When Emma attended on the 14th December, her pregnancy was confirmed. Emma was unaware that she was pregnant and was referred to her GP for antenatal care (although there is no information on the clinical record about Emma's reaction, this is the event Samantha referred to when Emma became aware she was pregnant. Samantha described Emma as being "*surprised*" but "*ecstatic*"). There is no record of Emma's relationship with Ryan recorded; and
- On 21st December Emma attended Emergency Department with abdominal pain, and on this occasion, she was accompanied by a friend. It is not documented whether this friend was male or female. The friend who accompanied Emma was "*unhappy with the level of questioning*" by the doctor who was asking questions about her symptoms and her past medical history. The records say that the "*patient agreed to stop*" after her friend had expressed unhappiness around the level of questioning. During the consultation Emma told the doctor that she was happy and supported and that she was living with her parents, her partner (it is not documented whether this was Ryan) and her sister. Following the consultation, Emma was discharged home with medication.

3.1.16 During Emma's attendance at the Emergency Department, Ryan was not recorded as her next of kin.

***2019***

3.1.17 At some point in early 2019, Emma and Ryan separated.

3.1.18 Between the 4th January 2019 and the 6th June Emma was seen on ten separate occasions for antenatal care by staff at CHS. For most of these appointments, there is little information recorded beyond confirmation of the reason for attendance. There was more detailed information recorded for two appointments:

- On the 22nd January Emma attended an antenatal booking appointment. Emma's records say that the assessment was completed but the standard domestic abuse question that is included in the booking template was not asked. This was because Emma's partner was present. The midwife who saw Emma said that her partner was silent throughout consultation; and
- On 18th March Emma attended an antenatal doctor's appointment, and it was recorded that she was seen in the presence of her sister. Again, the standard domestic abuse question was not asked.

3.1.19 Reflecting the information provided by Emma during her attendances, Ryan was not recorded in any hospital systems as Emma's next of kin or her partner.

3.1.20 During her booking appointment on the 22nd January, Emma reported back pain. This led to an appointment with GP 2 where she was provided with advice and referred for a physiotherapist assessment.

3.1.21 All Emma's subsequent contact with the GP 2 was related to various medical issues, largely related to her antenatal care. No issues were disclosed, or concerns identified, that might indicate an issue with domestic abuse.

3.1.22 Between 2010 and 2018, Emma attended KCH's Emergency Department on 11 occasions (at two of these, in November 2016 and December 2018, she left before being seen by a doctor). Her presentations did not require any in-patient admissions. The Review Panel has considered each attendance, and the medical issue with which Emma presented. These all appear to be related to Emma's physical health and, while there were no indicators of concern, there is also no evidence that staff attempted discussions regarding Emma's home life, domestic abuse, or her mental wellbeing.

3.1.23 On the 13th March, Emma made an application to Croydon Council Housing. This was an online application and Emma disclosed some basic information (e.g., that she was in part time employment, was applying for herself with no dependents) and identified what she would consider (i.e., she would consider housing outside the borough, specifically Lambeth). Emma did not provide any further information (e.g., medical details). This application did not progress any further. According to Victor, Emma went to Croydon Council Housing in June in the company of another family member to follow this application up. However, checks have revealed no record of her attendance.

3.1.24 After separating from Ryan, in the early summer Emma had started a new relationship with Joseph. For the reasons stated in Section 1, the Review Panel has no further information about this relationship.

3.1.25 After Emma's murder, the MPS murder enquiry identified that Ryan had access to Emma's emails via his phone (it is not clear when and how Ryan came to have access). The murder enquiry also identified that, on the day of her death, Emma's emails were accessed for approximately an hour, just prior to Ryan leaving to murder her. One hypothesis is that Ryan had become aware of Emma's new relationship with Joseph as a result of monitoring her emails and conducting his own covert enquiries rather than having been specifically told about it.

## Relevant agencies contact with Ryan before and after the timescales under review

### *Up to 2012 (i.e., when Ryan was under 18)*

3.1.26 As a child, Ryan was diagnosed with ASD in 2007. Thereafter, his behaviour became increasingly challenging. His mother reported being unable to manage this behaviour, and there was also at least one report of a period of paranoia. There were also several reports made to the MPS that Ryan had either intimidated or assaulted his mother between 2009-2010. This led to referrals to both Southwark Council Children's Social Care Service as

well as the Child and Adolescent Mental Health Service (CAHMS) at SLaM.[29] Ryan had one conviction as a child for theft.

***After 2012 (i.e., when Ryan was over 18)***

3.1.27 Ryan was known to the MPS for several reasons, including five convictions as an adult including a single drug offence.

3.1.28 Between May 2013 and October 2014, there are eight recorded domestic abuse incidents known to the MPS relating to Ryan's mother (Hazel). When Hazel spoke with police officers, she described all these incidents as being arguments that escalated when Ryan had either caused damage to the home or in some cases either threw things at her or pushed her. Hazel also talked about Ryan's anger and her difficulties in managing him, citing several issues including his aggression and saying on one occasion that Ryan had been diagnosed with ASD and she needed support to manage his behaviour. The main issue was housing, with Hazel asking police officers to remove Ryan at least once. Meanwhile, Ryan also told police officers on several occasions that the key issue was a lack of housing.

3.1.29 All these incidents were recorded as domestic abuse incidents and Domestic Abuse Stalking and Harassment (DASH) risk assessments were completed. These were all recorded as standard risk, bar one incident which was recorded as medium (this was not because of any specific disclosures, but because Hazel was unwilling to answer any questions. In this situation, MPS policy is to grade incidents as medium risk). However, as Hazel declined to support the investigation during each incident, these were all ultimately closed. As a result, none of these reported incidents led to any further action.

3.1.30 In some incidents, police officers took additional actions. For example:

- In September 2013, an Adult Come to Notice (ACN) was created in relation to Ryan and shared by email with Southwark Council Adult Social Care Services. (There is no record held by Adult Social Care relating to this).
- Additionally, a police officer took Ryan to Southwark Council's Housing Solutions Service to arrange temporary accommodation. The police officer made several follow up calls to Housing Solutions, but this does not appear to have led to anything as, when they later contacted Hazel, Ryan had slept rough overnight and then returned home. At this point, Hazel reported, "*there have been no problems with him since then*". (Although there is no record of this approach identified by Housing Solutions, see below);
- In January 2014, a police officer directly spoke with Southwark Council's Vulnerable Adult Team to discuss support for Ryan, although they did not complete an ACN (there is no record held by Adult Social Care relating to this). Additionally, the crime report states that Hazel said that she and Ryan had attended Southwark Council's

[29] The Review Panel made the decision to summarise this historical contact rather than undertaking an in-depth review. This was based on proportionality, as well as agency capacity. As a result, this DHR has not examined in detail what was known to agencies, or any single or multi-agency interventions, with Ryan as a child or young person.

Housing Solutions to get housing for him (attendance at Housing Solutions is discussed below). Hazel was recorded as telling police officers that Ryan had told Hazel that: "*I'm going to kill you, I don't know when, but I need to plan it properly, if I don't someone else will".*

- In October 2014, a police officer offered to refer Hazel to Solace Women's Aid in Southwark, but Hazel declined both the contact details and or a referral.

3.1.31 In addition to these actions relating to potential vulnerability, as well as housing, police officers were also aware that there may have been an issue around ASD. They, for example, in their contact with Ryan in January 2019, advised other agencies like the SAVU that they felt a diagnosis would assist Ryan in accessing housing support.

3.1.32 Southwark Council Housing's Resident Services, of whom Hazel was a tenant, was approached by Hazel in September 2013. When Hazel spoke with housing officers, she made similar disclosures as she had to the MPS, stating that Ryan was aggressive and destructive. At the time, she reported that Ryan had anger issues and had previously attended anger management counselling sessions[30] but was no longer engaging and could not be forced to attend the sessions. In addition to speaking directly to Hazel, Resident Services also received a risk assessment from the MPS about an incident that police officers had attended at the start of the month. Southwark Council Housing's Resident Services did not undertake a risk assessment itself. (Additionally, as discussed above, it appears that police officers had attempted to liaise with Southwark Council's Housing Solutions Service with limited success).

3.1.33 Hazel was however reluctant to take proactive steps, for example, declining to complete a risk assessment with a housing officer. When offered practical assistance like changes to door locks, Hazel said that she had arranged this herself. She also declined a referral to Solace Women's Aid.

3.1.34 In January 2014, Ryan approached Southwark Council's Housing Solutions Service (this is presumably the same attendance that was disclosed to a police officer, as discussed above). Ryan said he had been made homeless because his mother asked him to leave (it is unclear where he was staying during this time). As part of Ryan's assessment, the housing officer contacted Hazel, who confirmed that she was not willing to have Ryan back in the house, although there is no record as to whether it was explored why this was. It is recorded that "[Hazel] *states that her son was diagnosed with Asperger's, but she is not sure, he also said that he had been diagnosed with Asperger's"*. Ryan was provided with information on renting accommodation in the private sector and also asked to provide some further documentation to progress a homelessness application.

3.1.35 In this same month, Southwark Council Housing's Resident Services received a further risk assessment from the MPS (this related to the incident above, where Hazel told police officers about Ryan's threat to kill her; this was received a day after Ryan had approached

[30] Ryan had spoken about accessing anger management with staff at the SAVU, but this was not arranged or supplied by SAVU. It has not been possible to identify from which service Ryan accessed anger management.

Southwark Council's Housing Solutions Service). A housing officer contacted Hazel, but she did not want any further action to be taken but did ask that Ryan be rehoused. She confirmed that Southwark Council's Housing Solutions were involved, and all the required documentation had been submitted.

3.1.36 There is no evidence to indicate any liaison between Southwark Council Housing's Resident Services and Housing Solutions, which would have brought together Hazel's expressed wishes and Ryan's approach.

3.1.37 In March 2014, Southwark Council's Housing Solutions closed Ryan's case. Ryan had not returned or provided further documents, although it is not clear what other documents were requested. It is also not clear if any further contact was attempted by the service.

3.1.38 In this same month, Ryan became involved with the SAVU, following a referral from the CRC. Ryan was referred into the SAVU after reports of harassment and escalating violence towards him. This included two incidents in 2014 when he had been the reported victim of assaults by groups of men. During this time working with SAVU, he had just over 80 contacts with workers from different agencies. His primary worker was from the London CRC (his first Offender Manager), but he also accessed support from other organisations (including Southwark Anti-Social Behaviour Unit, Department of Work and Pensions, St Giles Trust, and Southwark Works).[31]

3.1.39 On his referral to SAVU, a goal was to find Ryan accommodation outside the borough. Ryan was subsequently rehoused as part of the Southwark Emergency Rehousing Victims of Violent Enterprise (SERVE).[32] Through this scheme, Ryan was placed in Hackney. Normally through the scheme individuals would be placed in hostel accommodation. In Ryan's case, SAVU worked with housing colleagues to try to support Ryan's needs as he had ASD. As part of SERVE, Ryan was supported by SHIAN Housing Association (a housing provider) and Victim Support (a Housing Advocate). He also accessed support from Southwark Council Southwark Council's Housing Solutions Service, as noted above.[33]

3.1.1 Ryan was in employment (in the construction industry, although this was often causal or short term) and had safe temporary accommodation and was bidding for a permanent housing placement, all seen, at the time, as examples of the positive lifestyle changes that he was making.

3.1.40 The SAVU would be involved with Ryan from June 2014 to February 2017 (when, as will be explored, he moved to Croydon).

3.1.41 The SAVU was:

---

[31] The Review Panel has made the decision to request an overarching IMR from SAVU, rather than from each of these individual agencies. The reasons for this are explored further in the analysis.

[32] SERVE provides safe accommodation and mentoring for individuals at serious risk of violence associated with gang and violent crime. This allows individuals to move to a safe property until long term housing can be arranged. SERVE accommodation is temporary accommodation.

[33] Except for Southwark Council Southwark Council's Housing Solutions Service, the Review Panel has made the decision to request an overarching IMR from SAVU, rather than from each of these individual agencies. The reasons for this are explored further in the analysis.

- Aware of Ryan's history of abuse towards his mother. For example, they had on record a comment from his mother that "*when he* [Ryan] *is denied anything or challenged he flies into fits of rage".* As a result, the SAVU team made attempts to reach out and support Hazel. Two attempts were made to meet Hazel, but she chose not to attend;
- SAVU was aware of Ryan's mental health issues from the risk assessment completed by the MPS. In discussion with the support workers who engaged with Ryan, it appears that this did not have a significant impact: Ryan was able to function well enough to secure employment and undertake one to one work, although he did not want to work in larger groups;
- The SAVU was aware of Ryan's ASD diagnosis. Additionally, Ryan had made comments that he did not always take his medication. However, there were no recorded details of his prescription in his notes.
- Ryan would have been asked about his relationships during contact with SAVU and partner agencies, but the IMR noted that Ryan "*never gave details or spoke about a relationship*".

3.1.42 Ryan had been registered with the same GP (GP 1) since his birth. The GP was aware of his ASD diagnosis, which was included in his health records. However, it is not clear from the records how this impacted his daily life, including his ability to access and interact with services.

3.1.43 Ryan had contact with his GP for several issues, including treatments for specific medical issues that the Review Panel determined were not related to this DHR and which are therefore not detailed in this chronology.

3.1.44 Additionally, Ryan attended his GP for multiple minor injuries, usually from falls. Of these, six appear to have been the result of motorcycle accidents between 2014 and 2016. While the GP responded to these presentations, there does not appear to have been any review of this by the GP to identify the cause for so many accidents and whether he was a danger to himself or others on the roads.

3.1.45 Ryan also attended his GP for his mood. The Review Panel felt these contacts may be relevant and they are described here, including on the 29th May 2014 when Ryan telephoned out of hours services stating he was feeling low in mood. He was advised to contact his GP surgery. He then saw the GP on 5th June 2014, who documented that he complained of feeling tired and sleeping all the time. While blood tests were undertaken, there was no exploration of his disclosure to the out of hours service about low mood or any documentation to suggest possible causes (like drug or alcohol use) were explored. There is no reference to any follow up consultation after this attendance.

3.1.46 Ryan was seen again at the GP on the 3rd March 2015, presenting with low mood and depression. His social circumstances were explored by the GP, such as homelessness and unemployment, which is an example of good practice. However, while there was a discussion about these issues as part of an exploration of Ryan's social circumstances, there is no documentation that any actions were taken in response. There is a comment

noting "*interpersonal relationships*", but no further information was recoded, so it is unclear what this means. There is no documentation to indicate that risk to himself or others was explored.

3.1.47 Ryan was prescribed anti-depressants (mirtazapine) and advised to self-refer to the local IAPT service. Although Ryan told the GP that he had made contact, there is no evidence that this happened.[34]

3.1.48 Although the usual follow up period after starting anti-depressants is two weeks, this did not happen, and it is unclear why. However, there were two follow up consultations to review Ryan's situation, on the 27th April and the 14th May 2015. At these consultations, Ryan presented with stress, anxiety and reported being unable to sleep.

3.1.49 In the records, suicide risk (protective and risk factors), risk to others, alcohol and substance misuse, and previous abuse was not documented in any of the consultations. Relationships, including any carer responsibilities, were also not documented. As part of the IMR process, the GP who had contact with Ryan said that they thought that Ryan had a "*chaotic*" lifestyle.

3.1.50 The last time Ryan saw his GP about his low mood was on the 3rd March 2016 when Ryan presented with stress and anxiety and was also treated for an unrelated medical issue. As before, there was no documentation of suicide risk/risk to others, drugs, alcohol, social circumstances, or triggers for relapse.

3.1.51 As the MPS were part of the SAVU, they were also able to provide reports of any further incidents. This would have included a report in May 2015 of an assault by a group of males.

3.1.52 Ryan also reported a few further incidents. In January 2015 he reported the theft of his motorcycle, with similar reports also being made in June and August (Ryan also made a similar report again in June 2019). In all but one of these reports, no further action was taken as there was insufficient evidence (in one, Ryan called back to say he had found his bike). On three occasions, this led to referrals to Victim Support but there was no substantive contact with Ryan.

3.1.53 In October 2016, Ryan was charged with a driving offence. He was sentenced to a 12-month Community Order[35] with 140 hours of unpaid work. As Ryan was assessed as presenting a low risk of harm, he was allocated to the London CRC. However, during his assessment, no Risk Management or Sentence Plans governing his journey through his Community Order were completed. Subsequently, Ryan missed several appointments and claimed this was due to scheduling conflicts with work. However, the result was that he did not complete the unpaid work requirement.

[34] IAPT services in Southwark and Croydon are provided by SLaM, for more information go to: https://slam-iapt.nhs.uk. SLaM has no record of Ryan accessing its services.

[35] A Community Order can be imposed for offences that are serious but not so serious as to warrant custody. It means punishment will be carried out in the community instead of prison.

3.1.54 In May 2017 Ryan was charged with a further driving offence, which led to an 18-month Suspended Sentence Order with 30 days Rehabilitation Requirement[36] and a 3-month curfew. An initial attempt to install monitoring equipment at an address in Southwark was unsuccessful. A person who is on probation can make an application to have a curfew address changed independent. In this case, Ryan made an application to change the curfew address directly via HM Courts & Tribunals Service (HMCTS), offering Emma's address in Croydon. This application was granted by the court, and it was initially made without the knowledge of his probation officer. Subsequently, Ryan completed his curfew, although there were some issues around his compliance.

3.1.55 While Ryan had independently applied to have his curfew address changed, the London CRC was aware that he had moved to Croydon because Ryan told them so. Reflecting this change of address, between May and June 2017 several emails were sent internally within the London CRC to arrange a transfer of Ryan's case from Southwark to Croydon. However, there was no risk assessment of this new address.

3.1.56 Subsequently, Ryan was managed by the London CRC in Croydon from the start of July 2017 by a new Offender Manager.

3.1.57 In July 2017 (the same month that Ryan's case was transferred internally by the London CRC from Southwark to Croydon), Ryan's case was closed to the SAVU because he had moved to another borough. While Ryan had a CRC new offender manager based in Croydon, so a single agency transfer could be made, at the time Croydon did not have the equivalent team as SAVU for Ryan's age group so no 'multi-agency' transfer could be made. Before SAVU cases are closed the individuals being supported are placed on a six-week watching brief. This was the case for Ryan: he was handed a letter stating his case was closed but if he required further help in the future, he could receive further support. He did not come to the attention of SAVU after this date.

