



Domestic Homicide Review - Executive Summary

**Khloemae Loy – July 2020**

Chair and Overview Report Author: Cheryl Henry-Leach

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### **Tribute to Khloemae**

Khloemae is missed by her family and friends. We all miss her bubbly personality; she was always the life and soul of the party, and she always tried to see the best in everyone. She was like our little China doll.

"At the age of 23 Khloemae had already endured five years of suffering at the hands of [the perpetrator] when all she did was seek love and commitment from him. Even though Khloemae is no longer here with us she still exists. He has taken Khloemae's life but in doing so he has also ruined ours.

"We no longer have her around. We cannot experience her love and happiness. At 23 she never really got to experience life. She didn't get the opportunity to settle down into a comfortable home; she was constantly moved around with him. She didn't get the chance to get engaged, get married or have a baby; experiences that others take for granted.

"We, as her family and friends, don't get to share these experiences with her. We should have been helping her to plan her wedding and looking forward to becoming grandparents but instead we have had to plan and arrange her funeral."

## Contents

1. Introduction .....	4
2. Establishing the Domestic Homicide Review Process .....	4
3. Decision Making.....	4
4. Independence and Expertise Statements - The Domestic Homicide Review Chair and Panel .....	5
5. Panel Membership .....	5
6. Parallel Reviews.....	6
7. Equality and Diversity.....	7
8. Confidentiality.....	10
9. Dissemination.....	10
10. Media Coverage .....	10
11. Terms of Reference .....	10
12. Methodology.....	14
13. Independence and Quality of IMRs .....	15
14. Documents Reviewed .....	15
15. Involvement with Family and Friends .....	15
16. Other Contributors to the Review.....	16
17. Conclusions .....	16
18. Learning and Recommendations .....	19

## **1. Introduction**

**1.1** The panel formally expresses its sincerest condolences to the family of Klohemae, and it is in line with their wishes that Khloemae is referred to by name throughout this report.

## **2. Establishing the Domestic Homicide Review Process**

- **Case Summary**

**2.1** In early July, around mid-morning, the police were called by the London Ambulance Service (LAS). LAS requested their attendance to a hotel where a female was stabbed in the neck. Khloemae was found by police seriously injured in a hotel room 515, which she and the perpetrator had briefly shared. The door to the room was barricaded, and Khloemae was found on the bed wearing only her lower underwear, suffering from an apparent stab wound to the neck. She subsequently died from her injury, and life was pronounced extinct at the scene.

**2.2** The perpetrator was seen on a ledge on the outside of the building, threatening to jump, and told officers he had killed his girlfriend. He either subsequently jumped or fell and was discovered by police injured on a 2nd floor roof.

**2.3** The perpetrator was taken to the Royal London Hospital by the Helicopter Emergency Medical Service (HEMS) where he was found to have sustained head injuries, broken ribs and collapsed lungs. His condition was initially treated as life-threatening but following treatment he stabilised and, in the afternoon, was arrested on suspicion of the murder of Khloemae.

**2.4** The Homicide Assessment Team (HAT) were called to the scene and a homicide investigation commenced.

**2.5** The postmortem examination of Khloemae was undertaken shortly after her death. The pathologist identified that the provisional cause of death was one incised wound to Khloemae's neck. No defensive injuries were found on her body, and the fatal injury was consistent with homicide.

## **3. Decision Making**

**3.1** The statutory requirement to complete a Domestic Homicide Review rests with the Community Safety Partnership (CSP) for the area in which a domestic homicide takes place.

**3.2** The Metropolitan Police Service (the Police) (see section 2), in line with locally agreed protocols, notified the Croydon Community Safety Partnership of Khloemae's death and the perpetrator's arrest, confirming that the death Khloemae appeared to be the result of domestic abuse.

**3.3** The Community Safety Partnership liaised with its constituent agencies, who were asked to share any information they held in Agencies relation to Khloemae and the perpetrator.

**3.4** At an initial core group, the known information was considered by agencies and agreement reached that a Domestic Homicide Review (DHR) should be undertaken. A commissioning exercise was undertaken and an independent DHR chair was commissioned but before the DHR could be progressed, Croydon Council experienced significant administrative issues which impact on the chair's ability to undertake the review. Another commissioning exercise was undertaken, and a second independent chair was appointed to lead the review and author the final overview report and executive summary report.

#### **4. Independence and Expertise Statements - The Domestic Homicide Review Chair and Panel**

**4.1** The chair and author of this report, Cheryl Henry-Leach, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR chair and holds the requisite skills as set out in the statutory guidance for the undertaking of Domestic Homicide Reviews<sup>1</sup>. This includes her experience in relation to domestic violence and abuse, having been active in this area of work for nearly three decades. These have included managerial roles at local, regional and senior management/executive national levels in both the voluntary and statutory sector.

