SAFER CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Adult J

July 2017

Independent Chair and Author of Report: Mark Yexley

Associate Standing Together Against Domestic Violence

Date of Completion (sent to CSP): December 2019

1. Preface

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1.1 Introduction

1.1.1 At 07:20 on a July morning in 2017 police were called to a house in Croydon, South London, when neighbours had heard screams coming from the premises. Police officers arrived to find that one of the occupants of a shared house had attacked three other residents. One of occupants, Adult J, was found unconscious inside the house, having suffered from multiple blows from a hammer. Adult J later died from her injuries. The other two victims, adult niece and nephews of Adult J, survived the attack. The perpetrator, Adult K, was a friend of the victims, who lived in the same household.

1.1.2 As Adult J and Adult K were living in the same household, the incident was considered to be a Domestic Homicide. Safer Croydon Community Safety Partnership (CSP) commissioned a Domestic Homicide Review (DHR) as required by Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.3 This report of a domestic homicide review examines agency responses and support given to Adult J, a resident of the London Borough of Croydon prior to the point of her murder at her home in July 2017.

1.1.4 This review will consider agencies contact/involvement with Adult J and Adult K from January 2010 to July 2017.

1.1.5 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

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

1.1.8 The Review Panel expresses its sympathy to the family, and colleagues of Adult J for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

1.2.1 The Safer Croydon Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified of the decision in writing on 18 August 2017.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent Chair for this DHR in November 2017. The CSP commissioned Standing Together to conduct this review on a proportionate basis. This was based on the initial information that the parties were not family members, not in an intimate relationship and there had been very limited contact with agencies. The completed report was handed to the Safer Croydon Community Safety Partnership in December 2019.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Initially there was a delay in the commissioning of the review chair.

1.2.4 Further delays took place due to the criminal trial process, time taken to liaise with family in Romania, the use of translation services and attempts to interview the perpetrator in prison. The chair also took steps to interview colleagues and friends of Adult J in order to gain a better understanding of her life. Whilst there was limited contact with agencies, the final chronology was not completed until June 2018. The police chronology indicated that the UK Border Force had conducted an investigation into packages of drugs being sent to Adult K. Several months were spent trying to obtain information from the UK Border Force concerning the investigation and they were unable to provide any information to review. The panel also believed it would assist the process to include experts who could provide advice on the impact of domestic abuse on Eastern European women. The chair requested that the CSP commissioned support from Refuge Eastern European Gender Violence Advocacy Service. This was not agreed until 2019. The process was delayed in order to allow Refuge to advise on the final report and recommendations. The final delays to the process was due to objections raised by the CSP on the wording of the draft of the report approved by other panel members in July 2019. The chair suggested that the comments of the CSP should be considered by all of the panel and requested authority to hold a further

meeting. This authority for that meeting was finally granted in October 2019 and the meeting was held in November 2019, when this Overview Report was agreed by all of the panel and CSP representatives.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is publicly available only to participating officers/professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed, and only the independent chair and Review Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this review:

1.3.4 The victim: Adult J

1.3.5 The perpetrator: Adult K

1.3.6 Niece of victim: Niece X

1.3.7 Nephew of victim: Nephew Y

1.3.8 In some DHRs pseudonyms are used, but these need to be agreed by family and friends. If names are chosen without reference persons who knew the victim or perpetrator, then there is potential to inadvertently cause distress or concern to the family. In this case the family were not in contact with the chair during the latter part of the review process. The panel decided to use anonymous initials for each party.

1.4 Equality and Diversity

1.4.1 The Chair of the DHR and the Review Panel did bear in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.4.2 Adult J was a 36 year old heterosexual white woman. Adult K was a heterosexual white man and was 34 years old at the time of Adult J's death. They were not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was disabled, was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs. Adult J was not pregnant. The DHR Panel provided special consideration to race, age, or marital or civil partnership status throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.

1.4.3 **Race:** Adult J and Adult K were both Romanian nationals. It is known that Adult J entered the UK six years prior to her death. The Review Panel gave special consideration to the nationality of both parties and whether their status, as migrant workers, in the UK affected contact with agencies.

1.4.4 The DHR process the chair established, with the local CSP lead, at the first panel meeting that there were no local links to services for Romanian or Eastern European women. In a previous Croydon DHR the chair had engaged the services of Refuge to provide expertise in this area and this was proposed at the outset. A request was made to commission this service to support this DHR. The CSP later agreed to commission Refuge in 2019.

1.4.5 The Refuge Eastern European Gender Violence Advocacy Service provide culturally-specific support to Eastern European women experiencing all forms of gender-based violence, including domestic violence, sexual violence, and stalking. The service has bilingual advocates who speak Romanian. As Adult J was a Romanian woman experiencing gender-based violence it was clear from the first meeting that Refuge were the most appropriate service to support the DHR.

1.4.6 **Sex:** Sex should always require special consideration. Recent analysis of Domestic Homicide Reviews; reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[1]

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

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

This characteristic is therefore relevant for this case, the victim of the homicide was female and perpetrator of the homicide was male.

1.4.7 In considering the impact of crimes on women from Eastern Europe there are other specific considerations. Refuge have found that Eastern European women are at particularly high risk of abuse compared to victims in other Refuge services. Victims can be more isolated than most and require specialist services who are aware of cultural and language needs.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from Adult J's and Adult K's 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 DHR Panel comprised agencies from the Croydon area, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.3 At the first meeting, the DHR Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from January 2010 to the date of the homicide. It was established that Adult J came to the UK in 2010 and there had been very limited contact with agencies over the years. It was decided that all agencies could check records back to 2010 without additional demands on resources.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in 2016 Guidance and identified and considered the following case specific issues:

- Experience of Adult J as a Romanian woman in the UK;
- Whether stalking behaviour, by Adult K towards Adult J, took place; and
- Review any evidence of substance misuse by Adult K.

1.5.5 As a result of identifying these key lines of enquiry, other agencies were invited to be part of the review due to their expertise in stalking, personal safety and additional barriers faced by East European women. These agencies had not been previously aware of the individuals involved.

There were no local options available to consider the aspects of stalking and eastern European women. The local statutory substance misuse service was included on the panel.

1.5.6 A leading national agency dealing with stalking were approached, inviting them to take part in the review. There was no response to emails after repeated request for support. A further Non-Government Agency (NGO) that offers support and advice on reducing the risk of violence were approached by the chair. The agency did offer to support the review, but the Croydon CSP decided that the cost of commissioning was not proportionate to the level of the review.

1.5.7 In relation to Eastern European input, Standing Together proposed that the domestic abuse charity Refuge be approached. Refuge provide expertise in the provision of services to Eastern European women experiencing abuse. It was agreed that Refuge would be commissioned by the CSP to review the Overview Report. The panel would like to express thanks to the expertise and advice Refuge provided to the panel and the chair.

1.5.8 After consulting with Refuge it is noted that they deal with victims of stalking on a daily basis. As a violence against women and girls (VAWG) organisation, Refuge has extensive experience in providing in-depth support to victims of stalking and sexual voyeurism. Refuge were able to provide expertise to the panel on the stalking aspects of the case. The panel would like to offer thanks for the support of Julia Dwyer of Refuge.

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 new definition states that domestic violence and abuse is:

1.6.2 “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.

1.6.3 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.

1.6.4 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."

1.6.5 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.

1.6.6 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. In considering cases that should be subject to a DHR, Section 2 Para 5 of the 2016 Guidance states:-

This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1. The Act states:

(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) ***a member of the same household as himself,***

held with a view to identifying the lessons to be learnt from the death.