3.1.58 Having been transferred, Ryan was assessed again by London CRC. He was assessed as posing a medium risk of reoffending and a low risk of serious harm to others. The key issues identified were supporting Ryan with employment and developing new community ties. However, Ryan's original Offender Manager did not share an up-to-date risk and needs assessment, nor did they share any information in relation to risk, such as background checks with the Police and Children's Services or any ongoing work with the professional network, such as the SAVU. Critically, this meant the new Offender Manager was not aware that SAVU had been working with Ryan when he was in Southwark and that SAVU had information about his relationships (his violence towards his mother), substance misuse (of cannabis), and mental health issues (although this was unconfirmed, and largely based on Ryan's self-disclosure, a Pre-Sentence Report in May 2017 noted that there was no evidence of suicide ideation and self-harm).

[36] When making a community or suspended sentence order, a court may include a rehabilitation activity requirement. This is a requirement that the defendant participates in particular activity to change their behaviour or make amends.

3.1.59 The new London CRC Offender Manager was aware of Ryan's ASD diagnosis. However, it does not appear that there was any exploration of whether Ryan's ASD might have impacted on his ability to engage with his supervision. There was consideration to other issues, with a Kessler assessment[37] being completed in 2016, but the assessment was below the threshold that would have prompted a referral around coping issues, so no referrals were made.

3.1.60 The new Offender Manager appears to have been unaware of Ryan's relationship with Emma. The assessment tools used by the CRC have a specific section on relationships and given Ryan's age, the CRC panel representative noted it would have been appropriate to adopt a more investigative approach around this area.

3.1.61 After this transfer, Ryan initially engaged well with his Offender Manager, either in person or by phone. However, there was some confusion over Ryan's sentence, with the new Offender Manager believing that the original Community Order with unpaid work had been revoked (in fact, the responsible Court had wrongly informed them that Ryan had received a Conditional Discharge[38]). They would also later be under the impression that the Suspended Sentence Order was shorter than in fact it was (because of a data entry error by an NPS administration officer). From November 2017, Ryan's attendance and engagement deteriorated.

3.1.62 Ryan attended CHS's Emergency Department on five occasions in 2017. The reasons for his presentation included back pain (in March), chest pain in April (when he also said he suffered from anxiety), an accident (in May), as well as ear pain (twice in June). On four of these occasions, Ryan said he had come to the Emergency Department because he did not want to wait to see a doctor, but each time he did not wait to be seen.

3.1.63 There is limited information available about these attendances, except for May 2017. On this occasion, Ryan said he had fallen during a recreational activity. As a result, he had been strapped to a trauma mattress (designed to keep a patient immobile). Ryan was with an unidentified female and was able to extract himself from the restraints. The records do not demonstrate whether staff considered, or discussed the safety of, the female who left the department with Ryan. Before he left the Emergency Department, Ryan is recorded as having "*screamed"* at staff. Although a discharge summary relating to this attendance was sent to Ryan's GP, this does not document any details about this incident.

3.1.64 As a result of Ryan's attendance and engagement with his Offender Manager, London CRC began enforcement action in January and February 2018 (this would have meant that Ryan was in breach of his conditions). However, because letters were sent to the wrong address, this could not be enforced. Ryan thereafter had some intermittent contact with his Offender Manager, although he missed several appointments, and in May 2018 his case was closed.

---

[37] The Kessler 6 is a screening tool utilised by the CRC to assess suitability for service users to be referred to further support. The Kessler 6 tool identifies indicators for depression and/or anxiety. It is based on self-disclosure rather than clinical assessment.

[38] The offender is released, and the offence registered on their criminal record. No further action is taken unless they commit a further offence within a time decided by the court (no more than three years).

3.1.65 Emma was recorded as Ryan's next of kin on his electronic patient record (although at one attendance, Ryan had provided another named individual[39] as his next of kin, but Emma was listed on another occasion).

3.1.66 Ryan last saw his GP on the 7th September 2018, this was for a medical issue that the Review Panel felt was unrelated to the DHR.

[39] This individual has not been identified.

# 4. Overview

## 4.1 Summary of Information from Family, Friends and Other Informal Networks

*Samantha (Emma's sister)*

4.1.1 Samantha described Emma as a loving and kind person, who was "*always having a laugh or making you laugh*". She was also someone who was private. Samantha said Emma was a "*secret romantic*" and that "*her one desire was to be a mother and have her own little family life and home*".

4.1.2 Samantha said that the relationship with Ryan started sometime around 2015. When Samantha first met Ryan, she said she knew he "*had a tag*". Although Samantha never found out why, Emma told her it was as a result of a "*misunderstanding"*.

4.1.3 Samantha said that Emma and Ryan had "*regular date nights, and* [they] *would see each other almost every day or night"*. When Samantha moved back in with her mother, she began seeing Ryan regularly in the company of Emma, saying "*it felt like Emma and him* [Ryan] *were going to be together forever*".

4.1.4 Samantha was not aware of any violence and abuse in the relationship, observing, *"I don't believe Emma would've stayed with someone that was abusing her, or keep that a secret".*

4.1.5 However, there were issues in the relationship. Samantha attributed this to Ryan's "maturity levels", saying that Emma referred to him as, "*being like a child*". She also said that Ryan, "*kept Emma away from his social entourage and family life"*.

4.1.6 Samantha said that Emma was "*surprised"* to become pregnant, describing this as a "*shock*", which only came to light after she had attended CHS's Emergency Department in December 2018. Nonetheless, Samantha said Emma was "*ecstatic"*. Samantha said that Ryan was excited too.

4.1.7 However, Emma and Ryan separated and decided to co-parent. Describing Emma's approach, Samantha said: "*Emma was keeping Ryan up to date with the pregnancy and invited him to the appointments. However, towards the end Emma had mentioned that he was no longer turning up to them, so I started to go with her when I was off work*".

4.1.8 Samantha was also aware that Emma had been trying to get new accommodation. Samantha also became aware that Emma was in a new relationship.[40] Emma told her about this relationship shortly before she was killed. Samantha was not sure if Ryan knew about this new relationship.

[40] This was with Joseph.

*Henry (Emma's manager at the Royal Mail)*

4.1.9 Henry knew Emma as he was the on-site manager where she worked. He described Emma as, "*the kind of person who would come in and buy food for staff, putting other people first. She was a very caring person*".

4.1.10 Henry was not aware of any concerns about or for Emma as an employee, with this, reflecting the information shared by Royal Mail in its Summary of Engagement.

4.1.11 Talking about Emma's pregnancy, Henry described Emma as "*very, very happy*". Henry was aware that Emma had been in a relationship with the baby's father that had ended. Like Samantha, he thought that Ryan was "*intending to be involved in the care of the baby saying the* [baby's] *father was apparently being a decent chap. He didn't run off into the hills. He was being proactive, helping financially. He stood up to his responsibilities*".

4.1.12 After Emma was murdered, Henry said: "*It was a really difficult time for everyone. I thought the way that Royal Mail handled the case was amazing. There was a call each day. There was counselling provided for frontline staff*."

## 4.2 Summary of Information from Perpetrator:

4.2.1 Unfortunately, as neither Ryan nor his mother (Hazel) participated in the DHR, there is no further information available relating to Ryan's experiences.

## 4.3 Summary of Information known to the Agencies and Professionals Involved

*Contact with Emma*

4.3.1 Emma had relatively limited contact with services and was resident in Croydon throughout the time period under review. The only significant contact appears to have been with the MPS, and also health providers.

4.3.2 Regarding the MPS, Emma reported a single incident of domestic abuse with a former female partner. This led to contact by Victim Support. When Victim Support received referral information from MPS, it only received basic information on the offence. This may have meant that the Victim Contact Officer would have been unaware that the alleged perpetrator was a female partner. Other than that, Emma only had one further contact with the MPS, when she was stopped and searched in the company of Ryan. No concerns relating to domestic abuse were identified during this incident.

4.3.3 Emma's most extensive contact was with health providers, including her GP (GP 2), as well as KCH (where she had a number of attendances at the Emergency Department), and CHS (attendances at the Emergency

Department, and for antenatal care). At these contacts, the medical response was appropriate, and no specific concerns were identified by professionals about domestic abuse, nor were any issues disclosed by Emma.

4.3.4 However, an examination of these contacts has identified that there were opportunities for professionals to exercise their professional curiosity. This includes an example when Emma attended CHS's Emergency Department in December 2018. Her presentation was related to a known chronic health issue. However, she was in the company of an unknown friend, who was unhappy about the level of questioning and ultimately left. This could have been explored further. Additionally, in her contact with her GP and CHS relating to her pregnancy, there was limited consideration about her family circumstances, including the father of the baby. While there could have been further exploration, it is important to recognise that this to some extent reflected Emma's preferences, as she had been asked about the father and declined to disclose any information. Regardless, this meant Ryan's presence in her life, including its changing circumstances, was not identified.

4.3.5 The only other contact Emma had with any other agency was with Croydon Council Housing, with an application for housing in March 2019. When she made this application, she did not disclose domestic abuse and, as she did not provide some missing information, this application had not progressed by the date of her death.

4.3.6 Notably, there was almost no overlapping contact by agencies with Ryan and Emma. As a result, the information about Emma and Ryan's relationship is limited. Emma and Ryan are believed to have begun their relationship in 2014 or 2015 before, separating in December 2018 or early 2019. In the early summer, Emma had started a new relationship with Joseph.

*Contact with Ryan*

4.3.7 In contrast to the limited agency contact with Emma, agencies had extensive contact with Ryan, albeit this was primarily in Southwark.

4.3.8 Contact with Ryan included concerns about possible domestic abuse involving his mother (Hazel). These were reported to the MPS, but all of these reports were ultimately closed as Hazel did not want to support an investigation. Although there appears to have been some consideration to Ryan's needs in this context, as Hazel said he had Asperger's, this did not lead to any interventions (this was because, for example, police officers did not complete an ACN, while other information sharing with Adult Social Care does not appear to have been successful for an unknown reason).

4.3.9 In her contact with the MPS, Hazel's primary concern was Ryan's housing. This led to contact with both Southwark Council Housing's Resident Services and Housing Solutions Services. However, this contact was disjointed and did not consider potential domestic abuse concerns. For example, Southwark Council Housing's Resident Services relied on a risk assessment by the MPS while

Ryan's approach to Southwark Council's Housing Solutions Service did not link to any coordination between the two services.

4.3.10 Ryan had extensive interaction with a range of agencies because he was referred to SAVU in March 2014. While there was work undertaken with Ryan in relation to a number of issues, in particular, housing, a range of issues have been identified. In particular, there was not a specific consideration of potential risk to Hazel. Additionally, there was limited exploration by, for example, the CRC of his intimate relationships (which may have identified his relationship with Emma).

4.3.11 While Ryan remained involved with the SAVU for some years, in 2017 he moved to Croydon. As a result of this move, in July 2017 his case was closed to SAVU. In the absence of any equivalent multi-agency partnership to manage his risks and needs, there was a reliance on the London CRC to manage this case on a single agency basis. However, internally, this transfer was inadequate and only limited case information was shared. Additionally, there was, for example, only limited exploration of the impact of Ryan's ASD.

4.3.12 Other agencies also had contact with Ryan, including his GP (GP 1). While the response to his health needs was appropriate, as with other agencies, an assessment of his ASD does not seem to have been considered. Ryan also had some contact with CHS's Emergency Department, but none of this contact was identified as being specifically relevant to the DHR.

# 5. Analysis

## 5.1 Domestic Abuse/Violence

5.1.1 Emma was killed following a brutal attack by Ryan. This same attack led to the death of their child a few days after their mother, having been born by emergency caesarean.

5.1.2 However, considering the government definition above, information gathered by the MPS as part of the murder investigation, as well as provided by agencies and family, there is no evidence to indicate whether there was any prior domestic abuse by Ryan toward Emma.

5.1.3 Some pieces of information might however raise potential flags, although they do not in themselves indicate that Ryan was controlling or abusive, for example:

- Based on Samantha's account, it appears that information about Ryan's contact with criminal justice services either had been withheld from Emma, or at least she felt she could not say more to her sister about it; and
- Information identified by the MPS about Ryan's access to Emma's email shortly before he killed her (although it is not clear how Ryan came to have access to Emma's account, and this could have been by agreement, notably he had not un-linked the emails from his phone after the relationship had ended. This access also potentially enabled him to find out about the relationship with Joseph).

5.1.4 The Review Panel also noted the limited information available to agencies about Ryan and Emma's relationship. Emma did not disclose this to agencies, in particular health agencies like CHS and GP 2. There may have been good reasons for this. Samantha has described Emma as a private person, and her relationship with Ryan would have been coming to an end or have ended. Moreover, in later contact with CHS in December 2018 (at the Emergency Department, where she had presented with abdominal pain linked to a pre-existing medical issue), Emma referred to her family and partner (although Ryan was not named) and said she was happy and supported.

5.1.5 Nonetheless, there are some contacts that could point to learning:

- At this same encounter with CHS in December 2018, Emma was accompanied by a friend. This may have been Ryan but is not documented whether this friend was male or female. However, the friend who accompanied Emma was recorded as being "*unhappy with the level of questioning*" and this brought the appointment to a close. Given the identity of this person was not documented, and in the absence of an interview with Ryan, it is not possible to explore this further. However, if this was Ryan, it would have been an opportunity for him to restrict opportunities for agencies to interact with Emma.

- Some agencies appear to have accepted the absence of information about Ryan, without always exploring with Emma why this might have been (such as GP 2). In their interaction with Emma, other agencies likely encountered Ryan but did not document this (such as CHS).
- Conversely, agencies in contact with Ryan (like the CRC and SAVU) were unaware of his relationship with Emma although, as will be explored in this section, this appears to be largely because he was not asked about intimate relationships or, if asked, did not disclose his relationship.

5.1.6 The Review Panel recognised the challenge of such explorations or recording in practice, for example, depending on the context or duration of contact. Nonetheless, further consideration would have been appropriate. In addition to allowing professionals to build a clearer picture of Emma's circumstances, it may have been an opportunity for Emma to disclose. This could have been concerns about domestic abuse if she had been worried or if Ryan's behaviour had escalated or changed after their separation. Alternatively, regardless of the presence of domestic abuse or not, it may have been an opportunity to talk about Emma's separation and what this might mean, including potentially raising a child as a single parent, thereby providing an opportunity to explore support options. Likewise, for Ryan, such consideration could have led to the identification of Emma and an explicit consideration of any risk. These issues are considered further below in relation to individual agencies.

5.1.7 The limited information available also makes it difficult to comment on any evidence of risk, including precursors to the killing of Emma. However, separation and jealousy were likely a factor. Notably, Emma had separated from Ryan. Separation is associated with significantly increased risk from a perpetrator.[41] Additionally, it appears likely that Ryan knew that Emma had started a new relationship with Joseph, possibly because of his access to her emails.

5.1.8 With reference to Ryan's reported access to Emma's emails, and the possibility that he was accessing these to monitor her, there is an increasing awareness of the potential impact of technology-facilitated domestic abuse.[42] However, the Review Panel had limited evidence of this, particularly given it was not possible to interview Ryan. As a result, the Review Panel agreed to note this issue but felt it could not explore technology-facilitated domestic abuse any further.[43]

5.1.9 The Review Panel also considered whether there was evidence of domestic abuse by Ryan towards others, specifically his mother (Hazel), with this consideration being particularly relevant given there is evidence of links between the abuse of

[41] Long, J. and Harvey, H. (2020). *Annual Report on UK Femicides 2018*. Available at: https://femicidescensus.org/wp-content/uploads/2020/02/Femicide-Census-Report-on-2018-Femicides-.pdf [Accessed: 22nd February 2020].

[42] Afrouz, R. (2021) 'The Nature, Patterns and Consequences of Technology-Facilitated Domestic Abuse: A Scoping Review', *Trauma, Violence, & Abuse*, doi: 10.1177/15248380211046752.

[43] The Home Office Quality Assurance Panel suggested that this be explored further but, for the reasons stated above, and in the interests of proportionality, the Review Panel felt it was not possible to do so.

intimate partners and the abuse of family members.[44] Domestic abuse in this context could be described as Adult Family Violence (AFV). Where AFV involves a child-parent relationship it is often referred to as Child to Parent Violence (CPV), although much of the available literature focuses on children and adolescents rather than violence and abuse by adult children.[45] There is no single definition of CPV, but it has been increasingly recognised that this issue is not age specific and there is a need to recognise that child to parent abuse can exist throughout the life course (i.e., adult children can use violence and abuse towards their parents).

5.1.10 There is certainly evidence of incidents which could be considered indicative of AFV/CPV, linked to Ryan's reported behavioural difficulties before the age of 18 and then as an adult, including when Hazel contacted the MPS and approached Southwark Council stating she wanted Ryan rehoused.

5.1.11 However, the Review Panel was not able to reach a conclusion as to the presence or absence of AFV/CPC specifically. This was because of the small number of reports, and because it was not possible to explore these with Ryan as he did not participate in the DHR. Additionally, Hazel has declined to take part in the DHR, and it was therefore also not possible to ask her about her experiences.

5.1.12 Nonetheless, the Review Panel felt there was potentially learning about AFV/CPV, based on whether agencies identified the possibility of AFV/CPV. The Review Panel felt that, because AFV is less well understood than Intimate Partner Violence (IPV), this means the *potential* for risk to others (here, Hazel) may have been less likely to be considered. This issue is explored specifically in relation to agency contact below, and then generally in relation to local strategy, but the Review Panel felt that there could be clearer guidance nationally in relation to these specific types of domestic abuse. [46]

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 in particular).

**Recommendation 1: 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 (to include adult children).**

## 5.2 Analysis of Agency Involvement with Emma (timescales under review relating to Emma and any associated contact with Ryan).

[44] Bracewell K, Jones C, Haines-Delmont A, Craig E, Duxbury J, Chantler K. (2021) 'Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide', *Journal of Gender-Based Violence*, doi: 10.1332/239868021X16316184865237

[45] Home Office. (2013) Information guide: Adolescent to parent violence and abuse (APVA). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf (Accessed: 15th March 2021).

[46] The Home Office Quality Assurance Panel suggested that this be explored further but, for the reasons stated above, the Review Panel felt it could not do so. However, because there is evidence that the potential risk to Hazel was not explored by agencies, national and local recommendations have nonetheless been identified as described in the text above.

*CHS*

5.2.1 Emma attended CHS's Emergency Department on five separate occasions between 2016 and 2018. Most of these attendances were for abdominal pain as a result of a pre-existing condition, which was treated appropriately.