**4.2** All panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

#### **5. Panel Membership**

The panel membership was:

<b>Name</b>	<b>Role</b>	<b>Agency</b>
<b>Cheryl Henry-Leach</b>	<b>Independent Chair</b>	
<b>Alison Kennedy</b>	<b>Operations Manager FJC and VAWG lead</b>	<b>LA Croydon</b>
<b>Ciara Goodwin</b>	<b>DASV Coordinator</b>	<b>LA Croydon</b>

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<sup>1</sup> [Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

<b>Jenny Moran</b>	<b>Quality Assurance Officer, Adult Social Care Operations</b>	<b>LA Croydon</b>
<b>Justin Armstrong</b>	<b>Review Officer for the MPS</b>	<b>Metropolitan Police Service</b>
<b>Dr. Shagufta Shaikh</b>	<b>GP</b>	<b>Parchmore Medical Practice</b>
<b>Dr Ravi -Shankar</b>	<b>GP</b>	<b>NHS/CCG Guhendran</b>
<b>David Lynch</b>	<b>Safeguarding Adult Lead</b>	<b>SLaM</b>
<b>Steve Hall</b>	<b>Quality Assurance &amp; Safeguarding Service Manager</b>	<b>Croydon Children's Service</b>
<b>Dr Nathan Brown</b>	<b>Lead GP</b>	<b>Knights Hill Surgery</b>
<b>Ene Odeh</b>	<b>Interim Named Nurse Safeguarding Adults</b>	<b>Croydon University Hospital</b>
<b>Greg Davies</b>	<b>Single Homeless Service Manager</b>	<b>SHS Croydon Housing</b>
<b>Kavitha Ramakrishnan</b>		<b>Kingston MARAC</b>
<b>Kauser Mukhtar</b>	<b>Deputy Head of Service</b>	<b>Bromley &amp; Lewisham Probation Delivery Unit</b>
<b>Dr Carol Rooney</b>	<b>Director</b>	<b>Niche Health &amp; Social Care Consulting</b>
<b>Estelene Klassan</b>	<b>Designated Nurse Safeguarding Adults</b>	<b>NHS/CCG</b>
<b>Tess Leake</b>	<b>GP</b>	<b>Adult Safeguarding Bromley CCG</b>

## 6. Parallel Reviews

**6.1** The perpetrator maintained his innocence and the case was adjourned for a criminal trial in the winter of 2021, and at its conclusion the perpetrator was found guilty, sentenced to life imprisonment with a minimum tariff of 23 years before he could be considered for parole. It is understood by the panel that the perpetrator appealed his conviction and sentence on a legal technicality and in the summer of 2022 this appeal was allowed. He was re-tried in relation to Khloemae's murder, and, in the late

summer of 2023, the perpetrator was found guilty of Khloemae's murder and sentenced to life imprisonment. The original tariff of 23 years, set by the first trial judge, was confirmed by the second sentencing judge, with time served on remand to count toward this tariff.

**6.2** When the panel became aware of the perpetrator's retrial, having confirmed that Khloemae's family may be called to give evidence if a retrial was order by the Appeal court, the Panel agreed to suspend this review. This review recommenced at the conclusion of the retrial.

**6.3** The panel were aware that the murder of Khloemae triggered other reviews, namely:

- The Independent Police Complaints Conduct (IOPCC) in relation to the Polices response to the fatal incident that resulted in Khloemae's death. This was completed by the time this review commenced.
- A review by the Multi-Agency Public Protection Panel in relation to the perpetrator. This was suspended until the outcome of the retrial.
- A review by the mental health services provider supporting both Khloemae and the perpetrator. This was suspended until the outcome of the retrial.
- An independent mental health homicide investigation commissioned by NHS England, London region.

**6.4** The panel agreed that the findings of these reviews would be shared with the chair of this review and reflected where appropriate in this report. It also agreed that this would ensure that this review would support, and possibly enhance, the findings and recommendations of these reviews would be reflected where appropriate in this report. Once the retrial concluded, it was further agreed that these reviews would be completed before this review to ensure this approach was maintained. This review's terms of reference were shared with the professionals leading these reviews, who shared their findings with the DHR chair, DHR reports were shared with the independent chairs once the DHR review concluded, and this enabled their feedback on the DHR content and findings.

**6.5** Very soon after Khloemae's death, a postmortem was undertaken, and this confirmed that her cause of death was a fatal stabbing injury. An inquest was opened by His Majesty's Coroner and the panel understand this process was opened and closed due to the criminal prosecution of the perpetrator, whose actions caused the fatal injury to Khloemae. During the course of this review, communication channels were established by the HM Coroner's Office with the independent chair to advise that, at the time of writing this report, the Coroner is deciding whether to re-open the inquest into Khloemae's death. To aid in this process, it was agreed that a confidential copy of this report will be provided to the Coroner prior to Home Office approval by the Community Safety Partnership.

## **7. Equality and Diversity**

**7.1** Throughout this review, the panel were mindful of the nine protected characteristics<sup>2</sup>. The review considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). The protected characteristics of gender reassignment, religion/belief, and sexual orientation do not pertain to this case in that this review established, as far as it possibly could, that neither party was at any stage of transitioning from one gender to the other. They did not hold particular religions or other beliefs.

**7.2** The panel determined that special consideration was warranted to age, gender, sex, maternity, and disability throughout this review to determine if the responses of agencies were motivated or aggravated by these characteristics.