1.6.7 On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. An initial meeting was held to discuss the findings of the agencies. There was very limited information known to local agencies. There were no previous concerns that any party had been subject to any reports of safeguarding or domestic abuse concerns. Guided by the CSP requirement to have a tightly focused review, the panel decided that it was not proportionate to request Individual Management Reviews (IMRs) from the agencies. A total of twelve agencies were contacted to check for involvement with the parties

concerned with this review. Nine agencies returned a nil contact, and three agencies provided chronologies only, due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.6.8 **Independence and Quality of IMRs:** There were no IMRs requested and therefore no associated recommendations made for single agencies during the review process. If information had been provided by the UK Border Force, then consideration would have been given to the need for an IMR. The lack of information from the UK Border Force will be considered in the recommendations of this Overview Report.

1.6.9 **Documents Reviewed:** In addition to the chronologies, documents reviewed during the review process have included police case summaries, CQC reports on GP Practice, Croydon DHR *Overview Report Into the Death of Victoria March* 2016, STADV and HO DHR Case Analysis, Refuge Report on *Eastern European Women and Violence Against Women and Girls 2019*, and London Borough of Croydon *Croydon's Domestic Abuse and Sexual Violence Strategy 2018-2021.*

1.6.10 **Interviews Undertaken:** The Chair of the Review has undertaken one interview in the course of this review. This was a face to face interview with the victim's employer. A number of attempts were made to offer an opportunity for interview with the victim's family. These attempts were unsuccessful. The chair also offered the perpetrator an opportunity to contribute to the review, he declined. The chair is very grateful for the time and assistance given by employer and the MPS Family Liaison Officer (FLO) who have contributed to this review.

1.7 Contributors to the Review

1.1.1. The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Croydon Family Justice Centre
- London Borough of Croydon – Adult Social Care
- London Borough of Croydon – Housing Services
- NHS England
- Probation – Community Rehabilitation Company
- South London and Maudsley (SLaM) NHS Foundation Trust

- Turning Point – Substance Misuse Service
- Victim Support

1.7.1 The following agencies had contact with the family during the period under review, or held relevant information, and their contributions to this DHR are:

Agency	**Contribution**
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	Chronology
Croydon Health Services	Chronology
Metropolitan Police Service	Case Summary and Chronology
UK Border Force	None

1.8 The Review Panel Members

1.8.1 The Review Panel Members were:

Panel Member	**Job Title**	**Organisation**
Dr Shade Alu	Designated Doctor for Safeguarding Children and Child Death Reviews	NHS Croydon Clinical Commissioning Group (CCG)
Caroline Birkett	Head of Service	Victim Support
Rachel Blaney	Lead Nurse for Safeguarding Adults at Risk	NHS Croydon Clinical Commissioning Group (CCG)
Eoin Bolger	Senior Operations Manager	Turning Point
Melanie Gamsu	Quality Assurance Officer	London Borough of Croydon - Adult Social Care

Ciara Goodwin	Domestic Abuse & Sexual Violence Coordinator	London Borough of Croydon
Sarah Hayward	Director Violence Reduction Network	London Borough of Croydon
Alison Kennedy	Operations Manager	Croydon FJC (Domestic Abuse Agency)
Estelene Klaasen	Named Safeguarding Nurse	Croydon Health Services NHS Trust
Richard McDonagh	Detective Inspector	Metropolitan Police Service (MPS) – Croydon Borough Community Safety Unit (CSU)
Angela Middleton	Patient Safety Lead, Mental Health	NHS England
Jenny Moran	Quality Assurance Officer	London Borough of Croydon Adult Support Services
Yvonne Murray	Head of Tenancy and Caretaking	London Borough of Croydon Housing
Sean Oliver	Safeguarding Coordinator Adult Social Care	London Borough of Croydon – Adult Social Care
Carl Parker	Partnership and Analyst Officer	Safer Croydon Community Safety Partnership
Helen Rendell	Review Officer	MPS – Serious Crime Review Group (SCRG)
Yvonne Shaw	Named Nurse for Safeguarding	South London and Maudsley (SLaM) NHS Trust
Lucien Spencer	Area Manager	Community Rehabilitation Company

Lucy Stubbings	Head of Patient Safety	South London and Maudsley (SLaM) NHS Trust
Cheryll Wright	Partnership and Intelligence Manager	Croydon Community Safety Partnership
Mark Yexley	Independent Chair	Standing Together Against Domestic Violence

1.8.2 Independence and expertise: Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy, and were independent of the case.

1.8.3 The Review Panel met on three occasions, with the first meeting of the Review Panel on the 20 February 2018. There was a panel meeting to review the Overview Report on 6 February 2019. This gap between meetings was due to attempts by the Chair to establish contact with family via a variety of routes, to contact a stalking service for expertise, and to ascertain information from UK Border Force. There was a final panel meeting to review CSP comments on the Overview Report on 6 November 2019.

1.8.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

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

1.9.1 At the outset of the DHR process the CSP should notify the family of the victim, in writing, of their decision to undertake a review. During the review process the CSP lead at Croydon retired and the new team members have not been able to establish if a letter was sent to the family. The Chair of the Review and the DHR panel acknowledged the important role Adult J's family could play in the review. From the outset, the panel decided that it was important to take steps to involve the family, friends, and work colleagues. The Chair of the DHR did write to the family, independently of the CSP.

1.9.2 Consideration was initially given to approach the brother of Adult J. He was the nominated member of the family dealing with the police investigation. Adult J's brother is resident in Romania and all contact required translation.

1.9.3 Initial contact, on behalf of the chair, was made through the police FLO and a police interpreter. Letters of introduction and explanation of the DHR process were provided through the FLO and the interpreter translated those face to face with Adult J's brother in February 2018. The initial letter outlined the services of Advocacy After Fatal Domestic Abuse (AAFDA). It was initially hoped that the chair could meet Adult J's brother when he attended the trial of Adult K, but that was not possible. Adult J's brother then did not return for the sentencing hearing and the chair was not able to meet face to face.

1.9.4 In February 2018, enquiries were made with AAFDA and they stated that they were able to offer services to any relatives remaining in the UK. This was considered in all contact with the family. The panel also established that the family had been offered the services of the Victim Support Homicide Service, but the family declined this support.

1.9.5 Adult J's brother agreed with the FLO that he could be contacted directly by the chair through email. Croydon CSP provided translation services for all correspondence. In April 2018, a letter of introduction and a copy of the Home Office DHR leaflet for families was translated into Romanian and sent by email to Adult J's brother. There was no response from Adult J's brother. A further email, in Romanian, was sent to Adult J's brother in September 2018. There was no response to that email. In October 2018 the chair contacted the FLO and asked that the police interpreter, known to have a good relationship with Adult J's brother, would send a further email to the brother. The email would ask Adult J's brother, whether he wished to talk to the chair by phone or whether he did not want contact. To date there has been no response from Adult J's brother.

1.9.6 Consideration was also given to contacting the niece and nephew of Adult J, children of her brother. The niece and nephew were housemates of Adult J and Adult K at the time of the homicide. They had also been seriously assaulted by Adult K during the incident. Nephew Y indicated that he did not want any contact after the incident. However, his sister Niece X was willing for her details to be passed to the Chair of the Review. There was no need for translation services and communication with Niece X would be in English.

1.9.7 The chair attempted contact with Niece X by phone in May 2018, and there was no response. A further attempt was made in June 2018, when the chair sent a text message to Niece X introducing himself. Niece X responded to the text message, stating that she would be happy for the chair to send her information about the DHR process by email. Before sending the full email the chair sent an initial email to Niece X to confirm he was sending information to the correct address, to respect confidentiality. Niece X replied immediately confirming that the chair had the correct address. The chair then sent a letter of introduction to Niece X. The letter included reference to the support offered by AAFDA. The chair also sent a copy of the Home Office DHR leaflet for families. The letter confirmed that the chair would attempt contact if he had not heard from Niece X after 30 days. A follow up call was made to Niece X and there was no reply. At the end of August 2018 a further email was sent to Niece X by the chair, there was no reply to the email. Enquiries were made with the FLO and they confirmed that they had not had any contact with the niece and nephew since the sentencing of Adult K earlier in 2018.