5.2.2 At one attendance, on the 14th December 2018, Emma's pregnancy – of which she was unaware – was confirmed. Emma was referred appropriately for antenatal care, including liaison with her GP.

5.2.3 On another occasion, on the 21st December 2018, Emma was accompanied by a friend who expressed their unhappiness about the questions that the doctor was asking (which suggests they were present during the assessment). It is standard practice for the practitioner to ask any person accompanying a patient to identify themselves, as well as asking the patient if they consent for someone to be present during their consultation. On this occasion the identity of the person accompanying Emma was not documented.

5.2.4 The CHS IMR noted that it was not possible to know if this person was Ryan (and, as Ryan declined to participate in the review, it has not been possible to ask him about this). However, if Ryan had attended with Emma, then this unhappiness could have been an indicator of controlling behaviour or coercion. It is also not clear, because there is limited information in the record, whether the practitioner who saw Emma could have found a way to manage this incident differently, for example, by finding a way to speak with Emma alone.

5.2.5 After Emma's pregnancy was confirmed, she accessed antenatal care. Women are seen at 16, 28, 34, 36, 38, 40 and 41 weeks of pregnancy (and there may be additional appointments if it is someone's first baby or there are specific health conditions). Emma attended all routine antenatal appointments to which she was invited. For two of these appointments, there is a record of her attendance which showed she was accompanied by someone, although it is however not clear who.

5.2.6 The handheld patient record is the main antenatal record, and it is not standard practice for midwives to duplicate the information in the electronic patient record unless safeguarding concerns have been identified. Initially, the handheld patient record was not available as it had been used as evidence during the MPS murder investigation. This was resolved and, subsequently, the handheld records were reviewed. This did not add any additional information to the above, beyond confirming that there was no record made about any disclosures of domestic abuse. In the handheld notes Ryan was listed as Emma's next of kin.

5.2.7 Currently, the question about domestic abuse is asked during the booking appointment (a further prompt is also included: women are asked about an Emergency Department attendance in the last 12 months, as well). However, if someone is present, the question will not be asked. As a result, at Emma's booking appointment on the 22nd January, she was not asked about domestic abuse.

5.2.8 Furthermore, it is not standard practice to ask at a second or subsequent appointments. Thus, for example, at a further appointment on the 18th March, the question was again not asked. It is unclear whether this was not asked because of this practice or because someone (in this case, Emma's sister) was present.

5.2.9 The exception is the 16-week appointment where, if the handheld record said that the domestic abuse question had not been asked at the booking appointment, this question would then be asked (assuming that the patient was alone). However, it is not possible to see from the records if Emma attended this appointment alone. It does not appear that Emma was asked about domestic abuse at this contact.

5.2.10 It is of note that during the time that Emma was accessing antenatal services, the midwifery team was being restructured. This means there would have been some instability in the team, and Emma would not have seen the same professional. However, the outcome of this re-structuring means that women are now seen by a team of midwives who hold a caseload, thereby ensuring that they are seen by the same midwife at each attendance.

5.2.11 Regardless of practice in relation to when to ask about domestic abuse, there are practical barriers to asking the question. In Emma's contact with antenatal care services, she was seen at a health centre where all the all weighing and measuring equipment is in the same room in which consultations are held. However, in some clinics the weighing and measuring equipment is in a different room. This 'builds in' an opportunity to speak with a woman alone when they leave the consultation room for weighing and measuring, as a partner would normally stay behind.

5.2.12 A theme across these contacts with Emma relates to both recording of information, as well as when and how to promote opportunities to raise awareness of, or enquire about, domestic abuse.

5.2.13 The CHS IMR identified that the key learning for the trust included documenting who was with someone at appointments. In addition to asking the accompanying family or friend to identify themselves, staff also need to be able to deal with challenging situations, as in this case in the Emergency Department where Emma was persuaded not to continue with an assessment. Similarly, for antenatal services, where on the two occasions Emma was seen with someone, this might mean creating opportunities to have seen her alone. In some cases, the built environment might help create these opportunities, if someone can be taken, for a legitimate reason, to another room.

5.2.14 The CHS IMR also identified that practice in relation to domestic abuse, in particular routine enquiry, could be improved. In this case, domestic abuse is only routinely asked about at the booking appointment and, if the domestic abuse question cannot be asked then, at 16 weeks. Moreover, this is only recorded on the trust's IT systems in relation to the booking appointment. The CHS IMR suggested that the trust should consider both a requirement to follow up if domestic abuse cannot be discussed at the booking appointment, as well as at other fixed points including the existing 16-week appointment and the 36-week appointment

(both these appointments are longer, so allowing for a more in-depth conversation). If this change in practice is implemented, staff would need to have the time to review the electronic patient record in addition to the handheld record.

5.2.15 While the acknowledgement of this is welcome, it is frustrating that such changes to practice are still being proposed in 2021, based on practice in 2019, despite for example, there being clear guidance on this practice issue for some considerable time.[47] Critically, asking about domestic abuse should not be a singular incident. In cases of domestic abuse, asking the question safely and sensitively may prompt a disclosure. However, a negative response does not mean that it should be assumed that domestic abuse is not present. For example, a victim may not feel able to disclose at that time. This underlines the importance of routine enquiry being approached not as a process but being relational, thereby creating a safe environment that might encourage a victim to make a disclosure.[48]

5.2.16 The CHS IMR made the following recommendations, which were accepted by the Review Panel:

- *"Practitioners to document the full names, and relationship of any friends or relatives who accompany patients into the consultation room, after consent has been sought. The relevance of this should be included in all learning opportunities and be evidenced through audit activity".*
- *"Raise awareness during domestic abuse training around professional curiosity. This should include the potential need for practitioners to create safe situations to speak with patients confidentially if the need arises and potential coercive control and risk is evident".*
- *"Consideration to be given to the development of posters and/or leaflets which provide information relating to domestic abuse, the Trust's commitment to supporting victims of abuse and explanation that in view of this, a standard domestic abuse question will be asked of all women during their maternity care. This could include a standard reference to domestic abuse in the handheld records".*
- *"Consideration to be given to Midwives asking standard questions in a sensitive manner about experiences of domestic abuse during all antenatal appointments and not just the booking appointment (if safe to do so) and to include in the electronic patient records".*
- *"Consider means of creating a 'safe space' which could be accessed during consultations if required. An example of this would be keeping the weighing*

[47] This includes, for example, guidance released by the Department of Health in 2017. For more information, go to: https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals.

[48] Heron, R.L., Eisma, M.C. and Browne, K. (2021) 'Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service', *Journal of Family Violence*. https://doi.org/10.1007/s10896-020-00236-3.

*and measuring equipment in a separate room. This requires further exploration with maternity and estate colleagues".*

5.2.17 While there were no disclosures by Emma that might have triggered a domestic abuse response, the Review Panel noted that Croydon University Hospital has a Health Independent Domestic Violence Advisor (HIDVA). In addition to providing support with assessment and safety planning, the HIDVA also delivers training to hospital staff around domestic abuse and sexual violence. Although the Review Panel did not consider the HIDVA provision specifically, it did feel this was an example of good practice. Additionally, it is positive that CHS has a domestic abuse policy, which was last reviewed in June 2020 (although this was not examined as part of this DHR).

5.2.18 During the DHR there was a delay in CHS being able to provide a complete picture of its response to Emma because the handheld records had been used as evidence during the MPS murder investigation. This was resolved and, subsequently, the handheld records did not contain any additional information that changed the Review Panel's deliberations.

5.2.19 However, in these discussions, it was noted that there is varied practice around the recording of information relating to domestic abuse in handheld records, the format of which is specific to the relevant trust. The NHS England panel representative noted that there is currently work being undertaken by the national maternity safeguarding leads with NHS X (the digital arm of the NHS). Among other work, this is considering how domestic abuse enquiry will be recorded in the digital records.[49] The intention is that there will be a discussion about domestic abuse at each antenatal appointment if a pregnant woman or person is unaccompanied and the response is documented while ensuring that a response is not available to be reviewed e.g., by a partner or family member. As a result, the Review Panel did not feel it was necessary to make a specific recommendation.

5.2.20 Additionally, Ryan attended CHS's Emergency Department on five occasions in 2017. These are discussed below.

*GP 2*

5.2.21 Emma had originally registered with the GP 2 in 2005 then, before being registered at two different practices at the Ackerman Health Centre between 2010 and 2018, before re-registering with GP 2 in 2018.

5.2.22 The Review Panel decided not to request an IMR from the two different practices at the Ackerman Health Centre.[50] However, as part of the IMR produced by the GP 2 / South West London CCG possible learning was identified:

[49] For more information, go to: https://www.england.nhs.uk/mat-transformation/harnessing-digital-technology/.

[50] This was because the medical records from these practices were available and reviewed as part of the production of the IMR. As a result, the Review Panel felt it would not be proportionate to ask two further practices to complete IMRs, particularly in the context of the pressure of capacity considering the Covid-19 pandemic.

- While the Ackerman Health Centre appears to have managed requests from Emma appropriately, there may have been opportunities to explore issues further. For example, when Emma talked about stress at work in August 2015, and was directed towards IAPTs (as detailed in the chronology, there is no evidence that Emma subsequently accessed this service).
- At this contact with the Ackerman Health Centre, Emma also disclosed being in a relationship with a female partner (this is presumably the partner from whom Emma also reported a single domestic abuse incident, triggering contact by the MPS and Victim Support).

5.2.23 In relation to the GP 2 itself, the practice was aware of Emma's attendances at the CHS Emergency Department (because of discharge notifications), as well as her engagement with antenatal care from the start of 2019. In this context, as well as other health issues like her chronic health issue, medical support provided by the practice was appropriate.

5.2.24 During her contacts with the practice, which was infrequent, Emma would normally attend alone, and she did not make any disclosures about domestic abuse. Nor were there any indicators, such as particular ailments, that would have been a cause for concern or triggered further enquiry about domestic abuse.

5.2.25 In relation to her pregnancy, about which Emma was reported to be pleased, Emma did not disclose her relationship status and did not mention who the father was. In relation to this, the practice confirmed Emma was not, in fact, asked explicitly about who the father was. The practice will be adding two additional questions to its clinical assessment relating to pregnancy to ask about a patient's support network, and whether the father of the unborn child part is part of this.

- *"Practice to revise the template used for clinical records in relation to pregnancy and add questions as part of the clinical assessment to ask about support network".*

5.2.26 The practice is part of the local Identification & Referral to Improve Safety (IRIS) programme. [51] However, its IMR identified some areas for further development, including ensuring the practice's safeguarding policy is updated to reflect the latest domestic abuse guidance. As a result, the practice's IMR made the following recommendations:

- *"Practice to strengthen arrangements with regards to the management of domestic abuse".*

[51] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial. For more information, go to: https://irisi.org/iris/what-is-iris/.

- *"The practice should ensure safeguarding arrangements are robust and that the practice has up to date safeguarding policies relating to domestic abuse".*
- *"The* [domestic abuse and sexual violence] *lead at the practice should attend at least 50% of the forums coordinated by the CCG and FJC".*

5.2.27 While it is beyond the scope of the DHR, the practice also appears to have taken proactive steps after the murder of Emma, which is to be commended. For example, the practice identified that it knew Emma (and other members of her family) soon after Emma's homicide had been reported. It then ensured that staff were supported and that it took appropriate steps to support family members, including priority access.

*KCH*

5.2.28 As noted in the chronology, KCH had limited contact with Emma, with 11 attendances at the Emergency Department between 2010 and 2018. While Emma attended the Emergency Department 11 times, each episode was brief and there is minimal documentation. None of the presentations required admissions, further investigations, or onward referrals. Discharge notifications were provided to the relevant GP on each occasion.

5.2.29 The KCH IMR noted that whilst the hospital attendances appear to be related to Emma's physical health, there is no indication that staff attempted discussions regarding Emma's home life, domestic abuse, or her mental wellbeing. This is evident in the recording, with minimal documentation for these attendances. With the benefit of hindsight, the KCH IMR suggested that this was a missed opportunity.

5.2.30 The KCH IMR made the following recommendation:

- *"Clinicians, particularly front-line practitioners in the Emergency Departments are encouraged to routinely ask questions regarding domestic abuse for all services users"*.

*MPS*

5.2.31 The MPS had limited contact with Emma prior to her death, with this including a single report of a historical domestic abuse incident with another partner (this has not been examined further, but it is discussed below with reference to implications for contact with Victim Support), and one incident when Ryan and Emma were stopped and searched (Ryan was then charged with a drug offence). No learning relating to Emma specifically has been identified, however, the MPS had numerous contacts with Ryan, and these are discussed below.

*Croydon Council Housing*

5.2.32 Croydon Council Housing limited contact with Emma, with her application in March 2020 being online. However, Victor reported that Emma had come into the housing department in June 2020. Croydon Council Housing has not been able to identify any record of Emma's attendance. It may be that if she had attended for general

advice, she would have been provided with information (for example on making an application) but this would not have been recorded.

5.2.33 As part of the DHR, Croydon Council Housing identified that the online application process used by Emma does not include any information about domestic abuse. This has been identified as an issue and the department is working with the FJC to incorporate a pop-up question. The intention is to have consistent messaging about domestic abuse, including sources of help and support. This work is currently underway: a new information technology system is due to be completed in September 2021.

5.2.34 The Review Panel were informed that Croydon Council Housing does not currently have a domestic abuse policy but is working with the FJC in relation to the new Domestic Abuse Bill.

5.2.35 In relation to training, staff have accessed this in the past, but this has not been part of a consistent training programme (for example, there has not been a training needs assessment for staff around domestic abuse) and there was a recognition that this needs to be revisited. Reflecting this, the Croydon Council Housing Short Report made a single recommendation:

- *"That Housing Staff to complete DVAS training via the FJC".*

5.2.36 The Review Panel considered making recommendations around both the issue of policy and training but were informed that Croydon Council Housing is also seeking Domestic Abuse Housing Alliance (DAHA) accreditation. The DAHA accreditation provides a benchmark for how housing providers should respond to domestic abuse.[52] This process is being overseen by the Director of Housing and began in July 2021, and forms part of the council's wider response to the Domestic Abuse Bill. Considering this commitment, and subject to DAHA accreditation being achieved, the Review Panel agreed no further recommendations were necessary.

*Victim Support*

5.2.37 Victim Support had a single contact with Emma in March 2015, following a referral from the MPS. There was a two-day delay between the incident (on the 7th March) and the referral to Victim Support (on the 9th March), with a three-day delay before the first contact attempt was made by Victim Support. In the case of the time taken for Victim Support to contact Emma, this is in line with their contract (which specifies contact within 72 hours). However, taken together, it does mean that Emma would have been waiting five days for a response. Further, when Emma declined support, the police were not notified. Finally, at the time of this contact, the Victim Contact Officer who took the call had not received any domestic abuse

[52] For more information, go to: https://www.dahalliance.org.uk/what-we-do/accreditation-for-housing-providers/what-is-accreditation/

training (although call handlers should normally have received Victim Support in-house domestic abuse training).

5.2.38 In response to these issues, the Victim Support Short Report noted that:

- Since April 2019, Victim Contact Officers (now called 'Independent Victim Advocates') have all had four-day in-house training on domestic abuse, with this covering risk assessment. As part of this training programme, the experiences of, and potential barriers for, victims in same-sex relationships are addressed. (The quality and content of this training has not been reviewed as part of the DHR); and
- Where a victim declines support, the case should be referred back to the police (or follow the relevant local protocol).

5.2.39 Reflecting on this information, Victim Support made no recommendations. This was accepted by the Review Panel.

5.2.40 However, the Review Panel did feel it was important to note that, in the referral to Victim Support, there was no additional information to indicate that the incident involved a former female partner. The MPS panel representative advised that it would have been possible for the Initial Investigating Officer to use a free text section when a report was generated, to identify the relationship as being a same-sex relationship. This information would then have been shared with Victim Support when the referral was made.

5.2.41 The Review Panel felt that this was potentially significant learning, albeit tangential to the main purpose of this DHR, which is concerned with the killing of Emma by Ryan.

5.2.42 There is evidence that LGBT+ victims/survivors face distinct systemic and personal barriers in accessing services, because of their sexual orientation and gender identity.[53] One way that these barriers occur is that the "*public story*" of domestic abuse is that victim/survivors are heterosexual,[54] meaning it can be hard for both victim/survivors and professionals to consider and identify domestic abuse. In this case, as the MPS had not flagged that the alleged perpetrator was a former female partner, it is entirely possible that the Victim Contact Officer would have assumed Emma had experienced domestic abuse from a man. This could then have presented a barrier to Emma if, for example, she had to make the decision to disclose that her relationship at the time was with a woman.

5.2.43 The MPS panel representative advised the Review Panel that a working group has been established to consider referral processes between the MPS and Victim Support, with this group meeting for the first time in June 2021.

---

[53] Magić, J. & Kelley, P. (October 2019). *Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse*. Available at: http://www.galop.org.uk/wp-content/uploads/Galop_RR-v4a.pdf (Accessed 15th March 2021).

[54] Donovan, C. and Hester, M. (2014) *Domestic Violence and Sexuality: What's Love Got to do with it?* Policy Press, Bristol.

Without relevant case information, it can be challenging for Victim Contact Officers to tailor their intervention with survivors to take account of their specific needs, experiences and personal characteristics.

**Recommendation 2: The MPS, as part of its current work to review referral processes with Victim Support, to review how information is transferred to Victim Support to ensure that relevant case details are included and can therefore inform the approach taken by Victim Contact Officers.**

*Royal Mail*

5.2.44 Although no concerns relating to Emma were known to Royal Mail, the company was invited to participate in the DHR. As part of this process, the Royal Mail was invited to provide a Short Report summarising the work undertaken to raise awareness of domestic abuse and, if disclosed, to support staff.

5.2.45 In 2012 the Royal Mail developed a Domestic Abuse Guide to assist managers in both identifying domestic abuse and supporting staff affected by it. The guide includes information on domestic abuse, as well as potential indicators which could signal someone needs support (tailored to the work setting). The guide also provides information on support for employees, including time off or changes to duties, as well as access to legal advice and counselling. The guide also identifies other avenues of support external to Royal Mail Group, such as the National Domestic Abuse helpline, and victim support services. This policy was last updated in 2021. (The policy was shared with the chair during the DHR and, although not reviewed, some feedback was provided on victim support services).