**7.3** Khloemae was an unmarried, heterosexual young woman who presented with vulnerabilities in relation to her mental health, and at times, was dependent on alcohol and cannabis. In this sense she was disabled. At the time of her murder, she was homeless. Domestic abuse can have a long-lasting effect on victims. It can lead to the development of long-lasting mental health and pre-existing mental health conditions<sup>3</sup>. The CSEW for year ending March 2018 found that just under half of partner abuse victims aged 16 to 59 (48.9%) reported mental or emotional problems and around a quarter (25.5%) had stopped trusting people and experienced difficulty in other relationships. Over a third (36%) received specialist mental health or psychiatric services because of their abuse. Some studies have found a significant relationship between alcohol and drug use and intimate partner violence<sup>4</sup> and that a proportion of victims may use alcohol and drugs as a coping mechanism in response to abuse<sup>5</sup>. Alcohol can also be embedded in a relationship with perpetrators of domestic abuse with perpetrators using alcohol to control victims. The prevalence of alcohol-related domestic violence is five times higher among the most disadvantaged groups compared to the least disadvantaged. However, both alcohol and substance misuse and domestic abuse can be hidden, and data may be impacted by differences in disclosure or detection within different socio-economic groups.<sup>6</sup> The co-occurrence of drug and alcohol use, homelessness, criminal justice system involvement and mental health will often mean that victims will face huge challenges when seeking support. It is paramount that statutory services take into consideration the multiple barriers, needs and potential for discrimination that can be faced by these groups, when planning and delivering services<sup>7</sup>.

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<sup>2</sup> [Protected characteristics | Equality and Human Rights Commission \(equalityhumanrights.com\)](https://equalityhumanrights.com)

<sup>3</sup> ONS. 2018. Partner abuse in detail – Appendix tables - Office for National Statistics (ons.gov.uk).

<sup>4</sup> 7 Costa, BM, et al. Longitudinal predictors of domestic violence perpetration and victimization: A systematic review. *Aggression and Violent Behaviour*: 2015; 24, 261-271; Schumacher JA, Feldbau-Kohn S, Smith Slep AM, Heyman RE. Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behaviour*: 2001;6(2-3):281-352.

<sup>5</sup> Home Office. Domestic Homicide Reviews: Key findings from analysis of domestic homicide reviews: 2022.

<sup>6</sup> Institute of Alcohol Studies. Inequalities in victimisation: alcohol, violence, and anti-social behaviour: 2020.

<sup>7</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1089015/Domestic\\_Abuse\\_Act\\_2021\\_Statutory\\_Guidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf)

**7.4** The panel understand that that Khloemae was and considered herself to be of dual heritage (White British and Indian descent). The panel understand that she had not been pregnant at any point before her murder and had no biological children. It noted that in 2020, the perpetrator referred to Khloemae as being pregnant, but the panel found no evidence to indicate this was the case.

**7.5** Khloemae was 18 years old when the panel understand that she met the perpetrator. The panel noted that Khloemae was younger than him. Research states domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and more women than men are affected by domestic abuse. Statistics from the last ONS bulletin<sup>8</sup> showed that in the previous year, women were around twice as likely to have experienced domestic abuse than men. Women are more likely than men to be killed by partners/ex-partners. From the year ending March 2018 to the year ending March 2020, the majority of victims aged 16 and over of domestic homicides were female (76%). This contrasts with non-domestic homicides where the majority of victims were male (86%)<sup>9</sup>. CSEW data from the year ending March 2020 shows that those with a disability were more likely to have been victims of domestic abuse in the previous year (11.8%) than those without (4.6%). Disabled victims may be at increased risk in relation to particular examples of abusive behaviour, either from an intimate partner, family member, or carer (who is "personally connected" to them) or face specific risks relating to their disability and related circumstances including: control of medication; denial of access to health services or equipment; actions which makes the person's health condition worse; and otherwise using the person's disability to control them. Disabled young people are more likely to experience coercive or controlling behaviours involving infantilisation and denying their independence, which may go unnoticed. Unequal power relations and a relationship of dependency are recognised as common factors<sup>10</sup>. This can be compounded by the age of the victim, younger victims of abuse are more likely to face higher risk of domestic abuse if their perpetrator is significantly older<sup>11</sup> and may face barriers, relating to their age or another protected characteristic, in disclosing abuse or accessing services. They may also be inherently more vulnerable to abuse because it is harder for them to distinguish between normal and abusive behaviours.

**7.6** The perpetrator was also of dual heritage, and unmarried. It is understood that he had at least three biological children with different partners, all of which alleged that he was abusive to them during their relationships with him and following the relationships ending.

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<sup>8</sup> ONS. 2020. Domestic abuse prevalence and victim characteristics - Office for National Statistics (ons.gov.uk).

<sup>9</sup> ONS. Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk): data year ending March 2021

<sup>10</sup> SafeLives. Spotlight Report #HiddenVictims: Disabled Survivors Too: Disabled people and domestic abuse: 2017.

<sup>11</sup> <https://safelives.org.uk/knowledge-hub/spotlights/spotlight-3-young-people-and-domestic-abuse>

## **8. Confidentiality**

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

**8.2** The review author discussed the use of pseudonym names with the victim's family in order to protect the identity of the victim, the perpetrator, and family members, however, on behalf of the family, the panel requested permission from the Home Office to use the real names as the case is widely known in the local area so the use of pseudonym names would not successfully protect the identities of the victims' confidentiality.

**8.3** It is the request of her parents that Khloemae is named in this report.

**8.4** Otherwise, this review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death and other lead identifiers have been removed, but the independent chair and review panel members are named. The perpetrator has not contributed to this report and so is not named and referred to within this report as the perpetrator.

## **9. Dissemination**

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

- Panel members listed below.
- Family members
- The Mayor's Office for Policing and Crime (MOPAC)
- DA Commissioners Office

## **10. Media Coverage**

**10.1** Media enquiries and publication were managed by the Croydon Community Safety Partnership and coordinated through the panel. No information was shared about the DHR until it was published. The published report was anonymised through changing the names of the individuals concerned and removing any specific dates that would identify the homicide.