1.9.8 To date there have been no interviews with the family. In all correspondence with the family they are informed that supporting a DHR is a voluntary matter and they are not obliged to become involved in the process. The panel respect the wishes of the family.

1.9.9 In reviewing the case, enquires on press reports revealed that a female friend of the victim had discussed her friendship with the victim with reporters. The FLO confirmed that the friend was known to the homicide investigation team. At the time of writing the chair is still awaiting contact with this friend.

1.9.10 The FLO was able to provide details of Adult J's employer. Adult J was a junior school teacher working in Croydon. The chair contacted Adult J's Head Teacher who was willing to support the review and she was interviewed face to face in October 2018. During the interview the chair discussed Adult J's friendship with colleagues. The Head Teacher informed the chair that Adult J had not disclosed any concerns about Adult K to colleagues at work. It was not felt appropriate for the chair to take any further steps to interview colleagues.

1.9.11 The interview with Adult J's Head Teacher was a valuable part of this DHR process. Although there were no disclosures of any concerns from Adult J before her death, there was learning from the handling of the trauma of the death of a colleague and teacher by the education authority and the police. This learning and good practice will feature in the review. The panel would like to express their thanks to the Head Teacher and the FLO for their support of this review.

1.10 Involvement of Perpetrator and/or his Family

1.10.1 On 6 June 2018 the perpetrator was sent a letter from the chair via his Probation Officer with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back.

1.10.2 On 15 August 2018 the Probation Officer confirmed that they had discussed the review with Adult K's Offender Supervisor. The Supervisor confirmed that Adult K had read the DHR papers and she had also explained it further to him. Adult K declined to be involved in the review and also declined to be interviewed.

1.10.3 The panel expresses thanks to the Probation and Prison Service for their support of this review.

1.11 Parallel Reviews

1.11.1 **Criminal trial:** The criminal trial concluded in March 2018. Adult K pleaded guilty to the murder of Adult J. He was sentenced to Life Imprisonment, with a recommendation that he serve at least 20 years. There were no representations as to Adult K's mental health at the time of the murder.

1.11.2 **Inquest:** The Coroner decided no investigation was required and therefore, no inquest held. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.11.3 There were no other known parallel reviews.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and author of the Review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 14 DHRs. Mark is a former Detective Chief Inspector with 36 years' experience of dealing with domestic abuse and was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work

involves independent reviews of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

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

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

1.12.4 *Independence:* The chair has no current connection with the London Borough of Croydon or other agencies mentioned in the report. He retired from the MPS in 2011 and whilst serving in the MPS, he was never posted to Croydon Borough.

1.13 Dissemination

1.13.1 The following recipients have received/will receive copies of this report:

- Panel members
- Family members
- London Borough of Croydon Education Department
- Standing Together Against Domestic Violence DHR Team
- United Kingdom Border Force

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to Victim**	**Age at time of Victim's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Adult J	Victim	36	White European	NK	European National exercising treaty rights	N
Adult K	Perpetrator and housemate	34	White European	NK	European National exercising treaty rights	N

2.1 The Homicide

2.1.1 *Homicide:* Adult J had known Adult K for several years and they had shared accommodation during that period. At the time of the homicide they were residing in a two story terraced house that was shared with Adult J's adult niece and nephew, Niece X and Nephew Y. All had separate rooms, with Adult J, Niece X and Adult K sleeping on the first floor and Nephew Y on the ground floor.

2.1.2 Adult J and Adult K were friends and were not in an intimate relationship. Adult K had made advances towards Adult J but she was not interested. It was believed by family that Adult K was infatuated with Adult J. It later transpired that Adult K had gained access to Adult J's laptop computer and had installed 'spyware'. This spyware had enabled Adult K to access video footage that Adult J had recorded of herself. It was also discovered that Adult K had been secretly filming Adult J in the shower at the house.

2.1.3 From after midnight on the date of the homicide Adult K had stayed up and had been watching pornographic films, on his computer. The films included scenes of graphic violence and death. He had also been taking cocaine throughout the night, he also had painkillers and Viagra.

2.1.4 In the early morning on a day in July 2017 Nephew Y came downstairs. He was confronted by Adult K as he approached the kitchen. Nephew Y saw Adult J laying on the kitchen floor, at that point Adult K hit him on the head with a hammer. Nephew Y tried to fight off Adult K, Niece X came

downstairs and tried to help her brother. Adult K then grabbed Niece X and tried to hit her with the hammer. Niece X then hit Adult K over the head with a wine bottle. They fought with Adult K and managed to get the brother out of the house. It was the opinion of the police that Niece X's intervention was pivotal in saving her brother's life.

2.1.5 Police were called by a neighbour of the household. The neighbour had heard screaming that someone had stabbed his sister. Police arrived to find Nephew Y and Niece X in the street covered in blood. Nephew Y told the police that he had been attacked by a male with a hammer and he was still inside their home. He also said that his aunt, Adult J, was inside the house and she was unconscious. The police went to the front door of the house, it was opened by Adult K. Adult K was arrested by the officers. Adult K told the officers that he had taken six or seven bags of cocaine throughout the night. He said that he had hit his friend with a hammer six or seven times. Adult K was later taken to hospital.

2.1.6 When they entered the house police found Adult J in a pool of blood on the kitchen floor. Adult J was found to be barely alert and could not speak. She had severe trauma to the side of her head and appeared to be scalded on both upper thighs. There was an empty kettle on the work surface next to the victim. Blood staining indicated that the attack had taken place on the ground floor. The officers administered first aid. The London Ambulance Service (LAS) attended the scene and stabilised Adult J. She was placed in an induced coma by clinicians and taken to the nearest NHS Major Trauma Unit.

2.1.7 Adult J was found to have severe head injuries and burns to her legs. She underwent a CT scan and was taken to Neurosurgery theatre. It was confirmed that her injuries were untreatable and she was unlikely to survive. It was considered that the burns on her legs were consistent with boiling water having been poured on her. After three and a half days in the Intensive Care Unit, Adult J's life support was turned off and she died from her injuries.

2.1.8 Nephew Y had sustained cuts and scratches to his hands, neck and head. Niece X had pain to her stomach where she had been hit in the stomach with a hammer by Adult K. She also sustained bruising from struggling with Adult K.

2.1.9 Adult K was detained in hospital after his initial arrest for assaulting Adult J. He was later arrested for Adult J's murder, attempted murder of Nephew Y, assault on Niece X and possession of Class A drugs. He was later charged and remained committed for trial at the Central Criminal Court.

2.1.10 Adult K was assessed by a Psychiatrist who concluded that insanity and diminished responsibility were unlikely to apply to the defence of murder and that cocaine was likely to have been the most significant factor in his abnormal state including his aggression at the time of the incident.

2.1.11 *Post Mortem*: The provisional cause of death is given as blunt force trauma to the head. Adult J received at least 15 blows to the head. She also had a number of small bruises to her arms and legs that are minor and non-specific. She had no defence type injuries. The top of the victim's thighs had burn injuries.

2.1.12 *Criminal trial outcome*: Adult K pleaded guilty to Adult J's murder and was sentenced to life imprisonment with a recommendation that he serve at least 20 years. There was no additional penalty in relation to the separate counts of assault on Adult J's niece and nephew.

2.1.13 *Judge sentencing summary:* The police were unable to provide further information on the Judge's sentencing summary and the officer in the case has since left the service.

