SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Emma and Child A

June 2019

Independent Chair and Author of Report: James Rowlands

Associate, Standing Together Against Domestic Abuse

Date of Final Version: August 2022

1. Executive Summary

1.1 The Review Process

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

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

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

1.1.4 This DHR will consider agencies' contact/involvement with Emma and/or Ryan from the beginning of January 2014 to the date of the homicide.

1.1.1 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of any children have been removed (with anonymity further enhanced by the only child related to this DHR being referred to as Child A). Only the Chair and Review Panel members are named.

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

Name	Relationship to Emma
Emma	n/a
Ryan	Ex-boyfriend
Child A	Child
Alice	Mother

[1] Not her real name.

[2] Not his real name.

[3] Not his real name.

Samantha	Sister
Victor	Father
Aria	Cousin
Hazel	Mother of Ryan
Joseph	New Boyfriend of Emma
Henry	Manager at Royal Mail

1.1.3 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Croydon Partnership – commissioned this DHR. Having received notification from the Metropolitan Police Service (MPS) in July 2019, a decision was made to conduct a DHR in consultation with CSP partners in the same month. Subsequently, the Home Office was notified of the decision in writing in August 2019.

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

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

1.2 Contributors to the Review

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

1.2.2 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. As there was involvement both in Croydon and Southwark, scoping was completed in both areas.

1.2.3 A total of 26 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, four had only limited contact and submitted a Summary of Engagement only. However, 12 had more extensive contact and were asked to submit either a Short Report or an Individual Management Review (IMR). A narrative chronology was also prepared.

1.2.4 The following agencies made contributions to this DHR:

Agency	Contribution
Croydon Council Housing	Short Report
Croydon Health Services NHS Trust (CHS)[4]	IMR and Chronology
General Practice (GP) 1 – GP for Ryan (Completed by South East London Clinical Commissioning Group (CCG) on behalf of the GP)	IMR and Chronology
King's College Hospital NHS Foundation Trust (KCH)[5]	Short Report
GP 2 – GP for Emma	IMR and Chronology
London Ambulance Service (LAS)	Summary of Engagement
London Community Rehabilitation Company (CRC)[6]	IMR and Chronology
MPS	Short Report
Royal Mail (Emma's employer)	Short Report
South London and Maudsley NHS Foundation Trust (SLaM)	Summary of Engagement
Southwark Council – Adult Social Care Services	Summary of Engagement[7]

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

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

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

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

Southwark Council – Community Harm & Exploitation Hub (on behalf of the Southwark Anti-Violence Unit (SAVU)[8]	IMR and Chronology
Southwark Council – Children Social Care Services	Summary of Engagement
Southwark Council – Housing Solutions	Short Report
Southwark Council – Resident Services	Short Report
Victim Support[9]	Short Report

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

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

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

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Job Title	Agency
Alison Eley	Named Nurse for Safeguarding Children and	SLaM

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

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

	Domestic Violence and Abuse Lead	
Alison Kennedy	Operations Manager	Family Justice Centre (FJC)[10]
Bethan West	Head of Community Harm and Exploitation Hub (CHEH) (representing the former SAVU)	Southwark Council
Ciara Goodwin	Domestic Abuse & Sexual Violence Coordinator	Violence Reduction Network, Place Department, Croydon Council
Clare Capito	Deputy Regional Maternity Lead for London	NHS England and NHS Improvement
Clare Tebbutt	Independent Casework Manager	Royal Mail
David Lynch	Trust Safeguarding Adults/Prevent Lead	SLaM
Dawn Mountier	Safeguarding Officer, Quality and Assurance Directorate	London Ambulance Service (LAS)
Dr Dene Robertson	Autism Spectrum Disorder (ASD) expert	SLaM
Estelene Klaasen	Designated Nurse Safeguarding Adults	South West London CCG (including Croydon)
Dr Fazia Mehdi[11]	Named GP Safeguarding Adults	South East London CCG (including Southwark)
Felisha Dussard	Critical Friend	Croydon BME Forum[12]
Florence Acquah	Designate Nurse Safeguarding Adults	South East London CCG
Hannah Edwards	Southwark Safeguarding Children Partnership and Southwark Safeguarding Adults Board manager – Southwark CSP link	London Borough of Southwark
Heather Payne	Head of Adult Safeguarding	KCH
Helen Rendell	Detective Sergeant – Specialist Crime Review Group	MPS