5.2.46 The Royal Mail panel representative informed the Review Panel these services are promoted to staff regularly. For example, information is included on payslips, displayed via an internal television channel, RMTV, and sent out monthly in a newsletter publication which is sent to all employees' home addresses. During the Covid-19 pandemic, the Royal Mail has taken an additional step to highlight domestic abuse to staff. This included launching an online 'Safe Space' in partnership with Hestia's 'UK Says No More' Campaign[55] (see Figure 1).

[55] For more information, go to: https://uksaysnomore.org.


*Figure 1: Royal Mail Domestic Abuse Awareness Poster*

5.2.47 The Review Panel did not consider the Royal Mail's response in detail but felt this was an example of an employer taking practical steps to raise awareness and support staff which should be commended. In a similar vein, the Review Panel also noted the positive comments from Emma's manager, Henry, about the support provided to staff after Emma's murder.

## 5.3 Analysis of Agency Involvement with Ryan (relating to relevant contact by Ryan only with agencies after the timescales under review)

*MPS*

5.3.1 As noted in the chronology, Ryan was known for several offences.

5.3.2 The MPS had contact with Ryan (in 2014, 2015 and 2019) when he was the victim of assaults or thefts. None of these incidents appear relevant to the DHR, and as such are not discussed further.

5.3.3 However, the MPS had contact on eight occasions with Ryan following reports from his mother. In response to these contacts, the MPS IMR identified two areas of learning, although it did not make any recommendations.

5.3.4 First, a referral could have been made to the Southwark MARAC, given the previous incidents reported by Hazel. As these incidents were risk assessed as

standard or medium risk, such a referral would have been under one of the two criteria for referral other than 'high risk', specifically either the 'professional judgement' or 'potential escalation' criteria.

5.3.5 At the time of the last incident in October 2014, consideration was given by the Initial Investigating Officer to a referral based on potential escalation. However, it was decided – following supervision – that the MARAC threshold at the time was not met. This was because the MARAC threshold in Southwark at this time related to three or more crimes in a 12-month period (this was described in the referral form at the time as "police call-outs" but the Review Panel was informed that non-crimes would not have been considered).

5.3.6 The Review Panel felt that, given the significance of this potential opportunity for a referral, it should examine escalation more thoroughly. Currently, SafeLives advises this criterion for referral to MARAC as: "*Potential for escalation can be assessed by looking at the frequency and/or severity of abuse."* This is further explained as:

5.3.7 *"It is common practice for services to determine there is a potential for serious harm or homicide when three domestic abuse events have been identified in a 12-month period. For example, three attendances at A&E, three police call outs or three calls to make housing repairs. This should alert professionals to the need to consider a referral to MARAC*".[56]

5.3.8 Currently, the Review Panel noted that Southwark and Croydon have different thresholds for this criterion. For Southwark, this is 3 or more crimes or 7 non crimes in a 12-month period and for Croydon, it is 4 police calls outs. Clearly, for both, these definitions are premised on police call outs, in contrast to the broader SafeLives definition which relates to domestic abuse events known to any service.

5.3.9 The Review Panel felt that both Southwark and Croydon should review their existing guidance relating to the MARAC.

While local areas can set MARAC thresholds, the requirement that crimes, not events, are the basis for an escalation referral, is inconsistent with national guidance. It is also a barrier to identifying potential for escalation.

**Recommendation 3: The Southwark Community Safety Partnership to review the local definition and threshold for making referrals to the local MARAC based on escalation.**

**Recommendation 4: The Safer Croydon Partnership to review the local definition and threshold for making referrals to the local MARAC based on escalation.**

[56] For more information, go to: https://safelives.org.uk/practice-support/resources-marac-meetings

5.3.10 However, while these recommendations may address the specific issue in each borough, the Review Panel felt this highlighted a broader issue. Specifically, different boroughs have different reporting rates and therefore different referral thresholds to manage MARAC volume. While the Review Panel recognised the reasons for this, and that standardisation across London boroughs would be difficult, these differences mean:

- There is, in effect, a postcode lottery in terms of access to multi-agency responses through this referral route to MARAC, and;
- Agencies that span boroughs will have to manage MARAC referrals differently depending on the borough.

5.3.11 The Review Panel considered making a recommendation in response to this issue but, with the assistance of review panel representatives, established that MOPAC had commissioned a pan-London review of MARACs. This is due to report in December 2021.[57] As a result, the chair was able to request, and MOPAC agreed, that this issue would be included in the scope of the review. As a result, the Review Panel agreed no specific recommendation was required.

5.3.12 A second issue was the consistency of ACN referrals. Consideration was given to Ryan's vulnerability general (and for example, an ACN completed in September 2013), and police officers identified that a diagnosis may have been helpful (this is discussed as a cross-cutting theme in 5.4 below). However, in January 2014, an ACN was not completed, although a police officer spoke with Southwark Council's Vulnerable Adult Team. MPS guidance then (and now) as to when to create an ACN sets out that one should be created when a vulnerable adult comes to notice on the basis of any one of the five criteria[58] identified in the guidance and there is a risk of harm to that person or another person. Here, this would have related to the concerns about physical abuse and Ryan's mental health. The MPS IMR noted that an ACN should have been made for this incident and shared with Adult Social Care.

5.3.13 The MPS IMR did not make any recommendations. This was accepted by the Review Panel. Although the Review Panel considered making a recommendation relating to the issues identified, it was advised that new guidance was issued in February 2019. As a result, it agreed to capture this learning, but not make a specific recommendation.

5.3.14 A final issue relates to the contacts with Southwark Council's Adult Social Care. It is noticeable that, despite an ACN being completed and contact made with the Vulnerable Adult Team, Adult Social Care had no record of contact with Ryan in 2013 and 2014. It has not been possible to resolve this issue and, given the focus

[57] Standing Together has been commissioned to deliver this review. In the interests of avoiding a conflict of interest, communication about this issue has been directly between MOPAC and the chair.

[58] This policy is contained in the MPS's Vulnerability Assessment Framework. It includes five domains including appearance, behaviour, communication capacity, danger, and environment circumstances.

of this DHR is properly on Emma and the time that elapsed, the Review Panel felt it would not be proportionate to examine this issue further.

*SAVU (now the CHEH)*

5.3.15 The SAVU was a multi-agency team tackling serious youth violence, gang involvement and its associated criminality in Southwark. The SAVU brought together a four-pronged approach of: community involvement; prevention and early identification; support and enforcement, with a particular focus on meaningful outcomes for those that are involved in, associated with, or at risk of, gang activity.

5.3.16 The SAVU had extensive contact with Ryan between March 2014 and July 2017. As a result, SAVU had a good knowledge of Ryan. This included a history of drug misuse (cannabis), violence towards his mother, as well as mental health problems.

5.3.17 There appear to be several positives to this contact, not least the extensive contact that members of the SAVU team (drawn from a number of different organisations) had with Ryan.

5.3.18 While a range of agencies was involved with Ryan, often with positive results, it is clear there were several challenges, not least when he moved to Croydon and this information was not shared. Broadly, the areas of weaknesses were:

- If and how Ryan's ASD was responded to (this is discussed as a cross-cutting theme in 5.4 below);
- If and how Ryan's mental health was responded to; and
- The case closure, which was in the same month that Ryan was transferred by London CRC to Croydon.

5.3.19 Additionally, further learning was that the initial assessment of referrals must include all the protected characteristics (including, for example, Ryan's race and ethnicity).

5.3.20 Moreover, the SAVU IMR identified that more support could have been given to Ryan's mother and work done to build and restore their relationship. This gap arose because SAVU's remit was seen at the time as being to work with an individual and, as a result, this meant work with a wider family was not always seen as within its remit (a broader approach is now recognised as being more effective). Additionally, the SAVU was unaware of Emma, and this highlights how more could have been done to explore Ryan's personal circumstances, including asking about intimate partners.

5.3.21 The Review Panel considered a detailed analysis of SAVU's contact with Ryan but decided against this for two reasons. Firstly, as will be detailed in this section, there has been both a review of, and significant changes to, local practice. This is discussed here, with a focus on strategic learning. Secondly, the CRC has also been part of this DHR, providing both an IMR and undertaking a SFO Review. This is the most pertinent information relating to Ryan, as it concerns both the transfer

from Southwark to Lewisham and contact with him through to May 2018. This is discussed in the next section.

5.3.22 In January 2019 the Southwark Safeguarding Executive commissioned the Home Office & MOPAC funded Violence and Vulnerability Unit (VVU) to undertake an Extended Learning Review (ELR).[59] The VVU were asked to review the Southwark Council's approach to violence, gangs, knife crime, county lines modern slavery, human trafficking and criminal and sexual exploitation. In summary, the ELR found examples of good and promising practice in the borough from a range of partnerships and agencies reflected in strong multiagency working, as well as strong leadership at a senior level across agencies and a will to learn and change. However, it also identified a concern that no single agency or partnership was perceived to own the gang/youth violence issue, with the result being that the partnership was sometimes reactive, with a complex partnership landscape that at times meant that work overlapped.

5.3.23 In response, the ELR made 15 recommendations covering governance and understanding of the problem, schools and parents, prevention and safeguarding, as well as enforcement. Critically for the purposes of this DHR, this included a recommendation that the council's work in this area should be pulled together under the new CHEH and Board to further this work, including partnership working. As a result, the SAVU team has been aborded/transferred into a new CHEH and partnership work is now managed on an operational level through the CHEH Operations Group.[60]

5.3.24 Additionally, an independent review of the SAVU was also completed in November 2019. The recommendations from this review are under consideration by the Head of the CHEH and the Assistant Head of Community Safety.

5.3.25 It is of note that the SAVU did not have a Domestic Abuse Policy. Nor does the new CHEH. It should be inconceivable that a new policy initiative should be developed in 2019, let alone 2021, without there being a robust policy, process, and training. As a result, it is incredibly frustrating that, despite the well-recognized links between youth crime and domestic abuse,[61] this was not the case in relation to the SAVU and now for the CHEH. However, the Review Panel was informed that a Domestic Abuse Policy is being developed.

5.3.26 The SAVU IMR made the following recommendations, which were accepted by the Review Panel:

---

[59] Violence and Vulnerability Unit (2019) *Southwark: Extended Learning Review*. Available at: https://moderngov.southwark.gov.uk/documents/s82118/Southwark%20Extended%20Learning%20Review.pdf (Accessed: 15th March 2021).

[60] For more information, go to: https://localoffer.southwark.gov.uk/wellbeing/keeping-safe/southwark-s-community-harm-and-exploitation-hub.

[61] Kincaid, S., Lumley, J. and Corlett, M. (2021) *Violence and Vulnerability*. Available at: https://www.crestadvisory.com/post/report-violence-and-vulnerability (Accessed: 24th July 2021).

- "Closer and revised monitoring of the referred CHEH clients (via the CHEH Operations Group, formerly SAVU)".
- "To adopt a whole family focused approach (including additional services such as a dedicated victim support worker. drugs and alcohol support workers family information, advice and guidance for parents and siblings, as well as a dedicated housing support worker)".
- "To undertake a training needs analysis for CHEO Operations Group staff to ensure a consistent level of knowledge and messaging for all clients".
- "To improve recording of engagement sessions".
- "To ensure more robust risk management at an operational level, including (a) risk assessment to be reviewed and refreshed to include details of close relationships which will be reviewed on a regular basis and (b) risk assessment will be quality controlled on acceptance and on a monthly basis".
- "To ensure more robust risk management at a strategic level (including introduction of a governance board – Community Harm & Exploitation Board)".
- "To introduce a Single Information Technology recording system or use one of the existing systems within the Council".
- "Commissioned services (i.e., service providers within the CHEH Operations Group) to be informed of the new approach for 2021/22 and the rationale behind it".
- "Increase monitoring meetings with commissioned services to better manage risk".

5.3.27 During the DHR, an additional single agency recommendation was also agreed. This reflected the learning from the DHR that there was an interconnectivity between different forms of violence and exploitation when working with young people, vulnerable adults, and their families. This means that staff must ensure that each family member has been referred to the appropriate and relevant multi-agency support groups that are available.

- "Training of staff and/or single points of contact for all support, whether single agency or multi-agency to ensure individuals and families are referred to the correct support services to cover all of their needs".

5.3.28 The Review Panel felt one significant area was not addressed in the ELR or by the SAVU IMR, specifically what happens when a multi-agency thematic response like the SAVU is in place, but someone moves to another borough where there is not a direct multi-agency equivalent. In Ryan's case, his move meant he was closed to SAVU and there was a reliance on a single agency transfer by the CRC. Clearly, there is a responsibility on single agencies to fulfil their duties when someone moves areas, including managing this process and ensuring case management is transferred. In this case, the response by the CRC was inadequate and is explored in the following section. However, the Review Panel has identified a broader issue.

It is problematic that there is an inconsistency in multi-agency response between boroughs. Here, this meant that, upon moving, Ryan was not referred to a multi-agency team which may have been able to, as a minimum, support his settlement and/or provide longer term support.

5.3.29 As part of the Review Panel's discussions, it became aware that the London Violence Reduction Unit (VRU)[62] has been working with boroughs across London to tackle violent crime, as well as exploitation. This includes developing a template action plan to support boroughs to develop Violence Reduction Plans and providing ongoing support around their development and delivery. Additionally, the VRU has developed ways of sharing learning and best practice regionally. This is through regular knowledge hub sessions. Additionally, the VRU is currently establishing a 'Violence Reduction Practitioners Network' to bring together operational leads from London boroughs to help share learning and practice, provide peer support around themes or challenges, and networking opportunities.

There is an inconsistency in multi-agency response between boroughs. The Review Panel recognises that there is no easy fix to this issue, not least because different boroughs will inevitably have different priorities and working practices. Nonetheless, this is a systemic vulnerability that needs to be addressed because it otherwise leaves responsibility with a single agency(s), and the transfer of information can be potentially disrupted or lost, meaning risks and needs are left unaddressed.

**Recommendation 5: The London VRU to review the learning from this DHR via the Violence Reduction Practitioners Network and:**

**- Raise awareness of the issues relating to the management of cross borough moves by sharing the lessons learnt from this DHR via its knowledge hub sessions and/or the newly established Violence Reduction Practitioners Network**

**- Encourage boroughs to ensure there is a robust mechanism to identify and manage any risk when young people move to different areas by including 'effective handover' as an action in the template Violence Reduction Plan**

*London CRC*[63]

5.3.30 The CRC was involved with Ryan between October 2016 and May 2018. While Ryan was in Southwark, and engaged with the SAVU, CRC would have undertaken some information sharing with this multi-agency partnership. This involvement largely related to Ryan's engagement with, or non-completion of unpaid work hours. Thereafter, Ryan was transferred from Southwark to Croydon in July 2017.

[62] For more information, go to: https://www.london.gov.uk/content/londons-violence-reduction-unit.

[63] In addition to submitting an IMR to the Review Panel, the CRC also shared a copy of the SFO Review with the chair.

5.3.31 Several issues have been identified in CRC's contact with Ryan:

5.3.32 First, there were several administrative errors. This meant a Court Duty Officer logged Ryan's initial sentence as a Conditional Discharge instead of a Community Order with Unpaid Work and then an NPS administration officer logged the length of the Suspended Sentence Order incorrectly.

5.3.33 Second, when Ryan's case was transferred from Southwark to Croydon, the quality of the transfer was poor. The first Offender Manager should have provided an up-to-date risk and needs assessment and shared any information in relation to risk (including information from other agencies like the SAVU), while the second Offender Manager should have undertaken local background checks. Neither did so.

5.3.34 Third, directly because of the poor transfer, the second risk assessment of Ryan's risk (completed after he had been transferred to Croydon) was incomplete. Critically, this meant information from Southwark, particularly via the SAVU, was unknown. Had this information been available, it would have contributed to the risk assessment of Ryan and any plans developed. This may have been particularly relevant in relation to Ryan's ASD, as well as his mental health (although, as noted in the chronology, this was largely based on Ryan's self-reporting and not meeting the threshold for additional support) and substance misuse (relating to cannabis use, though this does not appear to be problematic or enduring).

5.3.35 Moreover, this information would also have included information on his behaviour (towards his mother, Hazel) and exploration of his intimate relationships. If this information had been known to the new Offender Manager, it should have led the officer to complete a Spousal Assault Risk Assessment (SARA)[64]. If completed, A SARA may have identified risk to Emma which could triggered subsequently a referral to MARAC.

5.3.36 Additionally, as noted in the chronology, when Ryan was subject to a curfew in May 2017, he independently made an application to vary his curfew address, changing this from an address in Southwark to Emma's address in Croydon. While he made this application independently, the London CRC was aware of this change of address because Ryan told them about it, triggering the transfer of his case to Croydon. However, reflecting the issues already noted, because there was an inadequate transfer of information from Southwark to Croydon, and then an incomplete risk assessment, there was no risk assessment of this address.

5.3.37 Fourth, the management of Ryan was inadequate. For example, after his first sentence in October 2016, he was not assessed and there was no Risk Management or Sentence Plans that would have governed his journey through his Community Order. As a result, Ryan's inadequate engagement with the Community

[64] The SARA is a structured risk assessment tool that includes a range of domestic abuse-specific risk factors. It was developed for intimate partner abuse.

Order was not addressed. Enforcement action also failed, for example, when letters were sent to the wrong address. Importantly, the Offender Manager did not discuss the case with their Line Manager in line with policy.

5.3.38 As a final note, in work with Ryan, he showed an inflexibility in thinking and behaviour that may have been associated with his ASD. While staff were aware of Ryan's ASD, as with other services, this does not appear to have been explored further. (This is discussed as a cross-cutting theme in 5.4 below).

5.3.39 The London CRC IMR described significant changes to policy and procedure since their contact with Ryan, including:

- The Community Payback Team underwent a significant restructure in November 2017.
- The London CRC now has an Administration Service Centre. This provides central support for practitioners and so supports the management of cases, as well as timely enforcement action where appropriate. Additionally, the transfer process has been centralised through the Administration Service Centre.
- Additionally, although domestic abuse was not identified in this case, it is of note that policies and procedures in this area are regularly updated, most recently in March 2020 (not reviewed as part of the DHR).