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

2.2.1 **Background Information relating to Victim***:* Adult J was a 36 year old Romanian woman. She was single at the time of her death. She had previously been engaged to a man, but that relationship had ended a year before and he was living in Romania at the time of Adult J's death. As a Romanian citizen Adult J was entitled to employment rights in the UK. She was a qualified teacher in Romania. After entering the UK, Adult J trained to gain UK qualification to work as a primary school teacher. Whilst training, she supported herself financially working as a hairdresser. In 2016 Adult J started work as a teacher in a Croydon junior school teaching eight and nine year olds.

2.2.2 **Background Information relating to Perpetrator:** Adult K is a Romanian man. He was 34 years old when he murdered Adult J. As a Romanian citizen Adult K was entitled to employment rights in the UK. Adult K was known to have worked in a number of jobs, including construction work. At the time of the murder he was employed as a caretaker in a property in central London.

2.2.3 **Synopsis of relationship with the Perpetrator:** Adult K and Adult J had been living together, as friends, in shared accommodation for around 6 years. They had not been involved in an intimate relationship at any time. It is believed, by family, that Adult K was infatuated by Adult J. Material discovered on Adult K's computer would support the families view and he was effectively spying on Adult J.

2.2.4 **Members of the family and the household***:* Adult J and Adult K lived together with Adult J's adult niece and nephew in a privately rented terraced house. The nephew and niece were the son and daughter of Adult J's brother. The four people had been living in the house for 15 months before the homicide. Adult J, Adult K and Niece X had separate bedrooms on the first floor. Nephew Y had a room, converted to a bedroom, on the ground floor. There were no children in the house.

3. Chronology

3.1 Chronology from Year to Year (timescales under review)

Organisation Name	*Contact with V (Y/N)*	*Contact with P (Y/N)*
Croydon CCG - GP	***Y***	***N***
Croydon Health Services - Hospital	***Y***	***N***
Metropolitan Police Service	***N***	***N***

3.1.1 There was very limited contact between statutory agencies. It is known that Adult J came to the UK in 2010. There is no information on when Adult K entered the UK. There is no record of Adult K registering with a GP.

3.1.2 In 2013 Adult J attended her local Hospital with two minor medical complaints. There were no safeguarding concerns.

3.1.3 In November 2014 the MPS received information from the UK Border Force of seizure of a parcel addressed to Adult K at his home. The parcel contained 120 Alprazolam (Benzodiazepines) tablets, a drug used to treat anxiety disorders and nausea caused by chemotherapy. There is no other information forthcoming from UK Border Force about this investigation.

3.1.4 In January 2016 Adult J registered with a new GP service.

3.1.5 In September 2016 the MPS received information from the UK Border Force of seizure of a parcel addressed to Adult K at his home. The parcel contained 80 Alprazolam tablets. There is no other information forthcoming from UK Border Force about this investigation.

3.1.6 In September 2016, Adult J started her new job as a Teacher in Croydon.

3.1.7 In July 2017, Adult J was murdered by Adult K.

4. Overview

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

4.1.1 At the time of writing the only information available on Adult J comes from the homicide investigation team and her employer.

4.1.2 The panel noted that Adult J worked hard to gain teaching qualifications in Romania. She then set out to further her teaching career in the UK. This required a great deal of dedication, working in lower paid jobs and gaining further professional qualifications. This all took place in a new country, working in a second language. It is known that Adult J's family were extremely proud of her work ethic, and achievements in the UK. She was well respected by her colleagues and her pupils were very fond of her.

4.1.3 Adult J had qualified as a teacher in Romania. When she came to the UK her qualification was not sufficient to commence work as a teacher. Adult J worked as a hairdresser and at the same time trained to complete appropriate qualifications in the UK to enable her to teach here. The training would include supply teaching work.

4.1.4 Adult J started employment as a junior school teacher in September 2016. She joined the school through an agency. This was her first full-time teaching job in the UK. She taught Year 4, eight to nine year olds.

4.1.5 Adult J found her first terms a challenge but she eventually settled into her new role. She was not known very well and did not have particular friends at work. It was later noted by the school that they did not have emergency contact details for Adult J's family or next of kin.

4.1.6 The school knew of nothing to indicate that there were any concerns on Adult J. It was known that she was not in a relationship and that she was sharing a house with her niece, nephew and a friend.

4.1.7 The first that the school knew of the attack that led to Adult J's death was when her nephew telephoned the school from the Emergency Department at hospital and informed her employers that Adult J had been involved in an accident. The Education Department later contacted the Head Teacher to confirm that Adult J had been attacked. The incident had happened close to the end of term, before the summer holidays. When the school were informed that Adult J had died, the Head Teacher decided to open the school in the summer holiday and invited parents and children

into the school. This process allowed the school to speak to children and concerned parents to explain what had happened to Adult J. A local authority educational psychologist came to the school to break the news to the children.

4.2 Summary of Information from Perpetrator

4.2.1 The perpetrator did not agree to support the DHR process and declined to be interviewed.

4.3 Summary of Information Known to the Agencies and Professionals Involved

4.3.1 There was no information known to the agencies taking part in this review to indicate that there were any safeguarding concerns. The only contact came through the treatment of a minor injury by Croydon Health Services and Adult J's registration with the GP.

4.3.2 Both Croydon Health Services and the GP service concerned have completed IMRs for unconnected DHRs in recent years. The other DHRs had the same chair as this case. Given the limited amount of contact and the recent review of systems and procedures the panel felt that there was no need to conduct further IMRs for this review.

4.3.3 There were no gaps in information from the agencies represented in this review. The review identified the potential to gather further information from the UK Border Force that may assist the panel, unfortunately the UK Border Force were unable to provide the information requested.

4.4 Any other Relevant Facts or Information

4.4.1 **Police:** Checks were conducted on police databases on Adult J and Adult K. There were no known previous incidents of either person coming to the attention of the police. The only record on police databases came from intelligence reports submitted by UK Border Force.

4.4.2 **Victim Support:** A check was made of the Victim Support Homicide Service and it was established that Adult J's family had declined the services offered.

4.4.3 **Mental Health:** There were no records of any previous concerns on the mental health of either party. As part of the Criminal Justice process Adult K was examined by a psychiatrist. There was no defence put forward on the grounds of any abnormality of the mind. The panel did include the local Mental Health Trust from the outset to consider any issues, were they to arise.

4.4.4 **Substance Misuse:** It is clear that Adult K had problems with substance misuse and was under the influence of cocaine at the time of the homicide. There was no record of Adult K ever having accessed local substance misuse services. There were no medical records on Adult K as he had not registered with a GP.

4.4.5 Intelligence from UK Border Force shows that they intercepted two packages of Alprazolam addressed to Adult K at his home in November 2014 and September 2016. The drug is a prescription only drug of Class C in the UK. Enquiries were made with Interventions and Sanctions Directorate and the Criminal Casework teams of the UK Border Force and they were unable to provide any information. It appears that the only records are those references held by the police, no original records can be found. It is not known whether Adult K was abusing these drugs or concerned in the supply.

4.4.6 **Education***:* When interviewing Adult J's employer it was apparent that the handling of the information concerning Adult J's death demonstrated areas of Good Practice by school, education authority and police.

4.4.7 The Head Teacher confirmed that the school had access to Human Resources (HR) support if they became aware of any member of staff experiencing domestic abuse. Since the death of Adult J the school have changed HR providers. Both HR providers have established channels to report domestic abuse and provide support to staff reporting abuse. The school also has a Designated Safeguarding Lead, who acts as liaison with parents. Staff can also seek advice from the safeguarding lead. The Designated Safeguarding Lead also has established protocols and the policy when dealing with disclosures made at the school which would also involve taking advice from the Social Care Team at Croydon.

4.4.8 Safeguarding training at the school includes reference to domestic abuse. The school also has links to a local refuge and is experienced in supporting parents and children in abusive situations.