## **11. Terms of Reference**

**11.1** The panel agreed the following terms of reference for this review:

### **11 a - The overall purpose of a domestic homicide review<sup>12</sup> is to:**

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

### **11 b - Timescales for the Review**

**11b.1** Minimal agency involvement with either Khloemae or the perpetrator was a feature of this case. To ensure a meaningful review that was proportionate to the known agency information, to ensure a meaningful review, the timeframe for this review commenced on 1<sup>st</sup> January 2018 to the date of Khloemae's death. This reflected the very complex information in relation to Khloemae and the perpetrator, that was presented to the panel, as well as and the changes in policy, practice and agency responses to domestic abuse that have been led at a national level since 2018. However, when the panel considered the events in 2017, it agreed the scoping period for this review should begin in 2017.

**11b.2** Agencies with records prior were asked to summarise their involvement within these dates. Any relevant information from agencies that fell outside the timeframe that had an impact or the potential to have an impact on the key lines of enquiry was included as contextual or background information.

### **11 c - Case Specific Terms**

The Panel also agreed the following case specific terms to ensure a focused review:

- To review if practitioners involved with the family and perpetrator were knowledgeable about potential indicators of domestic violence and/or abuse including coercive control, and aware of how to act on concerns about domestic violence and/or abuse.
- To determine if appropriate consideration to accessibility for support was given by agencies involved with Khloemae, when making decisions in terms of the level and

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<sup>12</sup> Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

support provided to her. This includes Khloemae's capacity to understand those decisions and how she could respond to them.

- To establish if there were any opportunities for professionals to “routinely enquire” if domestic abuse, including coercive control, was being experienced by Khloemae, including missed opportunities to enquire, and if those enquiries would have recognised the need to provide any further support to Khloemae, including being undertaken safely in line with best practice.
- To establish and identify any learning as to how the impact of the Corona Virus (Covid-19) pandemic and national restrictions affected Khloemae specifically around isolation and access to services.
- To establish the relationship between agencies regarding Khloemae's homelessness, her mental health, her alcohol and substance use, her relationship with her family and if she was receiving care that met her needs.
- To establish if there was appropriate information sharing between agencies in relation to Khloemae and the perpetrator. If this did not happen what were the barriers or challenges for agencies.
- To establish how professionals carried out assessments, including whether assessments and management plans in relation to Khloemae and the perpetrator took account of any relevant history:
  - a. If any assessments could have afforded opportunities to assess risk.
  - b. Was fully considered alongside an evidence-led approach set out in the Criminal Justice Act 2003 to support gathering evidence of coercive and controlling behaviour (contrary to S76 of the Serious Crime Act 2015). Were the principles of positive action applied and/or the statutory guidance for the offence of coercive control considered in responses?
  - c. Were there any warning signs of serious risk leading up to the incident in which Khloemae died, that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems.
- To identify whether Croydon's Violence Reduction Network needs to consider any learning that would require further strategic review and/or analysis to inform tactical and operational responses when supporting victims or identifying/appropriately challenging perpetrators, and in particular serial perpetrators of domestic abuse within the local community.
- To identify learning in relation to community awareness, including how community and/or faith groups and other potential access points for support, are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns

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with professionals, including if pathways for community and/or faith groups require development.

- To review the appropriate use of legislation and relevant statutory guidance pertinent to Khloemae's situation.
- To consider how issues of diversity and equality were considered in assessing and providing services to Khloemae's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, sexual orientation, gender reassignment, pregnancy and maternity, marriage or civil partnership. This will include consideration of how agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on responses and interventions.
- To establish whether local safeguarding procedures were being properly followed, and how effectively local agencies and professionals worked together in relation to domestic abuse.
- To establish if there are any issues locally affecting public confidence in the protection of people in vulnerable situations.
- To identify any shared learning from ongoing domestic homicide reviews with similar emerging themes.
- To identify any good practice and changes that may have already taken place.
- Establish for consideration what may need to change locally, and/or nationally, to prevent serious harm to victims of domestic abuse in similar circumstances.
- Agencies completing IMRs were asked to analyse these issues in relation to their contact with Khloemae and the perpetrator, with specific reference to:
  - a) The relevant policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, if these were applied and whether current training and policies support professional identification of coercive controlling behaviour.
  - b) Any communication that should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

## 12. Methodology

**12.1** This review has followed the 2016 statutory guidance for Domestic Homicide Reviews<sup>13</sup> issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. In so far as they could, the panel attempted to ensure a timely review to ensure but the timescales for this process were adversely impacted by the following factors:

- The initial trial being delayed by the Covid 19 Pandemic restrictions on all court services.
- Changes in the charring arrangements following the Local Authority's administrative issues.
- The murder of Khloemae triggered a number of parallel processes, and the panel wanted to be sure that the review aligned with these processes.
- The re-trial of the perpetrator resulted in a further delay of 13 months – the panel noted that the retrial was scheduled to commence on the anniversary of Khloemae's murder which was distressing for the family. Whilst it is unable to make a recommendation in relation to this, the panel do invite the Home Office to note this concern and take the action it deems appropriate.
- Following the retrial, the family of Khloemae experienced a shift in dynamics which resulted in delays in the liaison between the Chair and family members.

**12.2** During this review, the Domestic Abuse Act 2021 came into being and the review has been cognisant of the content of the Act when undertaking the review. Throughout this report, the term domestic abuse is used interchangeably with domestic violence, and the report uses the cross-government definition of domestic violence and abuse in line with the Domestic Abuse Act 2021<sup>14</sup>.

**12.3** On notification of the homicide, a total of 36 agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Khloemae and the perpetrator.