5.3.40 The London CRC IMR made the following recommendations, which were accepted by the Review Panel. [*Note: for reasons described on page 13, the NPS will be responsible for the implementation of these actions*]:

- "The London CRC to ensure that all contact with service users is recorded in a timely manner and in accordance with London CRC quality practice standards".
- "The London CRC to revise the internal transfer policy to ensure that all internal transfers within London are undertaken following discussions between transferring officers and accompanied by a record of contact within the appropriate case management system".
- "The London CRC quality practice standards to make specific reference to sharing information and sentence plans with appropriate external partners, as to support collaborative working".
- "The London CRC to revise Community Payback operations, to ensure an increase in the number of service users completing unpaid work requirements within the statutory 12-month period from sentence".
- "The London CRC to mandate the completion of risk assessment and risk management training for all practitioners on a rolling 2-year basis".
- "The London CRC to ensure the accountability structure captures information relating to service user's engagement and recording (e.g., incomplete outcomes, case with no next appointments and acceptable absences). To

ensure these service delivery measures are reviewed at an area level on a monthly basis".

*Victim Support*

5.3.41 Victim Support had limited contact with Ryan, receiving three referrals (in 2014, 2015 and 2019) when he was the victim of assaults or thefts. In each case, Ryan did not take up support. The Review Panel considered this information but did not feel there was any further relevance to Victim Support's contact and so this was not examined further.

*Southwark Council Housing's Resident Services*

5.3.42 Ryan's mother, Hazel, is a council tenant. Southwark Council Housing's Resident Services had contact with Hazel in September 2013. The service also had information from the MPS relating to reports about Ryan's behaviour in the home. A further report from the MPS also led to contact with Hazel in January 2014, when Hazel said she wanted Ryan re-housed.

5.3.43 In these contacts, a Housing Officer discussed possible support with Hazel, including physical security at the home, as well as a referral to Solace. There is no record to indicate that Southwark Council Housing's Resident Services itself undertook a risk assessment.

5.3.44 The Housing Officer also knew that Ryan potentially had a learning disability, although when they spoke with Hazel, she described this as Asperger's. There is no record to indicate that this was explored further with Hazel (this is discussed as a cross-cutting theme in 5.4 below).

5.3.45 Hazel declined any support; however, she was clear that she wanted Ryan to be re-housed. It appears Southwark Council Housing's Resident Services accepted the assurance from Hazel that Ryan had made an approach to Southwark Council's Housing Solutions. Certainly, there is no record of any liaison. This is explored in the following section.

5.3.46 Southwark Council Housing's Resident Services does not have a stand-alone domestic abuse policy. The services Review Panel representative however did confirm that Housing Officers are taking the following action if a disclosure is made:

- Provide support to the victim;
- Conduct a risk assessment to determine if the case is eligible for placement in temporary accommodation pending consideration for rehousing;
- Consider contacting the MPS and requesting their risk assessment if the case is known;
- Consider completing a Solace/Victim Support referral form; and
- Consider referring the case for rehousing via a management move.

5.3.47 While it is positive that Housing Officers could potentially take a range of actions, it is disappointing that in 2021 a housing provider would not have a domestic abuse policy. Additionally, in this case, there was clearly no specific consideration of the risk to Hazel with a reliance on information from the MPS.

5.3.48 The Review Panel has however not made a recommendation around these two reasons. First, the Review Panel were informed that Housing Officers within Southwark Council Housing's Resident Services would receive refresher training, with this being provided by Solace Women's Aid. Second, there is an opportunity for the service to achieve DAHA accreditation. This is explored in the following section.

*Southwark Council's Housing Solutions*

5.3.49 Ryan was known to Southwark Council's Housing Solutions between January and March 2014, with his approach being because he had been made homeless as a result of his mother asking him to leave her property. There is no information to indicate that any exploration of the reasons why Hazel wanted Ryan to leave took place, nor to suggest that Hazel's approach to Council Housing's Resident Services (and the report from the MPS about his behaviour) in September 2013 was linked to this disclosure. There does not appear to have been any liaison with Southwark Council Housing's Resident Services, meaning when the case was closed, neither part of housing would have known that Ryan's housing need was unresolved, leaving him resident at his mother's home. While the passage of time means it is not possible to say what, if any difference a joined-up response may have made, clearly Hazel should not have been responsible for managing the interface between Housing's Resident Services and Housing Solutions.

5.3.50 Additionally, Housing Solutions was aware that Ryan may have had Asperger's (presumably because of Hazel's contact with Southwark Council Housing's Resident Services) but this does not appear to have been explored with Hazel. (This is discussed as a cross-cutting theme in 5.4 below).

5.3.51 Since this contact, the service has changed because of the Homelessness Reduction Act 2017. Significantly, single residents are now able to get greater assistance from the service, including the development of personal housing plans.

5.3.52 Moreover, while the Review Panel considered making recommendations to address the failure of Housing's Resident Services and Housing Solutions to offer a joined-up response, it has not done so. This is because Housing Solutions now have a single head of service, sharing with Resident Services, which allows better joint working and information sharing.

5.3.53 Additionally, other partnerships have been developed, including with Solace Women's Aid, whereby a domestic abuse specialist is co-located within the service who can provide advice and support to victims of domestic abuse. Additionally, Housing officers (managers, frontline staff, back-office staff) regularly receive training from Solace Women's Aid with the last round of training taking place in October/November 2020.

5.3.54 The Review Panel were informed that Southwark Council is currently in the process of applying for DAHA accreditation. This will include both Housing's Resident Services and Housing Solutions. This was welcomed by the Review Panel. Considering this commitment – which will address issues built around eight priority areas ranging from policy and procedure, and case management, to training, and publicity and awareness – no recommendation was made.

*GP 1 (IMR completed by South East London CCG)*

5.3.55 Ryan had the same GP from childhood, although this contact has not been considered in this DHR.

5.3.56 As an adult, in Ryan's contact with the GP, there appears to have been scope for the GP to have explored his social circumstances, including the reasons for his presentations, more fully. For example,

- The GP was aware of Ryan's childhood ASD diagnosis, although this was coded as an autistic disorder. While staff at the GP felt his ASD did not affect his everyday function, from the recorded notes, it is not possible to assess the severity of this or its impact on his daily life, including the ability to access and interact with services. As a result, the Review Panel concluded it does not appear there was any substantive consideration as to whether this should be considered further (this is discussed further in 5.4);
- During the period considered by this DHR, Ryan was seen regularly by the GP for unrelated minor medical issues and following several motorbike accidents;
- Ryan also presented five times reporting symptoms of low mood and anxiety over two years (he also called the out of service once, before going to his GP). At one of these consultations, Ryan was advised to self-refer to IAPT but, although Ryan reportedly told his GP he had done so, he is not known to SLaM (the local provider). It does not appear that there was any follow up by the GP. He was also prescribed anti-depressants; and
- There is also a single reference to "interpersonal relationship" in consultation in March 2015, but no further information on this is available.

5.3.57 The learning identified in the GPs contact including the importance of

- Following Ryan's disclosures of low mood and anxiety on several occasions, a risk assessment could have highlighted any suicidal ideation and thoughts about hurting others. There is no documentation to indicate that this happened. Enquiry after drug and alcohol use should also be a standard part of depression reviews. This highlights the importance of ensuring there is an exploration of the social circumstances as well as drug and alcohol use (and comprehensive documentation of this) when patients present with low mood and anxiety;
- Considering ways of improving follow-up when antidepressants are commenced (should be 2 weeks after starting antidepressant), e.g., book follow-up at the

time of issuing the first prescription or only offer a two-week supply of medication to start with; and

- Considering making the initial referral to IAPT services for selected patients.

5.3.58 As part of the DHR, GP 1 confirmed that the practice has a Domestic Abuse Policy (this was not reviewed as part of the DHR), that staff have completed domestic abuse training, and the practice also attends Safeguarding Forums and Protected Learning Time events (provided by CCG).

5.3.59 The South East London CCG made the following recommendations, in the IMR it completed on behalf of GP 1:

"*Feedback to individual practice as to the findings of this review to support individual learning needs and signposting to resources from previous CCG trainings on mental health and risk assessments".*

*"Healthcare professionals to have a lower threshold to make referral on behalf of a patient to counselling services where appropriate (instead of patient's being asked to self-refer) and ensure they follow-up with those asked to self-refer".*

*"Highlighting the role and use of social prescribers/navigators and Southwark Wellbeing Hub to GPs, e.g., when someone is faced with multiple issues such as unemployment and homelessness. The social prescribing service was introduced in Spring 2020. The service may be altered due to the Covid-19 pandemic"*

*"This case to be discussed with the local Mental Health Commissioner to review local services and establish whether any support is available in adulthood to those on the autistic spectrum or whether existing services have experience in/feel they are able to adapt sufficiently to meet the needs of this group of people, e.g., counselling services, job centre, etc."*

*CHS*

5.3.60 In four of five of these attendances, Ryan attended because he did not want to wait to see his own doctor. He usually left before being seen. Significantly, on the 22nd May 2017, Ryan was able to extract himself from a trauma mattress (which would require considerable force, unless assisted). He may have been helped by the unknown female who was with him (this could have been Emma). On leaving, he screamed at staff. The discharge notification does not document any details of this incident, either with regards to Ryan or the unknown female. While the Review Panel felt this was potentially a missing opportunity to share information about Ryan, it did not make a specific recommendation in relation to this issue.

*Health sector responses more generally*

5.3.61 The Review Panel noted that several health providers had been involved with either Emma and/or Ryan and that, in this DHR, a range of recommendations have been made in terms of domestic abuse responses. Broadly, these recommendations relate to issues like policy and practice about, as well as how to enable a consistent response to, domestic abuse.

5.3.62 However, Review Panel members identified what they felt were potential barriers to such responses. One potential barrier is the nature of contact with a health provider, including whether routine or targeted enquiry is recommended in that setting, as well as the circumstances in which someone presents. A further barrier relates to training: while there is national guidance on domestic abuse, and domestic abuse is included in intercollegiate documents regarding Safeguarding Children and Safeguarding Adults, an issue is that this is not itself mandatory or 'stand-alone'. Finally, even if the training was mandatory, and each health provider had a stand-alone domestic abuse policy, this would not necessarily mean staff would feel able to respond (both in terms of awareness, as well as confidence and capacity to 'ask and act') or that cultural change would be achieved.

While there is existing training and guidance around domestic abuse, it is clear from this DHR that there remain significant inconsistencies in relation to how consistently these are implemented, including the extent to which they change practice on the ground. There remains a need for further work to ensure a consistent response to domestic abuse in the health sector.

**Recommendation 6: The London NHS Domestic Violence and Abuse Clinical Reference Group work to consider the learning from this DHR and agree actions to ensure a more consistent health response, including whether there should be a national recommendation for the development of an intercollegiate document on DVA training for all health staff.**

## 5.4 Responding to the Terms of Reference

5.4.1 The following section responds to the lines of enquiry as set out in the Terms of Reference.

**Analyse the communication, procedures and discussions, which took place within and between agencies.**

**Analyse the co-operation between different agencies involved with Emma and Ryan [and wider family].**

5.4.2 The Review has not identified any evidence that agencies were aware of issues or concerns relating to Emma and Ryan. This reflected the limited information that agencies had about Emma and Ryan as a couple. In one sense, this appears to reflect a decision by either Emma and/or Ryan not to disclose that information although, as discussed in 5.1, in the absence of limited information more generally it is not possible to say why this was.

5.4.3 However, there was also a lack of consideration by some agencies to clarify or explore relationship status. There has been some significant learning in this context for what was the SAVU, as well as London CRC, in terms of exploring relationship status in their contact with Ryan.

5.4.4 Conversely, health providers (including CHS and GP 2) could also have done more. This is pertinent to consideration of Ryan as a possible abuser, but more generally,

as an invisible father. This Review Panel however faced a dilemma in relation to this issue. First, it is clear that professionals could have asked more pro-actively about the father of Child A, thus potentially identifying Ryan. That they did not reflect findings from case reviews relating to children, which highlights issues such as a reliance on mothers for essential information and conversely the importance of making active enquiries about the child's father.[65] At the same time, it appears that, although Emma wanted to involve Ryan in Child A's life, she had made an active decision not to share information about him as the father and was preparing to raise Child A with the support of her family. Given this complexity, the Review Panel decided not to make any further recommendation, as it feels identifying this learning and the single agency recommendations noted above are sufficient.

5.4.5 Significantly, when Ryan moved to Croydon there was a rupture in agency grip. His case was closed to SAVU, and the responsibility fell to CRC to manage this transfer. Regrettably, there was a failure to manage the transfer adequately within CRC, but this was exacerbated by the absence of an equivalent multi-agency partnership to the SAVU to which Ryan could have been transferred. These issues have been explored above.

**Analyse the opportunity for agencies to identify and assess domestic abuse risk.**

**Analyse agency responses to any identification of domestic abuse issues.**

**Analyse organisations' access to specialist domestic abuse agencies.**

5.4.6 There is no evidence that domestic abuse risk relating to Emma, and Ryan was known to agencies, and therefore no opportunity to respond to the same, albeit - as noted above - this was in part because relationship status was not always explored.

5.4.7 There was however information to consider the potential for a domestic abuse risk toward Ryan's mother, Hazel. However, there does not appear to have been a robust response to the possibility that Hazel was experiencing AFV/CPV. Instead, responses were incident based and there does not appear to have been any joined-up work that was sustained or facilitated opportunities for stand-alone interventions. This relates particularly to the MPS, as well as Southwark Housing (both Resident Services and Housing Solutions), as well as the work of SAVU and CRC.

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

5.4.8 As noted above, there was no evidence that domestic abuse risk relating to Emma and/or Ryan was known to agencies. However, the DHR has considered domestic abuse responses more generally. While some positives have been identified, this

[65] NSPCC (2015) *Hidden men: learning from case reviews*. Available at: https://learning.nspcc.org.uk/media/1341/learning-from-case-reviews_hidden-men.pdf (Accessed: 24th July 2021).

has also shown that policies, procedures, and training are not always robust. These issues have been explored by the agency above.

5.4.9 While the Review Panel has not been able to explore the experience of Hazel to any great extent, or indeed decide on whether she experienced AFV/CPV, it felt there was learning to be found. Specifically, there appears to be a gap in relation to professional understanding and response to AFV/CPV. In Review Panel discussions there was a recognition that much of the response to AFV/CPV takes place in the context of the wider response to domestic abuse and/or violence against women and girls. For example, while both local areas had identified issues around AFV/CPV, they have relatively limited information on prevalence and responses are, broadly, generic and situated within the context of IPV. The Review Panel also felt that professionals may often be unaware of, or underequipped to respond to, AFV/CPV specifically. For example, in relation to the assessment of risk, within the CRC, a domestic abuse risk assessment would be undertaken using SARA, which is designed for IPV. The same is true for other tools like the DASH RIC.

The CCR is based on the principle that no single agency or profession can respond to domestic abuse, but all agencies and professionals can offer insight that is crucial to the safety of victims and survivors. It is important that the CCR can support a robust response to AFV/CPV. While the case learning that this is based on occurred in Southwark, it is likely relevant to Croydon too.

**Recommendation 7: The Southwark Community Safety 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond.**

**Recommendation 8: The Safer Croydon 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond.**

**Specific consideration to the following issues: the impact of Ryan's reported violence against his mother, his childhood experiences and his ASD diagnosis.**

5.4.10 As outlined, this DHR has not explored Ryan's childhood experiences in depth and has not been able to reach a determination in relation to possible APV/CPV.

5.4.11 Nonetheless, the Review Panel also considered what might have helped or hindered access to help and support in relation to Ryan. In considering this, the Review Panel was mindful that Ryan was the perpetrator of this homicide and has been found guilty of Emma's murder and the manslaughter of Child A.

5.4.12 Without seeking to minimise Ryan's actions, the Review Panel also felt it appropriate to note that he had extensive contact with services, initially as a child (not explored substantively in this DHR), but also as a young adult (in particular with the criminal justice system).

5.4.13 Most noticeably, in this latter contact, to different degrees, a number of services knew that Ryan had been diagnosed with ASD. However, this does not appear to have been substantively considered in its own right. This may reflect a number of issues:

- After his transition to adulthood, Ryan did not have a further assessment. This is reportedly not uncommon for children diagnosed with ASD, who are unlikely to have a further assessment unless they have identified co-morbidities i.e., a psychiatric illness; and
- As an adult, Ryan appears to have been able to engage with services and achieve other milestones like employment and training. This may have prevented specific consideration of a further assessment.

5.4.14 Because Ryan's ASD was not considered specifically, it is unclear if and how it may have affected him. For example, his ASD may have had him more vulnerable to the influence of others, including in the context of criminal behaviour. Additionally, his ASD may not have been a significant issue in regard to his behaviour.

5.4.15 While it is unclear how ASD contributed to Ryan's behaviour and criminality the Review Panel felt that a key piece of learning was the need for services to have specifically considered ASD, including its impact on Ryan and on his ability to cope. As a result, the Review Panel considered the issue of responses to neurodiversity. [66] The need for increased awareness is reflected in the lack of evidence about how neurodevelopmental disorders like ASD are screened for and assessed, as well as interventions tailored, in youth justice.[67] There is also evidence that there is a need to better identify and respond to the specific needs of neurodiverse young people in a youth justice setting.[68]

---

[66] Neurodiversity refers to the different ways the brain can work and interpret information. It highlights that people naturally think about things differently. Neurodivergence includes a range of conditions including Attention Deficit Disorders, Autism, Dyslexia and Dyspraxia.

[67] Holland, L., Reid, N. and Smirnov, A. (2021) 'Neurodevelopmental disorders in youth justice: a systematic review of screening, assessment and interventions', *Journal of Experimental Criminology*. https://doi.org/10.1007/s10896-020-00236-3.

[68] Hughes, N. (2015) *Neurodisability in the youth justice system: recognising and responding to the criminalisation of neurodevelopmental impairment*. Available at: https://howardleague.org/wp-content/uploads/2016/04/HLWP_17_2015.pdf (Accessed: 24th July 2021).

5.4.16 Taken together, the Review Panel felt that this case illustrated the need for more awareness of neurodiversity in the criminal justice sector, including identification of need, assessment, and pathways to appropriate interventions.

This DHR has highlighted how neurodiversity may not be considered routinely in youth justice responses. The learning from this DHR should be used to raise awareness of this issue and identify how to ensure there is a consistent response to this issue. While the case learning that this is based on occurred in Southwark, it is likely relevant to Croydon too.

**Recommendation 9: The Southwark Community Safety Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally.**

**Recommendation 10: The Safer Croydon Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally.**

5.4.17 Other issues that could have been explored further include, for example, Ryan's mental health. Several agencies either received disclosures concerning this (e.g., SAVU, CRC) or were aware of it (e.g., GP) but this was not explored further.