4.4.9 In managing the impact of the homicide on the children at school, consideration was given to Adult J's own class and the class that she was due to teach in the Autumn term of 2017. The local authority education department have supported the school with educational psychologists talking to the children. It was noted that some children still do not understand what happened to their teacher.

4.4.10 The Head Teacher commented that the MPS FLO was very good in their dealings with the school and came to speak to Adult J's class on two occasions. The school also provided a victim impact statement to the court.

4.4.11 Adult J's brother also visited the school after his sister's death. The family found it useful to know what a good environment Adult J had worked in and how she was valued by her colleagues and pupils.

5. Analysis

5.1 Domestic Abuse and Adult J

5.1.1 The circumstances of Adult J's death and the conviction of a member of the same household for her murder, clearly show that she was a victim of a Domestic Homicide in line with the definition under the Domestic Violence, Crime and Victims Act 2004 (See Para 1.6.6 above). The relationship between victim and perpetrator does not meet the 2013 cross-government definition of Domestic Violence, as they had never been intimate partners and were not family. This is not a case of domestic violence or abuse as defined by the cross-government guidelines but it is a case to be subject of a DHR under the law.

5.1.2 The DHR process generally focuses on services for victims of domestic abuse, where the victim and perpetrator are intimate, or previously intimate, partners or family members. A victim in the same household falls outside these definitions for specialist service provision and yet housemates can experience violence and abuse and the similar pressures to those intimately related, as this case shows. The use of shared housing is very prevalent. This case raises concerns about potential for violence against women living in those circumstances. The use of shared amenities such as bathrooms can facilitate sexual voyeurism and stalking.

5.1.3 It has not been shown that Adult J had been aware that Adult K had effectively been stalking her, by means of using spyware on her computer or covertly filming her. If she had been aware of these acts, then the offence of Voyeurism could have been investigated by the police. Any investigation would not have been undertaken by officers specialising in domestic abuse and Adult J would not have been offered support services designated for survivors of abuse. The panel cannot be confident that Adult J would have had access to services, sensitive to her cultural background, that she could have shared concerns with. It is known that there were no locally commissioned VAWG services for Eastern Europeans in Croydon known to agencies at the first panel meeting.

5.1.4 Whilst the panel can look at this case with hindsight and identify Adult K's stalking behaviour, there is a likelihood that a person in Adult J's position would not have been aware that they were being stalked. A victim of stalking may have concerns around another's behaviour but may not consider themselves as a victim of abuse. Consideration needs to be given to how women and girls can raise concerns on behaviour that makes them feel uncomfortable. Even when there were

no actual crimes identified, women can still be given advice on personal safety and technology abuse.

5.1.5 One aspect that was discussed by the panel was Adult K's use of pornography on the night before he murdered Adult J. It was suspected that he was watching extreme violent pornography. This information was disclosed by the police but the nature of the pornography was not fully established. There were discussions on the links between extreme porn and violence against woman and the regulation of such material. The fact is that the panel did not know exactly what Adult K's use of pornography extended to, as there were no witnesses, and to comment further without the facts would be conjecture. The chair was also minded to the CSP's guide that this should be a tightly focused review. It was agreed that the panel could not restrict the use of pornography but they would always encourage local work on promoting healthy relationships. The panel were informed that Croydon schools are currently focusing on promoting healthy relationships and working with pupils on attitudes to pornography.

5.2 Analysis of Agency Involvement

5.2.1 Due to the scope of the review set by the CSP, and agreement of the panel, there were no Individual Management Reviews (IMRs) requested by the panel. In this case there was limited learning available for the panel agencies who had contact with Adult J. The agencies have recently had the opportunity to develop practice based on the outcomes of other DHRs. There was limited contact with the victim and not in circumstances that would have led professionals to consider safeguarding and communication protocols. The criminal investigation and DHR review have not found any evidence that Adult J was aware that she was being stalked or observed by her housemate Adult K. There were no occasions when safeguarding protocols should have been applied and no need for cross agency communication.

5.2.2 **Stalking:** In considering the element of stalking the panel has not had the opportunity to use the expertise of the UK's major agency dealing with stalking. Repeated emails were sent to the organisation requesting support for the DHR and there was no response. At the outset of the process the panel considered that, whilst Adult J was not known to have been aware that she was being stalked, the involvement of experts may have added to the analysis of local services and protocols. The panel were able to establish that the local domestic abuse service had previously advised clients to self-refer to the stalking agency. It is known that a client can request a case

worker, but it was also believed that the agency can sometimes close their books due to the high demand on a small service.

5.2.3 Whilst there was an initial concern that the panel should involve a specialist stalking agency, consideration needed to be given to the use of technical abuse and stalking as part of the everyday picture of domestic abuse[2]. The use of modern technology gives perpetrators the means of stalking, isolating and controlling their intended victims using the tools of everyday life. Abusers can gain access to victim's personal and home devices, look at finances online and even gain access to children's devices. Because of the routine use of technology by perpetrators, local services need to be able to deal with that aspect of abuse without reference to more specialist services.

5.2.4 In this case evidence shows that the perpetrator has installed technical surveillance devices to watch the Adult J when she had an expectation of privacy and had also introduced 'spyware' to her computer to monitor online communication.

5.2.5 **Substance Misuse:** One key line of enquiry established by the review was the link to substance misuse. It is known that two packages of controlled drugs had been intercepted in transit to Adult K. Adult K was also under the influence of cocaine when he murdered Adult J.

5.2.6 A search of police databases revealed that the police had been notified of the interception of drugs by the UK Border Force. This shows that there was some level of dissemination from the national agency to local police. The UK Border Force could find no record of the original case, even when specific details were supplied to them by the chair. The failure to find the original records cannot rule out the possibility that there may have been other packages intercepted by the Border Force en route to the perpetrator. This raises serious concerns on the integrity of UK Border Force systems in relation to Data Protection Regulation and Disclosure in criminal justice procedures. The fact that the UK Border Force were unable to provide information for two separate incidents suggests there is a systems failure in the management of personal data.

5.2.7 There was no information held by local substance misuse on Adult K or the address where he was living. In considering partnership working it appears that there was a missed opportunity for the UK Border Force to disseminate information to local substance misuse agencies. It is known

[2] https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/tech-abuse-2/

that Adult K had not registered with a GP at this time, but in other cases the dissemination of intelligence from the UK Border Force to substance misuse services could prove valuable.

5.2.8 **Education:** As this case did not involve any children as part of the household, the local education authority were not required as a statutory member. The issue of education was raised through the victim's employment as a junior school teacher. In this case the local education department worked as a communication channel between the police investigating the attack on Adult J and her school. The education department and the school showed high levels of care when considering the impact of the death of staff member on her pupils. They made very effective use of an educational psychologist to break the news to children and parents. The Head Teacher of the school also showed high levels of professionalism and care in ensuring that the school was opened during a holiday period to support children and parents. The school were effectively supported by the police FLO who spent two sessions meeting Adult J's former pupils. The Head Teacher also showed empathy to the family of Adult J in allowing them to visit her work place.

5.2.9 Whilst these examples of good practice may be very specific to this case, Adult J's death should be reviewed and promoted by the local Education Authority. The process could be readily applied to other areas where there are family tragedies.

5.3 Equality and Diversity

5.3.1 The Review Panel identified the following protected characteristics of Adult J as requiring specific consideration for this case; experience of Adult J as a Romanian woman in the UK and Sex.

5.3.2 In considering the nationality of Adult J and Adult K the panel received expert advice from Refuge. From discussions with Adult J's employer it appears that Adult J felt integrated with British society. She had an excellent understanding of the English language, gaining a UK qualification and teaching in English.

5.3.3 A key aspect of the case is the specific combination of Adult J being a Romanian Woman in the UK and being the victim of stalking and violence. Experts have informed the panel that Eastern European Women can be reluctant to report incidents of domestic abuse, because there is a lack of information on the support available to them. Their understanding of services is influenced by what they know of their home country, where support is very limited.