**12.4** 24 agencies returned a nil-contact, and after panel consideration, 12 IMRs were commissioned, and one summary report was also provided.

**12.5** The panel met a total of eight times. Throughout the period of review, there were further meetings between the chair and The Violence Reduction Coordinator, in addition to other key partners.

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<sup>13</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575273/DHR-Statutory-Guidance-161206.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf)

<sup>14</sup> [https://www.legislation.gov.uk/ukpga/2021/17/contents/enactedhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1089015/Domestic\\_Abuse\\_Act\\_2021\\_Statutory\\_Guidance.pdf](https://www.legislation.gov.uk/ukpga/2021/17/contents/enactedhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf)

### **13. Independence and Quality of IMRs**

**13.1** The IMRs were written by authors independent of case management or delivery of the service concerned. All reports received were comprehensive and enabled the panel to analyse the contact with Khloemae and/or the perpetrator and to produce the learning for this review.

**13.2** Where necessary, further questions were sent to agencies, and responses were received.

**13.3** The reports have informed the panel's discussion, and any recommendations made in this report. They have helpfully identified changes in practice and policies over time and highlighted areas for improvement not necessarily linked to the terms of reference for this review.

### **14. Documents Reviewed**

**14.1** In addition to the documents above, further documents reviewed as part of this review include the reports triggered by the death of Khloemae as follows:

- Independent mental health homicide investigation undertaken by Niche, the investigation company commissioned by NHS England. This also considered the terms of reference for this review and provided the panel with a review and analysis of contact in relation to mental health services of both individuals in this case.
- A review commissioned by the Multi-Agency Public Protection Panel. When he murdered Khloemae, the perpetrator was being managed at MAPPA level 2, following a referral by his police offender manager who was concerned that his mental health and housing status had led to an increased risk. The fact of the level 2 management made this serious case review mandatory.
- The findings of a review undertaken by the Independent Police Complaints Commission (IOPCC).

**14.2** Appropriate and relevant academic research was also considered by the Panel and reflected within this report where appropriate to do so.

**14.3** The Panel also were mindful of the content of the Victim Impact Statements of the family that were shared with the sentencing judge at the criminal trial, and DHR Case Analysis from the Home Office.

### **15. Involvement with Family and Friends**

**15.1** On behalf of the panel, the chair established contact with members of Khloemae's family, and the panel are particularly grateful to Khloemae's mother. Mrs. Loy was keen to contribute and hoped this review, alongside the other reviews, would give her answers in relation to the circumstances that she held in relation to the support Khloemae received prior to being murdered by the perpetrator. Mrs. Loy was

supported by a Victim Support Homicide Worker and advocate from Advocacy After Fatal Domestic Abuse.

**15.2** The Police investigation did not identify any individuals outside of the family who could give further insight as to the prevalence of domestic abuse within Khloemae's relationship with the perpetrator.

**15.3** Given the devastating impact the murder of Khloemae has had on members of her family, described by Mrs. Loy as being "indescribably overwhelming" at times - the chair is extremely grateful for the time and assistance extended by her in support of this review.

## **16. Other Contributors to the Review**

**16.1** Having received confirmation of Khloemae's murder, the Community Safety Partnership's Violence Reduction Coordinator asked all agencies to undertake a scoping exercise that enabled the panel to identify partners who would be required to submit individual management reports.

**16.2** At the inaugural panel meeting, the panel also identified:

- Information needed to be scoped from a number of Boroughs in London due to the couple moving around London, particularly during the Covid-19 pandemic restrictions.
- Additional reports were being undertaken in relation to this case and agreed to await the conclusion of those reports to ensure this review did not undermine their findings and could be a lever to enhance them. These are documented in further detail below and referenced within this report where appropriate to do so.

- **Contributions from the Perpetrator:**

**16.3** In line with the statutory guidance for the undertaking of such reviews, the chair attempted to invite the perpetrator to contribute to this review but was unable to do so. The perpetrator has not given his consent to be referred to by name in this report and is referred to as "the perpetrator" throughout this report.

**16.4** The chair thanks everyone who contributed their time, patience, and cooperation to this review.

## **17. Conclusions**

**17.1** Khloemae is remembered by her loved ones as being beautiful and kind, willing to help anyone in need. She was a vulnerable young woman who was susceptible to abuse. She was attending college and working in a local bar, at a time of her life when her experiences would form her views of relationship norms. When she met the perpetrator, she was a young adult enjoying the freedom and opportunities that life presented to her. At the time of her meeting the perpetrator, the perpetrator had a

well-established antecedent history of violence and abuse within his intimate partnerships that he kept hidden from Khloemae.

**17.2** In 2016, Khloemae and the perpetrator met, and an intimate relationship was quickly established. The panel understand that Khloemae met the perpetrator at some point in 2016, when she began working in a public house close to the college that she attended. Mrs Loy described the relationship between Khloemae and the perpetrator as one that developed very quickly, with Khloemae seeming to become less interested in maintaining her relationships with family and friends beyond her relationship with the perpetrator.