5.4.18 Likewise, there were concerns about his substance misuse and periods of insecure housing. While this DHR has sought to better understand Ryan's contact with services, a more extensive review of his experiences is beyond its scope, not least because the focus of the DHR is properly, Emma. Where appropriate, single agency recommendations have been made as detailed above.

5.4.19 It is also relevant to note that Ryan was Black British. Ryan had extensive contact with criminal justice agencies, including the police. There has been increased attention to the experiences of Black people, particularly young men, in relation to concerns that they are over-represented in the criminal justice system and can face discrimination. Similarly, the IMR completed by his GP (GP 1) noted that Black people can face health inequalities because of systemic racism which, for example, may affect their confidence in engaging with services. However, it has not been possible to explore how this may have influenced Ryan as we were not able to engage him or other family members in this DHR.

**Analyse any evidence of help-seeking (as Emma had limited contact with services), as well as consider what might have helped or hindered access to help and support.**

5.4.20 Because of the relatively limited nature of Emma's contact with services, it has not been possible to explore what might have helped or hindered her access to help and support. Additionally, there has been no information identified by either agencies or her family which would suggest that Emma faced specific barriers to help or support or, for example, had any concerns about discrimination. Nonetheless, the Review Panel sought to consider what factors may have been relevant.

5.4.21 Regarding domestic abuse, there is clear evidence that women from minoritized communities can face a range of barriers, including vulnerabilities to forms of abuse, as well as compounding effects like feelings of shame, language barriers and the impact of different cultural norms and expectations.[69] While the Review Panel has not been able to determine if Emma had previously experienced domestic abuse from Ryan, if she had, it's possible that Emma's experience would have been affected by the cultural environment in which she lived and the issues that may have impacted her ability to ask for help. Specifically, Emma was Black British, and of a Mauritian heritage.

5.4.22 Notably, in considering this possibility, there is relatively little information known about the Mauritian community in Croydon. As of 2020, Croydon has an estimated population of 388,563 of which 44.9% are recorded as being from a Black, Asian or other minority ethnic group. The Mauritian population is recorded within the sub-Saharan category of which there is 6,000 as of 2019. [70] This would indicate that the Mauritian community is a very small percentage of the Croydon population. This may create a barrier to accessing support if, for example, small communities are more likely to manage issues within the confines of the community. There is also the issue of minority communities being mistrustful of agencies such as the police.

5.4.23 Other issues may relate specifically to Emma in terms of access to health services. This is relevant because the most extensive contact that Emma had was with health providers, principally relating to the management of a chronic health issue (relating to abdominal pain), and later, her pregnancy. However, the Review Panel noted that there was no information included in the IMRs from health providers (specifically CHS, her GP, or KCH) that suggested any issues in relation to her race or ethnicity. This may of course reflect a lack of concern by practitioners and Emma in this regard, but it also may mean that potentially issues were not considered, despite evidence that Black (and Asian) backgrounds experience higher rates of maternal mortality.[71]

The unique needs of specific communities should be routinely considered in the development and delivery of services locally.

**Recommendation 11: The Safer Croydon Partnership to ensure that, in developing its partnership response to domestic abuse and other issues, there is a robust mechanism to enable the specific consideration of the needs of minoritized communities and the implications in terms of awareness raising, training, service provision, and strategy. This should**

[69] Gangoli, G., Bates, L. and Hester, M. (2020) What does justice mean to black and minority ethic (BME) victims/survivors of gender-based violence? *Journal of Ethnic and Migration Studies* 46(15), pp. 3119–3135.

[70] For more information, go to: https://www.croydonobservatory.org/population/.

[71] Knight M et al. (2020) *Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18.* Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf (Accessed: 24th July 2021).

**include targeted consultation with local communities and input from led by and for specialist services.**

## 5.5 Equality and Diversity

5.5.1 At the outset of this DHR, the Review Panel identified the following protected characteristics of Emma and Ryan as requiring specific consideration for this case:

5.5.2 *Disability:* Emma had a chronic health issue, but this does not appear to have significant enough an impact to have a day-to-day effect on her life and/or be considered a disability (i.e., substantial' and 'long-term' negative effect on her ability to do normal daily activities). Ryan had ASD, as discussed above, and, while different agencies were aware of this, it does not appear to have been considered specifically.

5.5.3 *Pregnancy and maternity:* At the time of her death, Emma was 8 months pregnant. As noted above, one example of health inequalities in the UK is that that Black (and Asian) backgrounds experience higher rates of maternal mortality.

5.5.4 *Race:* Building on the concertation around health inequalities, the Review Panel has noted that, while there were no concerns identified or disclosed in relation to race and ethnicity, at the same time there is no evidence that these were considered specifically, either for Ryan or Emma.

5.5.5 *Sexual Orientation:* Emma had been in a previous same sex relationship but, in terms of the relationship that is the focus of this DHR, had been in a heterosexual relationship with Ryan. The Review Panel has included this information because it has identified some relevant learning for the MPS in terms of how it shares case information. Based on the available information, Ryan was heterosexual.

5.5.6 *Sex:* As noted in section one, sex is a risk factor. Most domestic homicides involve a female victim and a male perpetrator.

5.5.7 Although the Review Panel has had no specific information regarding *Age*, it noted that at the time of Emma's death, Emma was 26. Ryan was 25. Although they had separated in early 2019, before this they had been together since 2014 or 2015, when Emma would have been 21/21 and Ryan would have been 20/21.

5.5.8 No information was presented that raised any issues regarding other Protected Characteristics, including *Gender Reassignment; Marriage and Civil Partnership*, or *Religion or belief*.

# 6. Conclusions and Lessons to be Learnt

## 6.1 Conclusions

6.1.1 Emma was a much-loved daughter and sister, and a well-liked colleague. Her death at the hands of Ryan was a tragedy, as was the death of Child A. The Review Panel extends its sympathy to her family and friends.

6.1.2 The Review Panel has sought to try and understand Emma's lived experiences and consider the issues she faced in order to try and understand the circumstances of the homicide and identify relevant learning. Despite Emma's death being a domestic homicide, there is no specific evidence that she experienced domestic abuse by Ryan. Nevertheless, the Review Panel has considered possible indicators of domestic abuse including, as a minimum, that separation can be a period of increased risk. In this endeavour, the Review Panel has been aided to a great extent by help from family members and extends its thanks to all those who have participated in this DHR.

6.1.3 Ryan is solely responsible for the deaths of both Emma and Child A. Nonetheless, there has been significant learning identified during this DHR in relation to how agencies identified and managed his potential risk and needs. While it is not possible to say if an improved response could have averted the death of Emma and Child A, it is vital that the appropriate agencies and partnerships consider this learning to develop responses. This is summarised below.

## 6.2 Lessons To Be Learnt

6.2.1 The learning in this DHR relates to several key areas. First, *understanding of, and response to, domestic abuse*. In terms of Emma's relationship with her former partner Ryan, the Review Panel is not able to say whether Emma experienced prior domestic abuse. However, it has explored a number of issues. This includes noting that Ryan's acts are a further reminder of the importance of understanding that separation (and starting a new relationship) are potential indicators of risk. Additionally, a range of agencies have also used this DHR to review their practice and policies and have consequently identified learning around their response to domestic abuse and made single agency recommendations to improve the same. While these recommendations are welcome, it is both disappointing and frustrating that in 2021 basic steps – like robust policy, procedures, and training to support staff to routinely consider and respond to domestic abuse – are still the outcome of processes like this DHR. Given the number of health providers where single agency recommendations were made, the Review Panel has made a regional recommendation to develop the response to domestic abuse further.

6.2.2 The Review Panel has examined the possibility of a familial form of domestic abuse, that is AFV/CPV. While there were incidents that could be considered as evidence of AFV/CPV by Ryan towards his mother (Hazel), the Review Panel has not been able to reach a determination or explore these further, in part because neither Ryan nor Hazel participated in the DHR. Nonetheless, important learning has been identified. This includes learning relating to both how these incidents were responded to at the time, but more general learning too about the extent to which there is an understanding of AFV/CPV in both Southwark and Croydon. The Review Panel has made recommendations for both boroughs, along with a national recommendation to enhance work in this context.

6.2.3 Second, *robust multi-agency responses, including work across boroughs*. The Review Panel has explored two specific issues in this context. This includes the multi-agency response to Ryan while he was in Southwark, with a range of single agency recommendations being made for the multi-agency response to serious youth violence, gang involvement and associated criminality. Additionally, the Review Panel has made a regional recommendation to use the learning from this case to support work to ensure that there is a consistent process between boroughs for the management of cases when someone moves.

6.2.4 The Review Panel has also identified inconsistencies in the pathways to the local MARACs in both areas, specifically in relation to the threshold for referral based on escalation. The Review Panel has made recommendations to address these and directed a regional recommendation to MOPAC to consider the issue of divergent MARAC referral thresholds regionally.

6.2.5 Third, *the response to neurodiversity*. In this case, it would appear that Ryan's childhood diagnosis of ASD was never reconsidered. This meant that, while many agencies were aware of his diagnosis, he did not receive any assessment or intervention relating to its potential impact on his life. It is not possible to say if and how ASD affected his behaviour, reflecting to a great extent this lack of consideration. As a result, the Review Panel has made recommendations for both boroughs to reflect on the extent to which policy and practice considers neurodiversity.

6.2.6 Finally, *consideration of race and ethnicity*. it is noticeable that, despite both Emma and Ryan being Black British, this was rarely considered specifically by agencies. While the Review Panel has only been able to explore this partly for Emma and is limited in the extent to which it can address this for Ryan, it has made a recommendation in relation to Emma. Specifically, this reflects the fact that Emma was of Mauritian heritage. The Review Panel has linked this recommendation to the issue of domestic abuse more generally, to emphasise the importance of targeted work – including consultation with local communities and input from led by and for specialist services – in developing local responses.

6.2.7 Despite this range of learning, the good practice has also been identified. It is positive that this DHR has been an opportunity to identify some good work by employers in relation to domestic abuse, notably the efforts of the Royal Mail in partnership with Hestia. So, many of the responses to Emma (for example, her broad health care) were to a good standard.

6.2.8 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. 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 is everybody's business to make the future safer for others yet, as demonstrated by the learning here, this aspiration has yet to be achieved.

# 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 5 following the analysis of contact by each agency and are also presented collectively in **Appendix 4**. These are as follows:

*CHS*

7.1.2 Practitioners to document the full names, and relationship of any friends or relatives who accompany patients into the consultation room, after consent has been sought. The relevance of this should be included in all learning opportunities and be evidenced through audit activity.

7.1.3 Raise awareness during domestic abuse training around professional curiosity. This should include the potential need for practitioners to create safe situations to speak with patients confidentially if the need arises and potential coercive control and risk is evident.

7.1.4 Consideration to be given to the development of posters and/or leaflets which provide information relating to domestic abuse, the Trust's commitment to supporting victims of abuse and explanation that in view of this, a standard domestic abuse question will be asked of all women during their maternity care. This could include a standard reference to domestic abuse in the handheld records.

7.1.5 Consideration to be given to Midwives asking standard questions in a sensitive manner about experiences of domestic abuse during all antenatal appointments and not just the booking appointment (if safe to do so) and to include in the electronic patient records.

7.1.6 Consider means of creating a 'safe space' which could be accessed during consultations if required. An example of this would be keeping the weighing and measuring equipment in a separate room. This requires further exploration with maternity and estate colleagues.

*CRC (now the NPS)*

7.1.7 The London CRC to ensure that all contact with service users is recorded in a timely manner, and in accordance with London CRC quality practice standards.

7.1.8 The London CRC to revise the internal transfer policy to ensure that all internal transfers within London are undertaken following discussions between transferring officers and accompanied by a record of contact within the appropriate case management system.

7.1.9 The London CRC quality practice standards to make specific reference to sharing information and sentence plans with appropriate external partners, to support collaborative working.

7.1.10 The London CRC to revise Community Payback operations, to ensure an increase in the number of service users completing unpaid work requirements within the statutory 12-month period from sentence.

7.1.11 The London CRC to mandate the completion of risk assessment and risk management training for all practitioners on a rolling 2-year basis.

7.1.12 The London CRC to ensure the accountability structure captures information relating to service user's engagement and recording (e.g., incomplete outcomes, case with no next appointments and acceptable absences). To ensure these service delivery measures are reviewed at an area level on a monthly basis.

*Croydon Council Housing*

7.1.13 That Housing Staff to completed DVAS training via the FJC.

*GP 1 (IMR completed by South East London CCG)*

7.1.14 Feedback to individual practice as to the findings of this review to support individual learning needs and signposting to resources from previous CCG trainings on mental health and risk assessments.

7.1.15 Healthcare professionals to have a lower threshold to make referral on behalf of a patient to counselling services where appropriate (instead of patient's being asked to self-refer) and ensure they follow-up with those asked to self-refer.

7.1.16 Highlighting the role and use of social prescribers/navigators and Southwark Wellbeing Hub to GPs e.g., when someone is faced with multiple issues such as unemployment and homelessness. The social prescribing service was introduced in Spring 2020. The service may be altered due to the Covid-19 pandemic.

7.1.17 The case to be discussed with the local Mental Health Commissioner to review local services and establish whether any support is available in adulthood to those on Autistic spectrum or whether existing services have experience in or feel they are able to adapt sufficiently to meet the needs of this group of people e.g., counselling services, job centre etc.

*KCH*

7.1.18 Clinicians, particularly front-line practitioners in the Emergency Departments are encouraged to routinely ask questions regarding domestic abuse for all services users.

*GP 2*

7.1.19 Practice to revise the template used for clinical records in relation to pregnancy and add questions as part of the clinical assessment to ask about support network.

7.1.20 Practice to strengthen arrangements with regards to the management of domestic abuse.

7.1.21 The practice should ensure safeguarding arrangements is robust and that the practice has up to date safeguarding policies relating to domestic abuse.

7.1.22 The [domestic abuse and sexual violence] lead at the practice should attend at least 50% of the forums coordinated by the CCG and FJC.

*SAVU (now the CHEH)*

7.1.23 To ensure closer and revised monitoring of the referred CHEH clients (via the CHEH Operations Group, formerly SAVU).

7.1.24 To adopt a whole family focused approach (including additional services such as a dedicated victim support worker, a drugs and alcohol support worker, family information, advice and guidance for parents and siblings, as well as a dedicated housing support worker).

7.1.25 To undertake a training needs analysis for CHEO Operations Group staff to ensure a consistent level of knowledge and messaging for all clients.

7.1.26 To improve recording of engagement sessions.

7.1.27 To ensure more robust risk management at an operational level (including (a) risk assessment to be reviewed and refreshed to include details of close relationships which will be reviewed on a regular basis and (b) risk assessment be quality controlled on acceptance and on a monthly basis.

7.1.28 To ensure more robust risk management at a strategic level (including introduction of a governance board – Community Harm & Exploitation Board).

7.1.29 To introduce a Single Information Technology recording system or use one of the existing systems within the Council.

7.1.30 Commissioned services (i.e., service providers within the CHEH Operations Group) to be informed of new approach for 2021/22 and the rationale behind it.

7.1.31 To increase monitoring meetings with commissioned services to better manage risk.

7.1.32 Training to be provided for staff and/or single points of contact, for all support, whether single agency or multi-agency, to ensure individuals and families are referred to the correct support services to cover all of their needs.

## 7.2 DHR Recommendations

7.2.1 The Review Panel has made the following recommendations as part of the DHR. These are described in section 5 as part of the analysis and are also presented collectively in **Appendix 3**.

7.2.2 **Recommendation 1:** 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 (to include adult children).

7.2.3 **Recommendation 2:** The MPS, as part of its current work to review referral processes with Victim Support, to review how information is transferred to Victim

Support to ensure that relevant case details are included and can therefore inform the approach taken by Victim Contact Officers.

7.2.4 **Recommendation 3:** The Southwark Community Safety to review the local definition and threshold for making referrals to the local MARAC based on escalation.

7.2.5 **Recommendation 4:** The Safer Croydon Partnership to review the local definition and threshold for making referrals to the local MARAC based on escalation.

7.2.6 **Recommendation 5:** The London VRU to review the learning from this DHR via the Violence Reduction Practitioners Network and:

- Raise awareness of the issues relating to the management of cross borough moves by sharing the lessons learnt from this DHR via its knowledge hub sessions and/or the newly established Violence Reduction Practitioners Network;

- Encourage boroughs to ensure there is a robust mechanism to identify and manage any risk when young people move to different areas by including 'effective handover' as an action in the template Violence Reduction Plan.

7.2.7 **Recommendation 6:** The London NHS Domestic Violence and Abuse Clinical Reference Group work to consider the learning from this DHR and agree actions to ensure a more consistent health response, including whether there should be a national recommendation for the development of an intercollegiate document on DVA training for all health staff.

7.2.8 **Recommendation 7:** The Southwark Community Safety 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond.

7.2.9 **Recommendation 8:** The Safer Croydon 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond.

7.2.10 **Recommendation 9:** The Southwark Community Safety Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally.

7.2.11 **Recommendation 10:** The Safer Croydon Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally.

7.2.12 **Recommendation 11:** The Safer Croydon Partnership to ensure that, in developing its partnership response to domestic abuse and other issues, there is

a robust mechanism to enable the specific consideration of the needs of minoritized communities and the implications in terms of awareness raising, training, service provision, and strategy. This should include targeted consultation with local communities and input from led by and for specialist services.

# Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Emma and Ryan following the death of Emma in June 2019. Child A, who was born under emergency caesarean section, also died. The Domestic Homicide Review 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 Emma and Ryan during the relevant period of time from the 1st January 2014 (the relationship is believed to have begun in 2014 or 2015) to the date of the homicide in June 2019 (inclusive). To summarise agency involvement prior to this time period where it is relevant.
2. 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.
3. 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.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. 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.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

### Role of the DHR Panel, Independent Chair and the CSP

8. *The Independent Chair of the DHR will:*
   a) Chair the Domestic Homicide 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.

9. *The Review Panel will:*
   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.
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 Croydon Safer Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

*Croydon Safer Partnership will*:

a) Be the lead Community Safety Partnership (CSP), with responsibility for the commissioning of the DHR process.
b) Translate recommendations from Overview Report into a SMART Action Plan.
c) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
d) Forward Home Office feedback to the family, Review Panel and STADV.
e) Agree publication date and method of the Executive Summary and Overview Report.
f) Notify the family, Review Panel and STADA of publication.