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

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

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

Jenny Moran	Quality Assurance Officer	Adult Social Care, Croydon Council
Jo Joannou	Operational Manager, Council Homes Districts and Regeneration	Housing Services, Croydon Council
Lucien Spencer	Area Manager – London South East Area	CRC
Paulin Sullivan	Young People's Team Manager	Turning Point
Rachel Nicholas	Head of Services	Victim Support
Rebecca Harding	Safeguarding Children and Adult Lead (Croydon)	SLaM
Ricky Bellot	Housing Choice and Supply Manager	London Borough of Southwark – Housing (Housing Options)
Robertson Egueye	Area Manager	London Borough of Southwark – Housing (Resident Services)
Sarah Hayward	Director, Violence Reduction Network	Place Department, Croydon Council
Selene Grandison	Head of Service Delivery – Croydon, Sutton and Merton	National Probation Services (NPS)
Dr Shade Alu	Director of Safeguarding	CHS
Shaun Hanks	Head of Quality Assurance & Safeguarding	Children Social Care Service, Croydon Council
Valentine Nweze	Head of Adult Mental Health Substance Misuse, Operations	Adult Social Care, Croydon Council
Yvonne Wright	Safeguarding Specialist	LAS

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

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

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

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of the review is James Rowlands, an Associate DHR Chair with Standing Together. James has received DHR Chair's training from Standing Together. He has chaired and authored 13 previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.4.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.

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

1.5 Terms of Reference for the Review

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

1.5.2 *Key Lines of Inquiry:* The Review Panel considered the statutory guidance and identified the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Emma and/or Ryan [and wider family];
- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved in domestic abuse issues;

- Specific consideration to the following issues: the impact of Ryan's reported violence against his mother, his childhood experiences, and his ASD diagnosis; and
- Analyse any evidence of help seeking (in particular as Emma had limited contact with services), as well as considering what might have helped or hindered access to help and support.

1.6 Summary of Chronology

Contact with Emma

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

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

1.6.3 Emma's most extensive contact was with health providers, including her GP (GP 2), KCH (where she had a number of attendances at the Emergency Department), and CHS (attendances at the Emergency Department, and for antenatal care). At these contacts, the medical response was appropriate, and no specific concerns were identified by professionals about domestic abuse, nor were any issues disclosed by Emma.

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

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

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

Contact with Ryan

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

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

1.6.9 In her contact with the MPS, Hazel's primary concern was Ryan's housing. This led to contact with both Southwark Council Housing's Resident Services and Housing Solutions Services. However, this contact was disjointed and did not consider potential domestic abuse concerns. For example, Southwark Council Housing's Resident Services relied on a risk assessment by the MPS while Ryan's approach to Southwark Council's Housing Solutions Service did not link to this, without any coordination between the two services.

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

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

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

Analysis

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

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

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

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

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

1.6.17 Nonetheless, the Review Panel identified some contacts that could point to learning, wherein either Emma was accompanied by an unidentified person or where there was an acceptance of the absence of information about Ryan without agencies exploring why this might have been. Conversely, agencies in contact with Ryan were unaware of his relationship with Emma (this appears to be largely because he was not asked about intimate relationships or, if asked, did not disclose his relationship).

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

1.6.19 The limited information available also makes it difficult to comment on any evidence of risk, including precursors to the killing of Emma. However, separation and jealousy were likely a factor. Notably, Emma had separated from Ryan. Separation is associated with significantly increased risk from a perpetrator.[13] Additionally, it appears likely that Ryan knew that Emma had started a new relationship with Joseph, possibly because of his access to her emails.

1.6.20 With reference to Ryan's reported access to Emma's emails, and the possibility that he was accessing these to monitor her, there is an increasing awareness of the potential impact of technology-facilitated domestic abuse.[14] However, the Review Panel had limited evidence of this, particularly given it was not possible to interview Ryan. As a result, the Review Panel agreed to note this issue but felt it could not explore technology-facilitated domestic abuse any further.[15]

1.6.21 The Review Panel also considered whether there was evidence of domestic abuse by Ryan towards others, specifically his mother (Hazel), with this consideration being particularly relevant given there is evidence of links between the abuse of intimate partners and the abuse of family members.[16] Domestic abuse in this context could be described as Adult Family Violence (AFV). Where AFV involves a child-parent relationship it is often referred to as Child to Parent Violence (CPV), although much of the available literature focuses on children and adolescents rather than violence

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

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

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

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

and abuse by adult children.[17] There is no single definition of CPV, but it has been increasingly recognised that this issue is not age specific and there is a need to recognise that child to parent abuse can exist throughout the life course (i.e., adult children can use violence and abuse towards their parents).

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

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

1.6.24 Nonetheless, the Review Panel felt there was potentially learning about AFV/CPV, based on whether agencies identified the possibility of AFV/CPV. The Review Panel felt that, because AFV is less well understood than Intimate Partner Violence (IPV), this means the *potential* for risk to others (here, Hazel) may have been less likely to be considered. This issue is explored specifically in relation to agency contact, and then generally in relation to local strategy, but the Review Panel felt that there could be clearer guidance nationally in relation to these specific types of domestic abuse.[18]

1.7 Conclusions

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

1.7.2 The Review Panel has sought to try and understand Emma's lived experiences and consider the issues she faced in order to try and understand the circumstances of the homicide and identify relevant learning. Despite Emma's death being a domestic homicide, there is no specific evidence that she experienced domestic abuse by Ryan. Nonetheless, the Review Panel has considered possible indicators of domestic abuse including, as a minimum, that separation can be a period of increased risk. In

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

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

this endeavour, the Review Panel has been aided to a great extent by help from family members and extends its thanks to all those who have participated in this DHR.

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

1.8 Lessons To Be Learnt

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

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

1.8.3 Second, *robust multi-agency responses, including work across boroughs*. The Review Panel has explored two specific issues in this context. This includes the multi-agency response to Ryan while he was in Southwark, with a range of single agency recommendations being made for the multi-agency response to serious youth violence, gang involvement and associated criminality. Additionally, the Review Panel

has made a regional recommendation to use the learning from this case to support work to ensure that there is a consistent process between boroughs for the management of cases when someone moves.

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

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

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

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

1.8.8 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it is everybody's business to make the future safer for others yet, as demonstrated by the learning here, this aspiration has yet to be achieved.

1.9 Single Agency Recommendations:

CHS

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

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

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

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

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

CRC (now the NPS)

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

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

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

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

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

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

Croydon Council Housing

1.9.12 Housing Staff to complete DVAS training via the FJC.

GP 1 (IMR completed by South East London CCG)

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

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

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

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

KCH

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

GP 2

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

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

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

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

SAVU (now the CHEH)

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

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

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

1.9.25 To improve recording of engagement sessions.

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

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

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

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

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

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

1.10 DHR Recommendations:

1.10.1 **Recommendation 1:** The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV. This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance (to include adult children).

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

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

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

1.10.5 **Recommendation 5:** The London Violence Reduction Unit (VRU)[19] to review the learning from this DHR via the Violence Reduction Practitioners Network and:

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

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

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

1.10.7 **Recommendation 7:** The Southwark Community Safety Partnership to work with local partners to review the findings from this DHR and develop the response to AFV/CPV locally. This should include identifying the actions that agencies can take individually and collectively, reviewing support pathways and services, and completing a training needs assessment to identify the skills and training that professionals require to respond.

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

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

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

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

1.10.11 **Recommendation 11:** The Safer Croydon Partnership to ensure that, in developing its partnership response to domestic abuse and other issues, there is a robust mechanism to enable the specific consideration of the needs of minoritized communities and the implications in terms of awareness raising, training, service provision, and strategy. This should include targeted consultation with local communities and input from led by and for specialist services.