5.3.4 We do not know whether Adult J was aware of Adult K's stalking behaviour towards her. We do know that there were no Eastern European specific services available locally, that she could go to and share any concerns or uncomfortable feelings about her housemate. This needs to be looked at in relation to Adult J's employment too. Adult J's employer manages a school that is very alert to the risks associated with domestic abuse. It should be noted that Adult J's employer reported that they were not aware of services specific to Eastern European women.

5.3.5 Although Adult J spoke English well and was well integrated, if she had been made aware that there were staff in a local VAWG service who were sensitive to her own background, then she may have been more likely to access such a service.

5.3.6 There was nothing in the review to demonstrate that the NHS services accessed by Adult J were impacted by her Romanian nationality or her sex. Adult K had not registered with GP services in all of his time in the UK. It is not known whether his nationality and knowledge of the NHS may have impacted his lack of registration.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions (key issues during this review)

6.1.1 There are no typical cases of domestic homicide, all emerge from specific circumstances and are tragic for families and friends. This case is particularly unique in that the relationship between victim and perpetrator falls outside guidelines that statutory agencies dealing with domestic abuse are focussed on. Adult J and Adult K had never been intimate partners and they were not members of the same family. Adult J was a victim of stalking behaviours of a housemate and it appears that she was completely unaware of his covert actions. This stalking behaviour does reflect the actions of many men in cases of intimate partner abuse and a DHR is the most appropriate forum to analyse that behaviour and make links to local services supporting women and girls subject to violence.

6.1.2 This case has only identified one agency who had contact with Adult J, the review did not reveal any concerns on the processes and procedures of this statutory agency. The panel are unable to comment on information held by UK Border Force, because they could not produce any records for the panel.

6.1.3 **Services for Eastern European Women:** This case should be examined alongside the DHR reviewing the murder of Victoria, a Polish woman murdered in Croydon in 2016. Examination of both cases together has revealed the lack of services, in Croydon, that are specific to the needs of Eastern European women victims of violence. In setting up both DHR panels the local CSP were unable to suggest any local agencies that could support the panel. The expertise of Refuge was commissioned for both DHRs.

6.1.4 It is essential that all partners, working to prevent abuse and support victims, ensure that there are locally commissioned services available for Eastern European women who are vulnerable to abuse. We cannot be sure whether Adult J was aware she was being stalked. We know that she came from a country where there are limited services available for victims of abuse. We know services specific to Eastern European women were not known to the panel or CSP during the review process**.**

6.1.5 **Stalking:** The case has shown how stalking of a person who is a member of the same household can result in a Domestic Homicide. It is appreciated that the main agencies dealing with stalking in the UK are Non-Government Organisations (NGOs). The engagement of organisations dealing

with stalking and personal safety have been challenging. One agency did not answer requests for support. When another agency, dealing with personal safety, was approached it was established that the cost of consultation was prohibitive to engagement with the DHR.

6.1.6 There is an appreciation of the panel that there is difficulty in accessing specialist services, but stalking should not be considered as a specialist element within domestic abuse services. Stalking and controlling behaviour is at the heart of domestic abuse and all local domestic abuse services should have available skills to support victims of stalking.

6.1.7 **Tech Abuse:** Adult J's death has brought to light the use, by Adult K, of recent technology to intrude into the private life of his female housemate using spyware on home computers to monitor private communication and hidden devices to watch her shower. The use of Tech Abuse by perpetrators has become more prevalent as computers and mobile devices are used constantly in our everyday lives. The abusive partner who would previously intercept mail or follow their victim can now use more covert means to stalk and exert control.

6.1.8 Historically, police advice for victims of Tech Abuse has often been for them to stop using mobile devices. This has the potential to isolate victims even more, increasing vulnerability. Local domestic abuse services need to be in position to support potential victims of Tech Abuse, increasing personal safety wherever possible. The FJC understand how internet connected devises can affect victims of gender-based domestic and sexual violence and abuse. The qualified IDVA's support and advice women everyday around perpetrators exploiting IoT devices to monitor, control and/or prevent victim from using devices. The FJC build awareness around location tracking, remote control, voice control, video/audio recording, social media and many more. Specific tech abuse training, delivered by UCL, in partnership with the London VAWG Consortium was attended by members of staff and shared with the service. The FJC induction for new IDVA's give staff the opportunity to learn about tech abuse and shadow experienced IDVA's when supporting clients.

6.1.9 **UK Border Force and Substance Misuse:** It is known that Adult K was under the influence of controlled drugs when he murdered Adult J. Whilst Adult K had not previously been arrested, there was UK Border Force intelligence available to suggest that he was to be the recipient of controlled drugs. Whilst there is evidence that the Border Force passed intelligence to the local force, there is no evidence that any action was taken to investigate potential criminal offences or engage with

local substance misuse services. This case has shown that there has been a systems failure in the management of investigation and information.

6.2 Lessons To Be Learnt

6.2.1 **Lesson 1. Culturally Specific Services.** Local VAWG services should provide language and culturally specific services, which reflect the demographics of the community it services, including Romanian/Eastern European women.

6.2.2 This case should be considered with reference to DHR on the Death of Victoria March 2016 in Croydon. Victoria was a Polish National living in Croydon and was murdered by her partner. The death of Adult J, a Romanian National, in the same borough 16 months later should bring into sharp focus the need for services that are specific to Eastern European women and girls in Croydon.

6.2.3 **Lesson 2. Abuse Using Technology.** This case has shown how technology can be used in stalking behaviour, intruding in the private lives of victims. The use of technology such as mobile devices and computers is becoming increasingly common. More needs to be done to increase awareness of the dangers of tech abuse and to understand women's experience of this. In addition to this, further studies are needed nationally to gather evidence into how women are particularly vulnerable to the dangers of technology abuse and tracking devices, to ensure that support is available to provide assistance to vulnerable women who are exploited by this type of abuse.

At the point of publication of this DHR, the Domestic Abuse Bill 2019-21 is being debated which will encompass abusive behaviour conducted using technology. The UK Government has also published an Online Harms White Paper, which outlines proposals to establish a duty of care for internet companies that will make clear their responsibilities to keep users safe. These are welcomed steps towards addressing this learning point.

6.2.4 **Lesson 3. Stalking.** Part of the review process has focused on the stalking behaviour of the perpetrator and has sought to rely on National Agencies and Non-Government bodies with specialisms in stalking. That advice was not available or very costly.

6.2.5 Stalking and controlling behaviour is a consistent factor in many cases of domestic abuse and there should be local expertise available to support victims without reliance on a National body.

6.2.6 **Lesson 4. Definition of Domestic Abuse.** This case has demonstrated that persons who are not in an intimate relationship or family member as defined by Cross-Government definitions of Domestic Abuse can still be victim of similar abusive behaviours and require similar services as those in defined abusive relationships.

6.2.7 The circumstances of this case of a woman being stalked and abused in a shared household, by a man known to her show the need for similar services to those in an intimate relationship with an abuser. Local services should promote that they have the flexibility to signpost or support the needs of a victim, rather than defining a person by their relationship status.

6.2.8 **Lesson 5. National Law Enforcement and Domestic Homicide Reviews.** In order to conduct effective DHRs, the panel needs to be in possession of all relevant information. In many cases, crucial information on immigration, major crimes including substance misuse will be held by National Agencies. These agencies are not subject to mandatory attendance at DHRs and yet are under the umbrella of the Home Office.

6.2.9 In this case it was clear that the perpetrator was under the influence of a controlled drug at the time Adult J was murdered, and yet the panel could not access information held by a National Agency who intercepted drugs being delivered to the perpetrator. If this information is not available for a Government prescribed review process, then it is hard to see how those National Agencies can help support victims of abuse on a daily basis.