**17.3** The panel had no doubt that the perpetrator developed a friendship with Khloemae and deliberately withheld from Khloemae his extensive offending history against females, including intimate partners, until Khloemae was emotionally invested in their relationship. Once he became aware of her vulnerabilities, he rapidly developed a relationship with her. In the formative stages of this relationship, there was evidence to lead the panel to conclude that the perpetrator skilfully:

- Presented himself as vulnerable and in need of Khloemae's support.
- Created a codependent relationship by isolating her from her social network and friends.
- This enabled him to lever abuse on Khloemae, who, as a result, experienced a decline in her mental well-being.
- The perpetrator deployed a number of abusive behaviours toward Khloemae, and this pattern included his threats toward her loved ones.
- When Khloemae sought out support from her friends and family, she was reluctant, for this reason, to tell them the full extent of the abuse she was suffering and some of the behaviours that Khloemae deployed were a means to ensure their safety as well as her own.
- The abuse she endured further impacted on her mental well-being and led to increased vulnerability. This was compounded by her experiences of homelessness, and, in turn, her decreased resilience and increased susceptibility to the perpetrator's abuse.
- There were times when Khloemae disclosed the abuse she was suffering to the professionals she was engaging with. The panel concluded that when Khloemae did this, she was testing out the support available to her and whether this was a viable safety option for her in the long term. Sadly, some of the responses she received were not in line with domestic abuse best practice of the time and did not result in a coordinated multi-agency risk-led response that focused on her safety or needs, in a trauma-informed way that took into account her intersectional experiences of abuse and barriers to the support she needed.
- There were times when she ended the relationship with the perpetrator. She experienced of the perpetrator's post-separation abuse and emotional abuse. This included stalking activity that no doubt led to Khloemae experiencing a heightened sense of fear and narrowed safety options.

- The year before she died perpetrator subjected Khloemae to a horrific incident that would no doubt have left her traumatised and in fear for her life. The support she received was invaluable in her recognising there was viable support for her, but this lacked cohesive multi-agency coordination and collaboration. However, Khloemae began to engage with the support and rebuild her fractured relationships with her family.

**17.4** The panel's conclusions were aided by their consideration of the eight steps within the Domestic Homicide Timeline alongside the Leaving Cycle. It concluded that:

Stage 1- The perpetrator had a history of sexual violence, stalking and coercive and controlling behaviour within his intimate relationships. He was a high-risk offender and was well-versed in evading scrutiny and accountability through intimidation and violence in his community.

Stage 2- There was evidence of the perpetrator seeking out a relationship with Khloemae, who was significantly younger than him and vulnerable to a sophisticated perpetrator of abuse who ensured her emotional investment in the relationship through skilled deployment of his vulnerabilities through grooming type behaviour. This ensured his relationship with Khloemae developed rapidly which reduced her mind space to reflect on his manipulated and enforced isolation from her friends and family that developed from an early stage within the relationship.

Stage 3- There was clear evidence of coercive and controlling behaviour of Khloemae by the perpetrator throughout their relationship.

Stage 4 – Khloemae, in the final two years of her life, had begun to disclose the increasing and escalating levels of abuse that she was suffering and enduring to professionals. Although professionals did not always respond appropriately to those disclosures, and up until the final Khloemae did not see that the support available to her was a realistic or viable option to her. In the final year of her life, she began to access the support offered to her, but, to the perpetrator, this served as a trigger to:

Stage 5 – The perpetrator led escalation of his isolation of Khloemae from her family or agencies that could support her through his manipulation of professionals and deflecting scrutiny away from his perpetration abuse from her. This resulted in professionals focusing on his creating the belief that he was experiencing a decline in his mental ill health and self-imposed homelessness during the Covid 19 restrictions. This enabled his high-level isolation of Khloemae that no doubt impacted on a rapid but high-level escalation of his abuse and increased the very credible fear Khloemae would no doubt have felt at this time.

Stage 6 - The Panel concluded that, during the Covid 19 pandemic restrictions, the perpetrator had a change in thinking. This followed Khloemae receiving viable support that enabled her to see a meaningful life away from her abuser and his abuse of her. Being fearful that Khloemae would leave him, and he would no longer exert the power

and control he had levered over her, the perpetrator believed the only way out of this turn of events was to kill her.

Stage 7- The panel concluded that the perpetrator planned the couple's homeless presentation as being homeless to frighten Khloemae further and prevent her engagement with, and possible further disclosure to, professionals and may have planned her murder. There was no evidence to support the perpetrator's assertions to professionals that he was fleeing violence from others, but he most definitely used this as a means to ensure Khloemae complied with his moving areas, ensuring her dependence on him by storing all of her possessions, that she could not access in her own right, in a facility in his name. Throughout this period the panel noted significantly heightened escalation in the coercive control he levered over Khloemae – she was only seen in his company in her final weeks, and although he publicly subjected her to abuse, the fact that he was not held to account for this would have cemented his ability to ensure Khloemae would feel completely alone and unable to access support due to her very real and escalating fear. This rapid escalation, escalated further on the day Khloemae was brutally murdered. This further escalation did not enable any professional to support Khloemae to access safety.

Stage 8 - He killed Khloemae. The perpetrator ensured that emergency services were barred access to Khloemae in her final moments, and in those actions, the perpetrator ensured that Khloemae would have been solely dependent on him and felt completely helpless. In this way, the perpetrator ensured total control over Khloemae's final moments of life.

**17.5** The panel's analysis of Khloemae's life and final weeks enabled them to make recommendations that will support the way professionals work together to prevent victims of abuse in similar circumstances to Khloemae experiencing her tragic loss of life.

**17.6** It is extremely grateful to all who contributed to this review and thanks Khloemae's family for their patience for this review to be undertaken.

**17.7** It expresses its sincerest condolences to the family and friends for the loss of Khloemae, whose life was stolen at the tender age of 23 years of age.