*Southwark CSP will:*

a) Be an associated CSP, with responsibility for supporting the DHR process.
b) Nominate a Single Point of Contact to be a member of the Review Panel.
c) Facilitate the engagement of other Review Panel members from Southwark as appropriate.
d) Support the translation of any recommendations from Overview Report into a SMART Action Plan where they relate to Southwark and takes responsibility for progressing these.

## Definitions: Domestic Violence and Coercive Control

10. 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.

## Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Emma and Ryan (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).
12. The Review Panel identified the following protected characteristics of Emma and Ryan as requiring specific consideration for this case:

- Disability (Emma had no known disability; Ryan had a diagnosed Autistic Spectrum Disorder (ASD);
- Pregnancy and maternity (Emma was pregnant when she was attacked);
- Race (Emma was Black British Mauritanian; Ryan was also Black British although his ethnicity is currently unknown); and
- Sex (Emma was female; Ryan is male)

13. Consideration has been 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.
    The Review Panel will consider this during the course of the DHR.
14. If Emma and Ryan 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. The Chair will make the link with relevant interested parties outside the Review Panel.
15. The Review Panel agrees it is important to have an intersectional framework to review Emma and Ryan'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.

## Membership

16. 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 (see paragraph 17 - 19).

## Key Lines of Inquiry

17. In order to critically analyse the incident and the agencies' responses to Emma and/or Ryan, 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 Emma and Ryan [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: the impact of Ryan's reported violence against his mother, his childhood experiences and his ASD diagnosis.
    h) Analyse any evidence of help seeking (in particular as Emma had limited contact with services), 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

18. 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 Croydon Partnership on their action plans within six months of the Review being completed.
19. Safer Croydon 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.

### Media handling

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

# Appendix 2: Single Agency Recommendations and Template Action Plan

| No. | Recommendation | Key Action | Evidence | Key Outcomes | Named Officer | Date | Update |
|---|---|---|---|---|---|---|---|
| *CHS* | | | | | | | |
| 1 | Practitioners to document the full names, and relationship of any friends or relatives who accompany patients into the consultation room, after consent has been sought. The relevance of this should be included in all learning opportunities and be evidenced through audit activity. | Clear documentation of full name and relationship of individuals who accompany patients into the consultation room<br><br>Staff need to be supported in considering pre-emptive practice, in situations where there is a need to ask accompanying friends and relatives to leave the room during the consultation, in a safe and sensitive manner. | Audit activity can be provided on request, | | SI NNSA | March 2022 | 21.3.22: 07:10:21;Ongoing work to improve domestic abuse sensitive enquiry, including changes to Cerner, training delivery and auditing within service. Ongoing<br><br>February 2022: CHS IDVA and safeguarding adult team have started delivering bespoke training to ED, around how to escalate safeguarding and domestic abuse concerns. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Incorporate 'how to ask difficult questions', and 'how to sensitively ask direct domestic abuse questions' into bespoke domestic abuse training | | | | | August 2021<br>Staff will record identifiable information about friends/relatives who accompany patients into consulting rooms. |
| 2 | Raise awareness during domestic abuse training around professional curiosity. This should include the potential need for practitioners to create safe situations to speak with patients confidentially if the need arises and potential coercive control and risk is evident. | Raise awareness of professional curiosity, and how to create situations where patients can be spoken to alone.<br><br>Incorporate professional curiosity into bespoke training. Develop a strategy where patients can be legitimately asked to leave the room, and indicate whether they are experiencing domestic abuse. | This action to be included in the annual audit cycle. | Increase confidence in professionals to ask question about domestic abuse | SI<br>NNSA | March 2022 | 21.3.22: 07:10:21; JS: Case-based learning and critical thinking delivered but need to be expanded to maternity teams. Ongoing<br><br>February 2022.<br>Three Safeguarding Champions have been identified in Adult ED, and have agreed to receive bespoke safeguarding and domestic abuse training. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | August 2021<br>Tangible strategy in place, where its effectiveness can be monitored |
| 3 | Consideration to be given to the development of posters and/or leaflets which provide information relating to domestic abuse, the Trust's commitment to supporting victims of abuse and explanation that in view of this, a standard domestic abuse question will be asked of all women during their maternity care. This could include a standard reference to domestic abuse in the handheld records. | Standard domestic abuse question to be asked during all antenatal appointments, and recorded in electronic patient record.<br><br>Joint strategy with midwifery services to incorporate this question into all antenatal contacts. | This action can be monitored via the audit cycle. | Increased opportunities for victims to disclose abusive behaviour. | SI<br>NNSA | March 2022 | 21.03.21: 7:10:21; February 2022:<br>Case-based learning, critical thinking and domestic sensitive enquiry training to be delivered to maternity and other services. Ongoing Cooperation from Heads of Services to support ownership and buy in, around embedding the change in practice.<br><br>June 2021<br>Clear documentation in electronic patient record that direct domestic abuse |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | question has been asked. |
| 4 | Consideration to be given to Midwives asking standard questions in a sensitive manner about experiences of domestic abuse during all antenatal appointments and not just the booking appointment (if safe to do so) and to include in the electronic patient records. | Standard domestic abuse question to be asked during all antenatal appointments, and recorded in electronic patient record. | This action can be monitored via the audit cycle. | Increased opportunities for victims to disclose abusive behaviour.<br><br>Reduced amount of victims repeating their story if recorded on their electronic patients records. | SI<br>NNSA | March 2022 | June 2021<br>Clear documentation in electronic patient record that direct domestic abuse question has been asked. |
| 5 | Consider means of creating a 'safe space' which could be accessed during consultations if required. An example of this would be keeping the weighing and measuring equipment in a separate room. This | Where practicable, weighing and measuring equipment to be kept in a separate room to where consultations are held.<br><br>Organisation wide discussions around having separate | | Increased opportunities for victims to disclose abuse in a safe environment. | SI<br>NNSA | March 2022 | 07:10:21: Feb 2022: awaiting update from public health nursing lead.<br>Case presentation to the Executive Team to support ownership and buy in, around embedding the change in practice, |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | requires further exploration with maternity and estate colleagues. | spaces for consultations and weighing and measuring equipment. | | | | | with support from the Estates Department.<br><br>November 2021<br>Provision of a separate space for practitioners to speak with patient's alone. |
| *CRC (now the NPS)* | | | | | | | |
| 1 | The London CRC to ensure that all contact with service users is recorded in a timely manner, and in accordance with London CRC quality practice standards. | Delius MIS reports to be produced. PP to use these to identify any blank outcomes.<br><br>Spo's to regularly raise issues of blank outcomes with PP's | The PS has a target that all contacts are recorded within 24 hours of a contact. The report prepared shows the number and the detail of contacts that have not been completed. This is raised in whiteboard meetings with practitioners | Greater awareness of the need to update quickly. PP's held to account if the work is not completed in a timely manner | HoS – Croydon PDU | 30/09/2021 | LCRC no longer exists and therefore the Probation Service – London have undertaken these actions. Process have been reviewed however they are still under review and are being revised to ensure that they are relevant and fit with the National processes. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2 | The London CRC to revise the internal transfer policy to ensure that all internal transfers within London are undertaken following discussions between transferring officers and accompanied by a record of contact within the appropriate case management system. | To ensure that all transfers follow the PS transfer PI.<br><br>Transfers document to be devised and used by OM's when transferring cases within the PDU to ensure important information is passed on.<br><br>Case record to be updated with contact between PP's | The PDU has a transfer mailbox. Transfers are triaged via this mailbox and allocated out by the Transfer SPO if appropriate to come to the PDU.<br>Transfer document has been developed in the PDU, roll out needs to take place and embedded.<br><br>Transfers that have not completed within an appropriate period of time are escalated to SPO and Head of Service. | There is a greater oversight of transfers within the PDU.<br>Transfers in are tracked so that once allocated it is clear how many appointments need to take place and actions before full transfer is completed. | HoS PDU | 28/02/2022 | Transfer OASYS (risk assessment) should be undertaken in all cases where a transfer is happening. |
| 3 | The London CRC quality practice standards to make specific reference to sharing information and sentence plans with appropriate | Risk assessments to be shared as appropriate to relevant partners.<br><br>All staff to be briefed in MAPPA | Information sharing protocols are held centrally.<br><br>MAPPA protocols for sharing information well established in the region and PDU. | Information is shared appropriately. | HoS | 30/08/2021 | Processes for sharing information embedded within the PDU. LCRC staff are reminded of the processes that are in place. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | external partners, to support collaborative working. | Information sharing protocols identify who the Probation Service should share information with such as police, SS, | Escalation process in place if there are any difficulties with the information that needs to be shared. | | | | |
| 4 | The London CRC to revise Community Payback operations, to ensure an increase in the number of service users completing unpaid work requirements within the statutory 12-month period from sentence. | Provide feedback on level of projects available. | Briefings held at SLT level as well as local level to update on current position. | There has been an increase in UPW projects however a backlog remains.<br><br>Cases where the operating period is expiring are being extended so that UPW hours are completed. | Head of Interventions | | COVID and current risk assessments have prevented an increase the number of service users completing UPW. Latest update 23/03/22.<br><br>Different projects are being looked at to improve completion rates. |
| 5 | The London CRC to mandate the completion of risk assessment and risk management training | All LCRC staff to undertake mandatory training in 4 pillars (Risk framework) | Training schedules are checked by SPO's. Mandatory training is reviewed regularly, and | Staff are more skilled in identifying risk issues. The current system | HoS | 28/02/22 | During unification there has been a raft of training. Mandatory training such as |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | for all practitioners on a rolling 2-year basis. | | training records held centrally are updated. | means that dependant on grade of staff assessments are countersigned by a manager. | | | safeguarding is renewed normally on a 3 year cycle. Training in different areas of work such as 4 pillars and risk training is readily available and can be accessed when training is updated e.g. sex offender training which includes elements of desistance and managing risk |
| 6 | The London CRC to ensure the accountability structure captures information relating to service user's engagement and recording (e.g., incomplete outcomes, case with no next appointments and acceptable absences). To ensure | Supervision framework to be implemented. Performance measures to be reviewed on a monthly basis in Managers meeting. Whiteboard meetings to take place weekly. Probation Practitioner dashboard to be produced. | Supervision framework in place. HoS checks that this is happening with staff. Whiteboard meetings have been set up and revised. Managers discuss probation dashboard and outstanding tasks such as no next appointment and blank contacts with Probation Practitioners during supervision. | More accountability. Discussions look at how to prevent performance misses. Data closure days have been introduced to ensure that data quality such as no | HoS | 30/08/2021 | Accountability meetings is an ongoing activity happening on a monthly basis. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | these service delivery measures are reviewed at an area level on a monthly basis. | | | next appointments are picked up and addressed | | | |
| Croydon Council Housing | | | | | | | |
| 1 | That Housing Staff to completed DVAS training via the FJC. | Training to be introduced to all tenancy team – 22 members of staff. | Emails confirming attendance. | Housing Staff will having an increased understanding of the following:<br>•Understand what domestic abuse is<br>•Increased awareness and signs of domestic abuse<br>•Assessment of risk<br>•The role of the Family Justice Centre<br>•Understanding the risk and | | | Completed in March and June 2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | impact on babies, children and Young people<br>•Brief overview of Risk Identification Checklist and the MARAC<br>•Barriers to accessing help and support<br>•Why doesn't she leave? | | | |
| | *GP 1 (IMR completed by South East London CCG)* | | | | | | |
| 1 | Feedback to individual practice as to the findings of this review to support individual learning needs and signposting to resources from previous CCG trainings on mental | Discuss recommendations and share final draft with practice member once it has been signed off<br><br>Share resources to strengthen learning in respect to mental | Correspondence and minutes of meetings | More thorough mental health risk assessments by primary care professionals at the practice | Dr Megan Morris (Named GP for Adult Safeguarding, Southwark SEL CCG) | March 2022 | Email to be sent out shortly, with final draft of review – to plan for further discussions. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | health and risk assessments. | health risk assessments | | | | | |
| 2 | Healthcare professionals to have a lower threshold to make referral on behalf of a patient to counselling services where appropriate (instead of patient's being asked to self-refer) and ensure they follow up with those asked to self-refer. | Share case with primary care clinicians at Borough-wide training event to exemplify the need to lower thresholds for assisted referral to IAPT for people with autistic spectrum disorder, learning disability, or other communication difficulties.<br><br>Discuss this scenario with IAPT to consider making jointly agreed guidance for GPs and IAPT staff to make reasonable adjustments for such patients. | Slides from training event<br><br>Correspondence/minutes from any discussions had with IAPT<br><br>Guidance documents | Reasonable adjustments made for people with communication difficulties, including autistic spectrum disorders, when sending or receiving referrals for counselling services | Dr Megan Morris (Named GP for Adult Safeguarding, Southwark SEL CCG) | March 2022 | Planning to present at Practice Safeguarding Leads Forum (Training event) in March<br><br>Have made contact with IAPT and been assured that they have a policy for making reasonable adjustments when it is known that someone has an ASD or learning disability, but the scope of their service is limited to those with mild impairments. We have agreed to try to create joint guidance for GPs and IAPT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | therapists to support patients who may need reasonable adjustments. |
| 3 | Highlighting the role and use of social prescribers/navigators and Southwark Wellbeing Hub to GPs e.g., when someone is faced with multiple issues such as unemployment and homelessness. The social prescribing service was introduced in Spring 2020. The service may be altered due to the Covid-19 pandemic. | Ensure all practices are using the social prescribers allocated to their practices by obtaining referral data from social prescribers to understand if there are practices who are not using the service, and reach out to these specific clinicians to highlight the service to them | Referral data by practice in the borough | Widespread use of Social Prescribing from Primary Care to ensure better social support for people facing multiple social issues. | Dr Megan Morris (Named GP for Adult Safeguarding, Southwark SEL CCG)<br><br>(returned from maternity leave) | March 2022 | Will make contact with the Primary Care Networks and social prescribing teams to ask for this information |
| 4 | The case to be discussed with the local Mental Health Commissioner to review local services and establish whether | Make contact with the Local Mental Health Commissioner and discuss services available to adults | Correspondence and minutes from meetings | Commissioners made aware of real case to influence decision making when | Dr Megan Morris (Named GP for Adult Safeguarding, Southwark SEL CCG) | December 2021 | Contact made by email and initial meeting had 8/12/21. Established that there is already an |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | any support is available in adulthood to those on Autistic spectrum or whether existing services have experience in or feel they are able to adapt sufficiently to meet the needs of this group of people e.g., counselling services, job centre etc. | with autistic spectrum disorders | | commissioning services. | (returned from maternity leave) | | ongoing review into services for people with autistic spectrum disorders. The first priority has been to develop a diagnostic service (not currently available for adults), but there is also a new LD/Autism Lead at the CCG who acts as an informal advisor to social prescribers and clinicians to help signpost them to/liaise with services to support patients with LD/autism, whether formally diagnosed or not. There is currently no autism specific service in Southwark, and |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | mental health support depends on the complexity/severity. If an individual has significant mental health difficulties they will be seen through CMHT, but IAPT services less well equipped. |
| *KCH* | | | | | | | |
| 1 | Clinicians, particularly front-line practitioners in the Emergency Departments are encouraged to routinely ask questions regarding domestic abuse for all services users. | Ongoing drive trust wide to raise awareness on Domestic Abuse ; specifically to be asking "How are things at Home? " at patient contact | Second Virtual DA awareness event held on the 22/3/2022 | Key outcome is to drive awareness. Event recorded and will be available Trust wide on the Safeguarding Education pages on Trust Intranet | Heather Payne, Head of Adult Safeguarding | 22/03/2022 | |
| *GP 2* | | | | | | | |
| 1 | Practice to revise the template used for clinical records in | Now using Ardens antenatal/pregnancy templates which | Screenshots from antenatal template is available at request | To provide better support, care & | Dr Ayesha Sharieff | 14/12/21 | Practice to revise the template used for clinical records |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | relation to pregnancy and add questions as part of the clinical assessment to ask about support network. | have questions about DVA, FGM & MH screening for all trimesters | | signposting to pregnant patients.<br>To prompt clinicians & raise awareness of DVA & MH issues | | | in relation to pregnancy and add questions as part of the clinical assessment to ask about support network. |
| 2 | Practice to strengthen arrangements with regards to the management of domestic abuse. | Practice fully engaged with the IRIS programme and has excellent referral record<br>All Practice staff have attended DVA training | Contact details for the Advocate Educator of the IRIS programme available to Practice staff.<br>Audit of training & referrals data available | To provide better support, care & signposting to all patients at risk of, or experiencing DVA | Dr Ayesha Sharieff | 14/12/21 | Practice to strengthen arrangements with regards to the management of domestic abuse. |
| 3 | The practice should ensure safeguarding arrangements is robust and that the practice has up to date safeguarding policies relating to domestic abuse. | Safeguarding policy updated Dec 2021<br>Policies in place & reviewed for domestic abuse both patients & staff who may be subject to domestic abuse | Safeguarding Policy available at request | To ensure all staff & patients are aware of, and are supported by, the appropriate safeguarding agencies.<br>Ensure appropriate referrals can be made | Dr Ayesha Sharieff | 14/12/21 | The practice should ensure safeguarding arrangements is robust and that the practice has up to date safeguarding policies relating to domestic abuse. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4 | The [domestic abuse and sexual violence] lead at the practice should attend at least 50% of the forums coordinated by the CCG and FJC. | | | | | | |
| *SAVU (now the CHEH)* | | | | | | | |
| 1 | To ensure closer and revised monitoring of the referred CHEH clients (via the CHEH Operations Group, formerly SAVU). | To set up monthly monitoring meeting with specific referral agencies<br><br>To move to weekly online or face to face meeting to ensure closer monitoring of clients<br><br>Review collection and storage of CHEH client's data | All meetings in the new meeting structure have action minutes held on a central Southwark database. | Monthly review meetings with specific referral agencies.<br><br>Weekly meeting to monitor progress or non-engagement of CHEH clients. | Bethan West | 31/08/2022<br><br>With immediate effect | Completed<br><br>Completed<br><br>Implementation currently ongoing – |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Data files review, new data storage platform identified and implemented. | | | will be completed by Dec 2022. |
| 2 | To adopt a whole family focused approach (including additional services such as a dedicated victim support worker, a drugs and alcohol support worker, family information, advice and guidance for parents and siblings, as well as a dedicated housing support worker). | Whole family approach adopted.<br><br>Review integration with Children Social Care and Early Health<br><br>Information, advice and guidance programme for parents funded and created. | Revised terms of reference document.<br><br>Additional membership of review meetings and attendance.<br><br>Evaluation document (when signed off). | Approach has been adopted.<br><br>Attendance at weekly review and monitoring meeting of a relevant children/adult social care staff, Youth Justice staff representative, a dedicated housing worker and parents IAG service.<br><br>Parents IAG service has | Bethan West | With immediate effect<br><br>Sept 30th 2022<br><br>October 2022 | Completed<br><br>Completed<br><br>Final draft of evaluation being reviewed for release in October 2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | been independently evaluation | | | |
| 3 | To undertake a training needs analysis for CHEO Operations Group staff to ensure a consistent level of knowledge and messaging for all clients. | Training needs assessment to be undertaken.<br><br>A programme of multi-agency training set up. | Reports for each action.<br><br>Training plan produced. | Training needs analysis undertaken<br><br>Plan in place with specific emphasis on contextual safeguarding and Modern slavery and County Lines and refresh training on risk management. | Bethan West | July 2022<br><br>September 2022 | Completed<br><br>Training Ongoing |
| 4 | To improve recording of engagement sessions. | Meetings are now recorded via teams with actions being recorded separately and circulated to staff individually for accountability. | Recoding of meetings held securely, and action minutes produced. | Recording of each meeting is stored and actions minutes are stored in a secure data base. | Bethan West | October 2022 | Implementation ongoing |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 5 | To ensure more robust risk management at an operational level (including (a) risk assessment to be reviewed and refreshed to include details of close relationships which will be reviewed on a regular basis and (b) risk assessment be quality controlled on acceptance and on a monthly basis. | All risk delivery management structures both internally and across the partnership reviewed.<br><br>Additional measures put in place suggested by statutory and voluntary sector partners. | Risk review report.<br>All additional measures partners form part of the review document. | Refresh delivery risk management plan in place. | BW and various partners | July 2022 | Completed<br>Risk management plan reviewed annually. |
| 6 | To ensure more robust risk management at a strategic level (including introduction of a governance board – Community Harm & Exploitation Board). | New Governance structure developed for Southwark Community Safety Partnership | New Boards launched. | Review of Governance Structure undertaken<br><br>Reducing violence Board created. | Various strategic Partners | Jan 2022<br><br>Nov 2022<br><br>Sept/Oct 2022 | Completed<br><br>Membership identified and terms of reference drafted.<br><br>Membership identified and terms |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Community Safety Partnership Board created | | | of reference drafted. |
| 7 | To introduce a Single Information Technology recording system or use one of the existing systems within the Council. | Recording system identified<br><br>Funding sought.<br><br>Implementation of single information technology system | New case work platform in place. | System identified – Upshott.<br><br>Funding identified from CHEH/CST budget.<br><br>Implementation ongoing. | BW | Oct 2022 | There may be some a short delay on the implementation until Nov 2022. |
| 8 | Commissioned services (i.e., service providers within the CHEH Operations Group) to be informed of new approach for 2021/22 and the rationale behind it. | Commissioned services managers and delivery staff briefed on new approach and changes in delivery | Minutes recorded | Briefing and workshop held | | | Completed - Dec 2021 |
| 9 | Increase monitoring meetings with commissioned | Monthly meeting to replace quarterly meeting | Terms of Reference | Briefing and workshop held partners | BW | Aug 2022 | Completed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | services to better manage risk. | Commissioned and relevant service managers meeting bi-monthly to ensure all services are up to date with high-risk cases and any emerging trends across the Borough | Minutes recorded | included when necessary.<br><br>Meeting schedule in place and bimonthly meetings are taking place. | | Aug 2022 | Completed and meetings are ongoing |
| 10 | Training to be provided for staff and/or single points of contact, for all support, whether single agency or multi-agency to ensure individuals and families are referred to the correct support services to cover all of their needs. | One hour awareness raising presentation prepared for partners and delivered. | Awareness raising material produced. | 12 awareness raising seminars delivered in 12 months. | BW and CHEH team | Started June 2022 | 8 delivered to date<br>2 additional sessions booked. |

# Appendix 3: DHR Recommendations and Template Action Plan

| No. | Recommendation | Key Action | Evidence | Key Outcomes | Named Officer | Date | Update |
|---|---|---|---|---|---|---|---|
| 1 | 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 (to include adult children). | | | | | | Emailed to the HO for a response. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2 | The MPS, as part of its current work to review referral processes with Victim Support, to review how information is transferred to Victim Support to ensure that relevant case details are included and can therefore inform the approach taken by Victim Contact Officers | The review process is ongoing and legal advice awaits regarding any change to the extent of the data currently shared. As this recommendation concerns an MPS wide procedure (Service Level) it has been referred for consideration by the Commander responsible for Continuous Policing Improvement Command (CPIC). | Service Level Recommendation response to SCRG | Updated guidance detailing the parameters for information sharing for Victim Support referrals | Commander Clayman | Referred March 2022 | Meetings regarding this process are ongoing. To date the MPS have not had a request from Victim Support to extend the level of information currently shared. Further updates will be provided to Croydon Community Safety Partnership |
| 3 | The Southwark Community Safety to review the local | Review undertaken between the | Review report<br><br>Awareness raising briefing | Review delivered, over 20 partner | B West | Sept 2022 | Completed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | definition and threshold for making referrals to the local MARAC based on escalation. | CHEH and MARAC.<br><br>Wider partnership awareness raising briefing created. | prepared and delivered to partners | agencies included.<br><br>Quarterly meeting arranged between CHEH and MARAC managers to ensure referral process is being implemented correctly.<br><br>Briefing presentation on new approach created and awareness sessions have been started. | | | |
| 4 | The Safer Croydon | Review of MARAC referral | DASV board meeting minutes | Enable more victims to be | SCP/VRN | March 2022 | March 2022: The decision has been |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Partnership to review the local definition and threshold for making referrals to the local MARAC based on escalation. | In partnership with MPS and MARAC partners<br><br>Reduce call outs from 3-4 in 12 months.<br><br>Promote new referral process locally and internally | Provide MARAC referral<br><br>Provide data from MARAC coordinator<br><br>DASV bulletin, Staff bulletin (CSC, Education, CCG) | heard at MARAC and reduce further risk of harm.<br><br>Increase awareness of new threshold locally | | | made as a partnerships to remain on 4 or more call out's which is within safe lives guidance in terms of criteria for MARAC unless it's been indorsed by the MOPAC. |
| 5 | The London VRU to review the learning from this DHR via the Violence Reduction Practitioners Network and:<br><br>- Raise awareness of the issues relating to the management of cross borough moves by sharing the | a)Include Management of Cross-Borough Moves within a joint VRU/London Heads of Community Safety Partnership Learning Session<br><br>b)Include Management of Cross-Borough Moves within a | Included within a meeting agenda foe a meeting before end of January 2023<br><br>Included within a meeting agenda foe a meeting | Raised awareness of risks and effective practice options<br><br>Raised awareness of risks and effective | Steve Bending<br><br>Jain Lemom | 31/3/23<br><br>31/3/23 | Formal response from VRU and MOPAC VAWG team provided on 01/08/22. The VRU will include the awareness action within an effective practice session for London Heads of Community Safety before end of January 2023 and will report back to confirm when complete. The |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | lessons learnt from this DHR via its knowledge hub sessions and/or the newly established Violence Reduction Practitioners Network;<br><br>- Encourage boroughs to ensure there is a robust mechanism to identify and manage any risk when young people move to different areas by including 'effective handover' as an action in the template Violence Reduction Plan. | London VAWG Coordinators Meeting<br><br>c)Include handover of at risk young person to/from one London Borough to another, in the Menu of Options for local violence and vulnerability action plans; in relation to those young people under 25 who are at risk as perpetrators or victims of violence | before end of January 2023<br><br>Included within the next revision of the action plan template | practice options<br><br>Raised awareness of risks and effective practice options | Steve Bending | 31/3/23 | VAWG Team will to similarly in relation to the VAWG Coordinators Meeting. Once the V&V plan template is updated in 2023, the VRU will confirm by update. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6 | The London NHS Domestic Violence and Abuse Clinical Reference Group work to consider the learning from this DHR and agree actions to ensure a more consistent health response, including whether there should be a national recommendation for the development of an intercollegiate document on DVA training for all health staff. | DVA CRG meeting is on 19/05/2022<br><br>Ash Kurup is project lead for safeguarding at NHSE/London region and to meet with the DVA CRG chair. Asked for access to the DHR report to discuss with Chairs only. | | | aiswaryakurup@nhs.net | | Update from Clarecapito@nhs.net<br><br>16/03/22 16 03 22 Clare to ask Croydon Safety Partnership and DHR chair if the report can be shared with the DVA CRG chairs.<br><br>17/03/2022 Safer Croydon Partnership agreed to share the report and emailed to Claire. |
| 7 | The Southwark Community Safety Partnership to work with local | Staff to be briefed DHR outcomes and referral pathways. | Presentation slides. | Presentation given to partners, delivery, and strategic staff. | B West | Sept 2022 | Completed |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond. | Training needs assessment undertaken. | Minutes of development meetings.<br><br>Training needs assessment | Pathways have been reviewed and expanded.<br><br>CHEH and MARAC briefed about refreshed approached.<br><br>Training assessment completed. | | | |
| 8 | The Safer Croydon | Present recommendation | Minutes from meeting | Actions will be identified | All VRN | 4/04/2022 | Chair has been invited to the SCP |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 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, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond. | s and key actions at SCP meeting<br><br>Present action plan at adults and children SG boards.<br><br>Promote webinar on CPA/AFC.<br><br>A summary of the findings of this DHR will be developed and shared with local partners. | <br><br>Minutes from the meeting<br><br>Event poster and email invite<br><br>A copy of the summary of the learning.<br><br>Confirmation and evidence that the leaning was | for agencies through this meeting and included into this action plan<br><br>Identify opportunities to increase learning and understanding of CPV/AFC.<br><br>Increase earlier identification of CPV/AFC and referrals to the FJC | | TBC<br><br>TBC<br><br>June 2022 | meeting on the 4th April 2022 to brief the board on the report including the action plan and recommendations<br><br>Currently being planned during the 16 days of action 2022<br>7 minute briefing will be shared with the Croydon VAWG network, DASV Partnership Board and the Bame |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Include module of AFC/CPV to current FJC training package | shared and who with.<br><br>Provide evidence of training package link | Builds awareness of this abuse internally and externally.<br><br>Learning from this case will be cascaded and fully understood by staff and outside agencies - and applied in practice<br><br>In-depth learning of AFC/CPV, the role of the FJC, MARAC, RIC assessment and barriers to leaving. This training is available to | | From Septembe r 2022 | Domestic abuse forum |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | any professional working in Croydon for free. | | | |
| 9 | The Southwark Community Safety Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally. | Additional work to be done with NHS England, Public Health and voluntary sector organisations supporting mental health ( and complex needs where mental health and drug use present)<br><br>Examination of the CHEH cohort | Meetings held.<br><br>Several new approaches being reviewed with voluntary sector organisations including drugs and alcohol support.<br><br>Confidential assessment process initiated | Additional processes to review cohort neurodiversity have been created and implemented.<br><br>Cohort reviewed by mental health professional | B West | Ongoing | Ongoing. Challenge getting consent from clients for further assessments and a reluctance to engage with support services that can help due to deep rooted stigma and misunderstanding linked to mental health diagnosis |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | for any neurodiversity needs assessments | | | | | |
| 10 | The Safer Croydon Partnership to work with local partners to review the findings from this DHR and evaluate the response to neurodiversity locally. | Present findings from this DHR at both the DASV board and the SCP board as well as the children SG and adult SG boards.<br><br>Work in partnership with SLaM to evaluate link between DA and neurodiversity<br><br>Arrange a neurodiversity presentation to the DASV board | Minutes of meetings | | SCP/VRN | March 2022 | 7 minute briefings have been planned to share at these meetings<br><br>The MPS have been emailed to deliver ND presentation. |
| 11 | The Safer Croydon Partnership to ensure that, in | The SCP to ensure representation at the BAME | Minutes/notes from meeting | | SCP/VRN for all | March 2022 | DASV Coordinator and the Hate Crime Coordinator both |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | developing its partnership response to domestic abuse and other issues, there is a robust mechanism to enable the specific consideration of the needs of minoritized communities and the implications in terms of awareness raising, training, service provision, and strategy. This should include targeted consultation with local communities and input from led by and for specialist services. | Domestic Abuse Partnership (BDAP) meetings and the Women of Colour Safety Forum.<br><br>Member of BDAP to continue to be a member of the DASV partnership board meeting<br><br>Engage with BDAP to co-deliver and support a survey specifically engaging with WOC around domestic abuse | Minutes from the meeting | BDAP can scrutinise the decisions of the board and have input over strategic oversight.<br><br>Feedback and update the board on BDAP to ensure views are represented. | | March 2022<br><br>March 2022 | represent SCP at these meetings.<br><br>Chair of the BDAP is a member of the board.<br><br>BDAP and the Croydon VAWG network are contributing to the BDAP survey for release this year to support the call for evidence for the new Croydon VAWG strategy. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | BDAP to consult on the VAWG public survey which will capture views to input into the new Croydon VAWG strategy.<br><br>Member of BDAP to sit on the Task and Finish Group for Croydon's new VAWG Strategy<br><br>Undertake a review of current awareness campaigns to ensure we are targeting specific areas and communities.<br><br>BDAP co-deliver on appropriate | FJC Data<br><br>Emails | Increase of referrals from women of colour to the FJC. | | | BDAP will sit on the task and finish group which will hold oversight of the survey.<br><br>Invites for this group will be sent out in April 2022. A member of BDAP will sit on the group.<br><br>2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | training and/or consult on cultural competency of training package. | | Improved training package | | | BDAP will be approached to work with DASV coordinator to review all training offers in Croydon. |

# Appendix 4: Glossary

| | |
|---|---|
| **AAFDA** | Advocacy After Fatal Domestic Abuse |
| **ACN** | Adult Come to Notice |
| **AFV** | Adult Family Violence |
| **ASD** | Autistic Spectrum Disorder |
| **BAMER** | Black, Asian, Minority Ethnic and Refugee |
| **CCTV** | Closed Circuit Television |
| **CHEH** | Community Harm & Exploitation Hub |
| **CHS** | Croydon Health Services NHS Trust |
| **CSP** | Community Safety Partnership |
| **CPV** | Child to Parent Violence |
| **CCG** | Clinical Commissioning Group |
| **CCR** | Coordinated Community Response |
| **CPV** | Child to Parent Violence |
| **CRC** | Community Rehabilitation Company |
| **CSP** | Community Safety Partnership |
| **DAHA** | Domestic Abuse Housing Alliance |
| **DASH RIC** | Domestic Abuse Stalking and Harassment Risk Indicator Checklist |
| **DHR** | Domestic Homicide Review |
| **ELR** | Extended Learning Review |
| **FJC** | Family Justice Centre |
| **FLO** | (MPS) Family Liaison Officer |
| **GP** | General Practice / Practitioner |
| **HIDVA** | Health Independent Domestic Violence Advisor |
| **HMCTS** | HM Courts & Tribunals Service |
| **IAPT** | Improving Access to Psychological Therapies |
| **IMR** | Individual Management Review |
| **IPV** | Intimate Partner Violence |
| **IRIS** | Identification & Referral to Improve Safety |
| **KCH** | King's College Hospital NHS Foundation Trust |
| **LAS** | London Ambulance Service |
| **MARAC** | Multi-Agency Risk Assessment Conference |
| **MOPAC** | Mayor's Office for Policing and Crime |
| **MPS** | Metropolitan Police Service |
| **NPS** | National Probation Service |
| **SARA** | Spousal Assault Risk Assessment |
| **SAVU** | Southwark Anti-Violence Unit |
| **SERVE** | Southwark Emergency Rehousing Victims of Violent Enterprise |
| **SFO** | Serious Further Offence (Review) |
| **VSHS** | Victim Support Homicide Service |
| **VRU** | Violence Reduction Unit |
| **VVU** | Violence and Vulnerability Unit |

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Ciara Goodwin
Domestic Abuse & Sexual Violence Coordinator
Violence Reduction Network
8 Mint Walk
Croydon
CR0 1EA

6 July 2022

Dear Ciara,

Thank you for submitting the Domestic Homicide Review (DHR) report (Emma) for Croydon Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25th May 2022. I apologise for the delay in responding to you.

The QA Panel felt this is a good quality, easy to read report. It has a good section on equality and diversity and provided some intersectional analysis on the identities and protected characteristics of the victim and perpetrator, including possible barriers to accessing services.

The report also robustly challenged agencies Individual Management Reviews (IMRs) and their lack of effective analysis around equality and diversity. There was appropriate representation on the panel from specialist agencies and experts providing BAME, mental health and domestic abuse expertise.

The inclusion of the family pen portrait at the beginning of the report gives weight to the family's contribution and keeps Emma central to the review. There was a very good recommendation around local areas reviewing their Multi Agency Risk Assessment Conference (MARAC) thresholds around escalation. This is a point often missed by DHRs and it can be critical in ensuring that cases involving escalating risk are referred to MARAC. The QA Panel found the recommendations to be clear and SMART, and there is an important focus in the report on cross borough working and the problems in continuity of service provision when perpetrators (and victims) move boroughs.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

**Areas for final development:**

- The cover page and throughout the report refer to a single victim “Emma” it may be more appropriate to include “Child A” who was also killed in the same attack, to acknowledge that two people were murdered.
- The report states accurately at 1.1.5 that Emma was killed / murdered whereas the Overview Report opens by describing her death. The language should refer to murder in order to not diminish the murder or create uncertainty for the reader.
- Given that it was learned that the perpetrator accessed emails on Emma’s phone and critically may have seen emails about her new relationship leading up to the murder, it would have been good for the report to put more emphasis on technology abuse and learning for agencies. Although agencies were not aware of this, it would be helpful to explore whether they have appropriate policies and practice in place to support victims of technology abuse.
- It would have been helpful to see more exploration at the connection between risks from perpetrators of adult family violence and how these relate to risks of intimate partner violence, as well as a gendered analysis around these risks.
- The Action Plans reflect the key requirements of the statutory guidance, and the actions are SMART. However, there is not enough detail included for a number of recommendations, and this appears to reflect a lack of response from the relevant agencies. This should be addressed before publication.
- There are several typos in the report. A thorough proofread is required.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

**Lynne Abrams**

Chair of the Home Office DHR Quality Assurance Panel