7. Recommendations

7.1 Single agency recommendations

7.1.1 There are no single agency recommendations.

7.2 Overview Report Recommendations

7.2.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Croydon Community Safety Partnership within six months of the review being approved by the partnership.

National Recommendations

7.2.2 **Recommendation 1** That the Home Office ensures the UK Border Force and National Crime agencies are included as a statutory agency on all appropriate Domestic Homicide Reviews.

7.2.3 **Recommendation 2** That the Home Office establish information sharing protocols between the UK Border Force and the police to ensure they have a much more robust and auditable process for recording information and disseminating information.

7.2.4 **Recommendation 3** That the Home Office commission research across VAWG services and local communities in England and Wales to establish the impact of Domestic Abuse on Eastern European women. The findings should be used to ensure, where appropriate, that VAWG services provide language and culturally specific services for Eastern European women.

Local Recommendations

7.2.5 **Recommendation 3** That Safer Croydon Community Safety Partnership reviews awareness and signposting across all membership to ensure services are available to women experiencing a wide range of violence against women and girls from men, including sexual voyeurism, stalking, and technology abuse.

7.2.6 **Recommendation 4** That Safer Croydon Community Safety Partnership reviews local commissioned VAWG services, and ensure that partnerships are in place to provide language and culturally specific services if not in place locally, which reflect the demographics of the community it services, including Romanian/Eastern European women.

7.2.7 **Recommendation 5** That London Borough of Croydon Education Department considers a reflective practice event on the good work of the MPS Homicide Investigation Team and London

Borough of Croydon Education Department in managing the death of Adult J. This should demonstrate the importance of having a domestic abuse lead within education settings.

7.2.8 **Recommendation 6** That Safer Croydon Community Safety Partnership should develop awareness around a wider spectrum of abuse against women and girls. This should take into account that women can be subject to gender-based violence and stalking outside of intimate relationships.

Appendix 1: Domestic Homicide Review Terms of Reference

Domestic Homicide Review Terms of Reference: Case of Adult J

This Domestic Homicide Review is being completed to consider agency involvement with Adult J and Adult K following the death of Adult J in July 2017. 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 Adult J and Adult K during the relevant period of time 1 January 2010 to date of death in July 2017 (inclusive). To summarise agency involvement prior to 1 January 2010.
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.

Membership

8. 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.

9. The following agencies are to be on the Review Panel:

a) Clinical Commissioning Group (Will cover GP)

b) Croydon Health Services NHS Trust (Includes Hospital)

c) Local Authority Adult Social Care Services

d) Local Authority Community Safety

e) Local domestic violence specialist service provider

f) NHS England

g) Metropolitan Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)

h) Paladin

i) Refuge

j) Substance misuse services

k) Victim Support

Collating evidence

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

11. Chronologies will be completed by the following organisations known to have had contact with Adult J and Adult K during the relevant time period (N.B. Individual Management Reviews not required at initial meeting):

    a. Croydon CCG
    b. Croydon Health Services
    c. MPS

12. Further agencies may be asked to completed chronologies and IMRs if their involvement with Adult J and Adult K becomes apparent through the information received as part of the review.

13. Each IMR will:

- Set out the facts of their involvement with Adult J and/or Adult K;
- Critically analyse the service they provided in line with the specific terms of reference;
- Identify any recommendations for practice or policy in relation to their agency;
- Consider issues of agency activity in other areas and review the impact in this specific case.

14. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Adult J and Adult K in contact with their agency. These agencies are:

    a) Local Authority Adult Social Care Services
    b) Local Authority Community Safety
    c) Local domestic violence specialist service provider
    d) Substance misuse services
    e) Victim Support

Key Lines of Inquiry

15. In order to critically analyse the incident and the agencies' responses to Adult J and/or Adult K, 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 Adult J / Adult K [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) Analyse the experience of Adult J as a Romanian woman in the UK and whether this would impact on her access to services.

h) Analyse whether stalking behaviour took place and whether procedures should be adapted to consider this behaviour

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

16. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in any IMRs. The Overview Report will make clear that agencies should report to the Croydon Community Safety Partnership on their action plans within six months of the review being completed.

17. Croydon Community Safety 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

18. Any enquiries from the media and family should be forwarded to the Croydon Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Croydon Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

19. The Croydon Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

20. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

21. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

Appendix 2: Action Plan

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1 That the Home Office ensures the UK Border Force and National Crime agencies are included as a statutory agency on all appropriate Domestic Homicide Reviews.	National		To be decided by Home Office			
Recommendation 2 That the Home Office establish that information sharing protocols between the UK Border Force and police service are robust and auditable process for recording information and disseminating information.	National		To be decided by Home Office			

Recommendation 3: That Safer Croydon Community Safety Partnership reviews awareness and signposting across all membership to ensure services are available to women experiencing a wide range of violence against women and girls from men, including sexual voyeurism, stalking, and	Local	Propose a specific campaign on tech abuse within the borough to the comms team.	CSP/VRN/FJC	The DASV coordinator arranged a meeting with the council comms team in September 2019 to discuss the upcoming Christmas campaign and request this focussed on how devises can be used to further abuse in a relationship. This was agreed in October 2020 in agreement with staff. Designs were presented to the CSP and the poster went live in December 2019. DASV coordinator worked in partnership with the IDVA's at the FJC to ensure poster/words would promote the message needed.	2019/2020	Completed: Dec 2019/Jan 2020 Croydon/s DASV Christmas campaign focused on the dangers of digital abuse and control and cohesive behaviour. This was displayed before and over Christmas on Decaux board across the borough.

	Local	The FJC have an ISVA from RASASC based full time at the FJC who promotes the work of RASASC to the team and clients and refers clients who need further support.			Ongoing.	Ongoing
	Local	The CEO of RASASC is a member of the DASV partnership board promoting the work of RASASC within Croydon and to other services.				RASASC is based in Croydon and also tackles the issues of stalking and voyeurism. RASASC work closely with Croydon's DASV service the FJC in supporting all women who experience violence. This is an ongoing partnership.
	Local	Extend invite to all DASV leads in primary and senior schools across Croydon. Continue to work closely with schools to raise the profile of the FJC.	DASV coordinator	The DASV coordinator worked closely with the SG lead in education to update the DASV school leads.	November 2020	Croydon now has over 95% of schools with a designated lead who are responsible for promoting the FJC, increasing awareness of the signs of domestic abuse and attending events which increase their own learning.

			DASV coordinator	The DASV coordinator to work with the head of safeguarding and inclusion for schools in Croydon to promote the FJC.	2020	In November 2020 the Croydon schools Safe Space campaign was implemented. 122 schools in Croydon placed posters around their schools promoting the FJC and offering a safe space for victims to take action.
	Local	Work with other local VAWG organisations to promote an online webinar on the subject of stalking and tech abuse including keynote speakers and partners from local services.	DASV coordinator	Arrange or promote an online webinar amongst the VAWG community including schools	March 2021	
	Local	Extend invite to DASV leads in GP surgeries across the borough.	DASV coordinator		September 2020	Croydon received funding from MOPAC to implement IRIS in the borough. Two AE have been employed and a partnership with Bromley and Croydon Women's Aid to push the project forward. A steering group has been set up with partners from health

						involved.
Recommendation 4 That Safer Croydon Community Safety Partnership reviews local commissioned VAWG services, and ensure that partnerships are in place to provide language and culturally specific services if not in place locally, which reflect the demographics of the community it services, including Romanian/Eastern European women.	Local	DASV Coordinator will contact DA services in London who can provide language and culturally specific services to victims where English may not be their first language in Croydon and set up a partnership which enables a pathway for these victim to access support	CSP/VRN/FJC		June 2021	
Recommendation 5 That London Borough of Croydon Education Department considers a reflective practice event on the good work of the MPS Homicide Investigation Team and London Borough of Croydon Education Department in managing the death of Adult J. This should demonstrate the importance	Local	Promote at Croydon's Headmaster meetings	Croydon Education Department	Croydon holds regular headmasters meeting – all serious incidents are reflected on during the meeting and good practice is shared. This has taken place for this case.	Completed 2018.	Croydon also has safeguarding leads in all schools which are supported by Croydon education department – this may not be the case in academies/voluntary aided.