## **18. Learning and Recommendations**

**Learning Point 1** - *We need to be sure that reviews are meaningful, with learning identified to prevent repetition. Our panel members and their IMR authors receive training to undertake their support of future DHRs in line with the statutory guidance.*

**Learning Point 2** - *When there are periods of restrictions that can profoundly and adversely impact on the isolation experienced by victims of abuse, we need to be confident that our services can adapt to ensure flexible person-centric support that can*

*be accessed regardless of the wider issues that may be beyond our control (e.g. Government restrictions to prevent virus control).*

**Learning Point 3** – *To ensure victims of domestic abuse are appropriately supported in relation to all patterns of abuse they are suffering, we need to ensure that our practitioners understand the tactics deployed by perpetrators and so identify how perpetrators of domestic abuse manipulate and/or sabotage their victim's access to support.*

**Learning Point 4** – *When victims of domestic abuse are impacted by the abuse they are suffering to the extent that they may consider taking action to stop the abuse they are suffering could result in their being seriously harmed. This may not indicate suicidal intent. We need to ensure timely adherence to processes that ensure information sharing with all partners so we can support each other to mitigate the risk to, and impact of the abuse on, the victim.*

**Learning Point 5** - *Complex cases that relate to adults with complex vulnerabilities and impacted by domestic abuse should prompt agencies to seek case conferences and joint planning meetings.*

**Learning Point 6** - *Supported housing provision for vulnerable women at risk remains a gap in service provision which the Domestic Act seeks to redress.*

**Learning Point 7** - *Reciprocal arrangements with other LAs need to be revisited and formalised to support victims fleeing domestic being seen as need of priority support when moving out of their locality into a new area.*

**Learning Point 8** - *Victims of domestic abuse are likely to become more susceptible to abuse in future relationships and we need to be alert to this, and the possibility that the victim may not recognise patterns of abuse in those new relationships if they differ from those in past relationships.*

**Learning Point 9** – *We need to take that our focus on the management of perpetrators who pose significant risk to themselves may cause us to lose sight of the need consider who else they pose a risk to.*

**Learning Point 10** - *Where we know that a perpetrator poses risks to intimate partners and/or named individuals, we must ensure that risk management of the risks posed by the perpetrator reflects victim safety, clearly documents how this will be ensured and all partners are clear on the safeguarding action and/or risk mitigation activity they need to undertake.*

**Learning Point 11** – *There may cases where an overlap will occur with MAAPA arrangements and MARAC arrangements. Where this occurs, we need to ensure improved interface by supporting information sharing that reflects the victim's perspective in meetings.*

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**Learning Point 12** – *We need to take every available opportunity to disrupt perpetrators so we can ensure they understand that the use of abuse to cause harm to others has consequences.*

**Learning Point 13** – *When we become aware of concerns about individuals who are in relationships, we need to understand who their partners are. If we do not seek out the information, we may not know if this person has a known history of domestic abuse and if they pose a risk to new partners.*

**Learning Point 14** – *Our responses to domestic abuse must consider patterns of behaviour that interlinks and reinforce the control the abuser will seek to lever over a victim. When we respond on an incident-by-incident basis, we may not see the patterns, and this can result in missed opportunities to coordinate responses that may mitigate risk and ensure victim safety.*

**Learning point 15** – *We need to equip colleagues to appropriately challenge decisions that can support risk mitigation activity that could include disruption of a perpetrator.*

**Learning Point 16** – *We need to ensure that we have a shared understanding of referral criterion so that we can collaborate and work in partnership to reduce risk.*

**Learning Point 17** – *We need to ensure that best practice in relation to the use of professional judgment is understood so that we can ensure all high-risk incidents are referred to MARAC.*

**Learning Point 18** – *We need to be evidence-led in approach to charging advice and decisions to ensure justice for victims who may not feel safe or confident to face their abusers in formal processes.*

**Learning Point 19** – *Risk assessments can inform safeguarding beyond our service remit and enable joint working underpinned by multi-agency collaboration.*

**Learning Point 20** – *We must ensure that, when working with perpetrators of domestic abuse, we are not inadvertently increasing the risk to their victims by our approach. This requires us to be fully cognisant of domestic abuse best practice.*

**Learning Point 21** – *When offenders are subject to monitoring and reporting requirements, we need to clearly document that we have advised them of the consequences of non-compliance and ensure that noncompliance does trigger the processes that reinforce the expectations on them.*

**18.1** Agency IMRs considered by the panel made single agency recommendations, all of which the panel endorse. These are:

**Metropolitan Police Service:**

Local level recommendations were made within some IMRs. To prevent the identification of the staff involved in the incidents referred to these will be redacted prior to publication.

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- Recommendation 1 – MPS Local Level

It is recommended that the SOUTH BCU Senior Leadership Team (SLT) utilise the circumstances of this case to remind all staff of the importance of compliance in the completion of vulnerable adult coming to notice reports on MERLIN in order to share information with partners.

- Recommendation 2 – MPS Local Level

It is recommended that a member of METCC's SLT debrief the operator who dealt with this in order to deal with any areas of personal learning in regard to the MPS expectations in responding to incidents involving domestic abuse.

- Recommendation 3 – MPS Local level

It is recommended that the SW BCU SLT remind all officers of the importance of completing MERLIN ACN reports for identified vulnerable adults in order to share information with key partners.

- Recommendation 4 – MPS Local Level

It is recommended that a member of the SW BCU SLT debrief the investigating and supervisory officers in relation to the investigation and closure of CRIS 0403800/19 in order to address any personal learning connected to this incident in regard to the investigation of domestic abuse.

- Recommendation 5 – MPS Local Level

It is recommended that a member of the SW BCU SLT debrief the attending officers to cad 670 05FEB20 in order to address any personal learning connected to this incident in regard to the investigation of incidents of domestic abuse and the use of intelligence to inform decision-making, and information sharing with partners regarding vulnerable adults.

- Recommendation 6 – MPS Local Level

It is recommended that the SW BCU MH lead utilises the scheduled front-line staff briefings to highlight the issues emanating from this review in regard to the appropriate recording of MH concerns, emergency section 135 procedures, and appropriate focus on individuals that are within the household of those suffering from poor MH that may also be vulnerable or at risk.

- Recommendation 7 – MPS Local Level

It is recommended that a member of the SW BCU SLT debrief the attending officer to cad 409 15MAY20 in order to address any personal learning connected to this incident in regard to the use of intelligence to inform decision-making.

## **SLaM**

The IMR submitted on behalf of SLaM made the following recommendations:

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- Recommendation 8:

Current training to be reviewed and extended if required to include the use of indirect questions about domestic abuse, risk assessment, and risk escalation, asking questions about domestic abuse in a safe manner and environment, following up on contacts when it has been unsafe to ask and gathering information on significant others.

- Recommendation 9:

Training and supervision to emphasise the need to use professional judgement and/or curiosity when a disclosure, or presentation suggests, that the patient is experiencing domestic abuse.

- Recommendation 10:

Review of safeguarding/DASV support to ED staff to ensure that practitioners are confident in their practice. This should include the provision and delivery of safeguarding supervision.

- Recommendation 11:

Hospital Training and supervision to include trauma-informed practice and the impact of ACEs.

### **SHS Croydon Housing**

The IMR submitted on behalf of SHS Croydon Housing made a number of recommendations, but the Panel agreed these should form part of the framework of the strategic review it recommends in recommendation 17. As such, it does not replicate those recommendations here.

### **The National Probation Service**

The IMR submitted on behalf of the National Probation Service made the following recommendations:

- Recommendation 12:

It is recommended that the learning of this case is cascaded as a learning brief for this service, to support learning through supervision and critical reflection on current and future management of vulnerable adults that have been victims. of domestic abuse.

- Recommendation 13:

Practitioners are expected to provide complex cases including safeguarding for discussion during supervision with their senior probation officer during monthly supervision.

- Recommendation 14:

It is recommended that the specific learning for this case is provided to the Probation Head of Service for this PDU to disseminate to practitioners involved in the

management of the case and to ensure tailored learning plans are in place and feed into Continual Professional Development Days.

- Recommendation 15:

All practitioners undertake training to support professionally curious and sensitive working with victims of domestic abuse. This training should reflect obligations to safeguard vulnerable adults. This training should also embed the lessons identified from this IMR and be carried through to continual professional development days so that in similar situations, practitioners will consider safeguarding adult checks and referrals when a risk of abuse or neglect is identified.

**Panel recommendations:**

**18.2** The panel noted that some key developments had been undertaken and progressed whilst this review was undertaken. As stated above it recommends that these are monitored as part of the action plan for this review. Additionally, after considering all the evidence available to it, the panel made the further following recommendations to support the changes required, locally, and/or nationally, as learning from this review, to prevent serious harm to victims of domestic abuse in similar circumstances:

- Recommendation 16:

The SCP require agencies, to provide reassurance that their panel members and IMR authors receive appropriate and contemporary training to undertake their support of future DHRs in line with the statutory guidance for the conduct of DHR's.

- Recommendation 17:

CHS and SLaM to ensure that training to Health colleagues, including Mental Health Clinicians, is to be reviewed and that learning from this review is embedded into ensuring it supports practitioners to improve responses to domestic abuse.

- Recommendation 18:

The Director of Housing is to commission the undertaking of an audit of housing provision in relation to victims of domestic abuse and provide assurance that there is:

- Embedded compliance with the standards and obligations as set out in the Domestic Abuse Act.
- Initiatives to improve responses to victims of domestic abuse who are homeless are appropriately commissioned and require no improvement
- Reciprocal housing arrangements with other The Pan-London Housing Reciprocal is already an
- Local Authorities are formalised and reflect proportionate intersectional responses to those with vulnerabilities and/or multiple needs.

- Recommendation 19:

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The Director of Housing is to commission a review of the domestic abuse training provided to their workforce and ensure it reflects current best practices in domestic abuse training for housing providers.

- Recommendation 20:

The Director of Housing is to commission a thematic analysis of domestic abuse case management and provide reassurance that practice current best practices in relation to supporting victims of domestic abuse who present with multiple disadvantages.

- Recommendation 21:

The Safer Croydon Partnership to form a multi-agency working group to oversee a review process and provide reassurance that locally available multi-agency domestic abuse training reflects:

- Shared understanding of risk and risk clusters.
- Identification of high-risk victims.
- Increased understanding of perpetrator manipulation of professionals, the impact that this manipulation can have on its victims and explores safe challenge to perpetrators.

**18.3** The panel endorses and supports the progression of all recommendations made within the MAPPa report, IOPC report, and the report submitted on behalf of Mental Health Services. It does not replicate these recommendations in this report but invites the Community Safety Partnership to seek agreement that they are amalgamated into the action plan for this review.

**18.4** In the addition, the panel invites the Home Office to share the learning from this review with the Ministry of Justice to support the development of training for the Crown Prosecution Service.