of having a domestic abuse lead within education settings.		Continue to use the DASV leads in primary and senior schools to increase awareness of DASV amongst staff and parents.	DASV Coordinator	DASV leads to continue to be sent the quarterly DASV bulletin.		Croydon has DASV leads in 95% of schools in Croydon – primary and secondary. This is an ongoing programme and Croydon is committed to increasing this percentage throughout each year.
		Article in the DASV bulletin sharing good practice in this case with the school and the police.	DASV Coordinator		Feb 2021	
		Article in the Education bulletin celebrating the good practice in this case. This is sent to all Croydon schools	Croydon Education Department			

Recommendation 6 That Safer Croydon Community Safety Partnership should develop awareness around a wider spectrum of abuse against women and girls. This should take into account that women can be subject to gender-based violence and stalking outside of intimate relationships.	Local	To adopt a new violence reduction approach in the borough which will be evidenced led and target types of violence that are most harmful to our communities.	CSP/VRN/FJC	VRN in place from 2019. Employment of a new data analyst to support the VRN with collecting data on different crimes against women and how best to target and support victims.		This position has now been filled and contributes to the DASV board highlighting data which impact victims and supporting the VRN focus for the year.

				Croydon Council in partnership with Survivors, The National FGM centre, FORWARD UK, RASASC, Police, Croydon BME Forum and healthcare professionals hosted a 'let's talk about it' FGM conference.		Completed November 2019. This was an extremely well-attended conference which saw professionals from across the borough come together to talk about FGM, working more closely with communities and what change is needed.

	Local	Create a VAWG network group	VRN	Email VAWG organisations in Croydon to invite them to join the network to enable us to work more closely together to build awareness and ensure no victim in Croydon goes unheard.	January 2021	The Croydon VAWG Network had its first meeting in January 2021. The meeting was attending by 10 local VAWG organisations. TOR's have been agreed and the group now sit within the council VAWG framework and is governed by the DASV partnership board.
	Local	Croydon to introduce a VAWG strategy which sets out the boroughs aims in tackling all violence against women's and girls' including stalking. Taking into account that this can take place outside of an intimate relationship.		Seek approval from VRN director and DASV board to implement VAWG strategy.		Proposal email sent to director of VRN Aug 2020 to bring together a number of strategies under one umbrella of VAWG e.g. DASV and FGM, HBV, Trafficking.

	Local	Work in partnership with other organisations and services to promote awareness of all forms of VAWG.		Build stronger partnerships within the LB Croydon and outside.	2020	Completed July 2020: The FJC and Croydon's ASB team have started to work in partnership to tackle the issues of domestic abuse within the borough. On notification of a potential brothel in Croydon the ASB team in partnership with the police and a qualified ISVA (Independent Sexual Violence Advocate) from the FJC will attend the property to manage any risk and support the women involved. This has taken place once since the partnership was set up and ensured that 5 women were risk assessed and safely supported into accommodation. This is ongoing work The VRN has created a pathway between the ASB team and the FJC. The community IDVA's work closely with the ASB team to

						support victims who come into contact with the ASB team. The community IDVAs are also working in partnerships with locally commissioned housing providers in Croydon to support women who are extremely vulnerable within these settings by offering triaging to staff and case consultations as well as onsite assessments.
			VRN	Send invite to FORWARD UK to promote their service at the DASV forum attended by practitioners and professionals working in Croydon within the VAWG Sector	2019	Completed October 2019. FORWARD attended the forum in October 2019 to present information about their organisation and build awareness of FGM.

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30 November 2020

Dear Ciara,

Thank you for submitting the Domestic Homicide Review (DHR) report (Adult J) for Croydon Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 23rd September therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office Secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel commended the report for being very well written, well considered and sensitively handled. It is clear a rigorous approach was employed. The points raised by the PQAA have been dealt with, amendments made and return template complete. Specific and relevant themes were highlighted and discussed and there were clear explanations throughout as to why decisions were made on what to include in review. There's clear evidence of a strong understanding of Domestic Abuse and the various ways that it can present itself along with justification as to why the review was commissioned despite the case not obviously coming under the DA umbrella.

It was clear that efforts were made to contact and involve the family, friend, employer, and other agencies, including a specialist service that supports Eastern European women that have experienced stalking. The report highlights issue of difficulties in gaining information from agencies that could have been used to provide support to the victim and implications for victims; if the Chair was unable to make contact with them it raises the question about how victims can. The report also highlights flaws in data sharing and record keeping by Border Force and the Police and the implications of this. Specialist Domestic violence and Substance misuse services were on the panel.

The report referenced previous DHRs carried out by same CSP in which a Polish woman was killed and drew comparison and made recommendations based on both murders which adds weight to the issues highlighted in the review and why lessons need to be learnt.

The review recognises the good practice of the school the victim worked at around how

they told the children she taught, and the ongoing support that was available to them regarding her death. Finally, the flagging up of 'new' forms of abuse such as tech abuse and the use of spyware was welcomed.

The QA Panel believe 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 include:

- It is unclear why there was a delay in commissioning a Chair.

- Lesson two
    - The way this lesson is phrased does not enable people to understand the risk of stalking and how to check for devices in and around their home/devices.
    - The wording – "Women need to be made aware of how they can use tech safely, with a focus on using technology to support their own well-being" needs to be reconsidered. There was no issue of Adult J not using technology unsafely (though this framing in itself would be victim blaming), the issue was Adult K's secret monitoring of her, including filming her in the shower, and the wording could be construed as victim blaming. In addition, given the emerging area of technology facilitated abuse and VAWG, the review might find research, such as work by Molly Dragiewicz and Delaine helpful.

- Lesson three and throughout the report, the author has indicated that stalking is part of domestic abuse. However, it can also be very nuanced and stand alone, and it is important that there are specialist organisations for stalking specifically. A learning point or action point could be that those national organisations are engaged with to enable better working partnerships long term, so that their expertise can be brought to the table. Perhaps a missed opportunity to identify whether there needs to be more education around what constitutes DA such as 'uncomfortable behaviour' and stalking – how to identify it and reassurance that it is not ok - as has been done with coercive control in recent years.

- The action plan was difficult to read, it was not well laid out

- One of the lessons to be learnt explores a gap in services for the victim but speaks of it on a local level. Perhaps there is a need for exploration of whether this is a more national problem?

- It would be helpful to clarify earlier on that Adult J's niece and nephew are adults as this was not stated until 2.1.1/page 19 of the overview report.

- For future cases it is suggested to try to preserve the humanity of the victim that where the family is not engaged the Panel might wish to consider agreeing pseudonyms themselves and explain sensitively the reasons for this.

- Spelling and grammatical errors to be rectified:
    - 1.9.8 'they are no obliged'
    - 2.2.1 'she had a previously been' and 'J stated (she) work as a'
    - 2.2.2 'he was 34 years old when her murdered Adult J'
    - 4.4.7 'disclosures made by the school (which) would'
    - 5.1.5 'was disclosed by the Police but (the) nature'

- 5.2.3 ‘the means of stalking, isolating and controlling’
- 6.1.1 ‘Adult J was (a) victim’
- 7.2.3 ‘Are (have a) robust and auditable process
- 2.1.5 “screaming that someone had his sister” is there a missing word?
- 6.1.8 in the last paragraph the word ‘news’ should probably be ‘new’.

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.

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,

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel