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Domestic Homicide Review – Overview Report

Khloemae Loy - July 2020

Chair and Overview Report Author: Cherryl 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."

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1. Introduction

1.1 The panel formally expresses its sincerest condolences to the family of Khloemae, 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 defence injuries were found on her body and the 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)¹ (see section 2), in line with locally agreed protocols, notified the Croydon Community Safety Partnership of Khloemae's

¹ [The Domestic Violence, Crime and Victims Act 2004. - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

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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 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.

3.5 The DHR process began in November 2023. It concluded in 30/6/2025. The review was impacted by:

- The change in Charing arrangements.
- The perpetrator's appeal against conviction and sentence.
- The need to conclude all other processes to ensure that the DHR did not undermine the findings of those processes and supported them.
- Family liaison which was impacted by the differing stages of grief experienced by Khloemae's parents and the need to ensure they were supported appropriately to enable their contributions to the review.
- The need to address the feedback from the Home Office Quality Assurance Panel prior to publication.

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 Reviews². 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.

² [Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/guidance/domestic-homicide-reviews)

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5. Panel Membership

The panel membership was:

| Name | Role | Agency |
|-----------------------------|--|---|
| Cherryl Henry-Leach | Independent Chair | |
| Alison Kennedy | Operations Manager FJC and VAWG lead | LA Croydon |
| Ciara Goodwin | DASV Coordinator | LA Croydon |
| Jenny Moran | Quality Assurance Officer, Adult Social Care Operations | LA Croydon |
| Justin Armstrong | Review Officer for the MPS | Metropolitan Police Service |
| Dr. Shagufta Shaikh | GP | Parchmore Medical Practice |
| Dr Ravi -Shankar | GP | NHS/CCG Guhendran |
| David Lynch | Safeguarding Adult Lead | SLaM |
| Steve Hall | Quality Assurance & Safeguarding Service Manager | Croydon Children's Service |
| Dr Nathan Brown | Lead GP | Knights Hill Surgery |
| Ene Odeh | Interim Named Nurse Safeguarding Adults | Croydon University Hospital |
| Greg Davies | Single Homeless Service Manager | SHS Croydon Housing |
| Kavitha Ramakrishnan | | Kingston MARAC |
| Kauser Mukhtar | Deputy Head of Service | Bromley & Lewisham Probation Delivery Unit |
| Dr Carol Rooney | Director | Niche Health & Social Care Consulting |

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| | | |
|-------------------------|---|---|
| Estelene Klassan | Designated Nurse Safeguarding Adults | NHS/CCG |
| Tess Leake | GP | Adult Safeguarding Bromley CCG |

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 ordered 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

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independent chairs once the DHR review concluded, and this enabled their feedback on the DHR content and findings, prior to publication.

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 characteristics³. 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 dependant 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 conditions⁴. 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 violence⁵ and that a proportion of

³ [Protected characteristics | Equality and Human Rights Commission \(equalityhumanrights.com\)](https://equalityhumanrights.com)

⁴ ONS. 2018. Partner abuse in detail – Appendix tables - Office for National Statistics (ons.gov.uk).

⁵ 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.

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victims may use alcohol and drugs as a coping mechanism in response to abuse⁶. 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.⁷ 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 services⁸.

7.4 The panel understand that that Khloemae was and considered herself to be of dual heritage (White British and Asian) It is understood 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 no evidence to indicate this was the case.

7.5 Khloemae was 18 years old when the panel understand that she met the perpetrator. 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 bulletin⁹ 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%)¹⁰. 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

⁶ Home Office. Domestic Homicide Reviews: Key findings from analysis of domestic homicide reviews: 2022.

⁷ Institute of Alcohol Studies. Inequalities in victimisation: alcohol, violence, and anti-social behaviour: 2020.

⁸ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

⁹ ONS. 2020. Domestic abuse prevalence and victim characteristics - Office for National Statistics (ons.gov.uk).

¹⁰ ONS. Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk): data year ending March 2021

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relationship of dependency are recognised as common factors¹¹. 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 older¹² 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.

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, 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

¹¹ SafeLives. Spotlight Report #HiddenVictims: Disabled Survivors Too: Disabled people and domestic abuse: 2017.

¹² <https://safelives.org.uk/knowledge-hub/spotlights/spotlight-3-young-people-and-domestic-abuse>

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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 review¹³ 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

11.b.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 1st 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 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.

11.b.2 Agencies with records prior were asked to summarise their involvement within these dates. Any relevant information from agencies that fell outside the timeframe

¹³ Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

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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 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

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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 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

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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 Reviews¹⁴ 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 chairing 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 2021¹⁵.

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.

¹⁴ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

¹⁵ 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

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12.4 24 agencies returned a nil-contact, and after panel consideration, 12 IMRs were commissioned, and 1 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.

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.¹⁶⁶ 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.

¹⁶⁶ Following the NHS England Serious Incident Framework (March 2015) guidance.
<https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

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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 advised the panel that Khloemae's relationship with members of her family was, at times, problematic. The family of Khloemae advised that this was due to their increasing concern about the support needs of Khloemae that they did not feel were being addressed by agencies in a timely manner and agency attempts to support her were compounded by Khloemae's perceived reluctance to engage with services. They also advised that after Khloemae's murder, they became aware of the level of control exerted over her by the perpetrator and that this, in their view, was a contributing factor to her perceived lack of engagement. The family were also concerned that a significant offender such as the perpetrator was not held to account and left to target and abuse Khloemae, advising they became increasingly isolated from her as the control exerted by the perpetrator levered over her. There were times when Khloemae reached out to them, but they advised that she was unwilling to discuss her relationship with them, and they now recognise that this was indicative of the fear that she felt within her relationship with the perpetrator. It is understood by the panel, and confirmed by Mrs Loy, that beyond her familial relationships, Khloemae, nor the perpetrator, had many close friends and this appeared, in the family's view, to be led very much by the perpetrator's intense paranoid tendencies.

15.3 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.

15.4 After the perpetrator's retrial, the family dynamic experienced a significant change. Mr. Loy was contacted separately to Mrs Loy by the independent chair, but he did not respond. Mrs Loy maintained contact and the contributions, feedback, and suggestions received from Mrs Loy have been included where appropriate to do so within this report. Mrs Loy was clear these were made on behalf of her family.

15.5 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.

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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.

16 a - 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 and found locating him to be problematic. The panel noted that, within the current statutory guidance, there appears to be no defined pathway to enable this, and the panel invites the Home Office to give this consideration in future updates to this guidance. The independent chair approached the perpetrator's legal team but received no response from them or directly from the perpetrator. 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. Background Information

17.1 Khloemae is reported by her parents to be the youngest of three siblings. They advised that Khloemae experienced difficulties with her mental health and well-being in her early life, and the family struggled to receive a diagnosis and appropriate support for her. They advised that, as a result, family arguments and criminal justice involvement ensued and culminated in her being under the supervision of the Probation Service. Information from Croydon Children's Social Care records established that there are 9 references in Children's services case records relating to Khloemae which began in August 1989, when she was aged 9 years. None of these contacts led to involvement or related to safeguarding and as a result, records have been destroyed in line with Retention of Records Policies. It is likely that these records were notifications by partner agencies, but the panel were unable to determine the content of the concerns that triggered the notifications. GP information indicates that in June 1997 Khloemae was treated for depression.

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17.2 As a young adult, Khloemae was made subject to a Restraining Order regarding the family home and contact with her mother, and this remains a great source of frustration and sadness for her parents who wanted to support their daughter fully but, at times, felt unable to do so, in part because of this order, but also because of the abuse Khloemae suffered at the hands of the perpetrator and the impact this had on her mental well-being in the months before she died.

17.3 The following information, also forms a narrative chronology of agency involvement with Khloemae and the perpetrator, was considered relevant by the panel but fell out of the time frame of this review. It is provided for contextual information and sets out the complexities within the case. Details and information pertaining, individually, to Khloemae and the perpetrator that do not reference or link to their relationship, are recorded separately below.

- October 2013 – Information from Croydon Children's Social Care records indicate that Khloemae, aged 16, presented to the Turnaround Centre (the access point for Adolescent services) as homeless. Initial enquiries led to her family being contacted, who asserted that Khloemae could return home, and mediation was offered. Khloemae declined this and as a result the housing application was closed.
- **2016 – Khloemae and the perpetrator meet, and an intimate relationship is quickly established.**
- September 2016 - Khloemae was ejected from a nightclub in Croydon whilst drunk, Khloemae was ordered to leave the area as it was subject of a dispersal order¹⁷. She failed to do so and was arrested. She was later released from custody with no further action (NFA) taken.
- December 2016 – Khloemae was arrested in a Public House (PH) located in Croydon after being seen to take shopping bags from behind the bar. She was also found to be in possession of cannabis and was charged with both offences and made subject to a Community Order.
- Beginning of May 2017 - Khloemae was sentenced for Failing to Comply with the Community Order imposed in December 2016, and she received a further requirement to undertake 20 hours of unpaid community service requirement, costs and the original order was to continue.
- May 2017 - Police were called by Khloemae's mother, who stated that she had asked Khloemae to tidy some clothes from the hallway, but Khloemae became angry and slapped and punched her. Khloemae then went to the kitchen picked up a knife and brandished it in front of her mother, saying that she (Khloemae) was not going to hurt her mother but kill her. Khloemae was restrained and disarmed by her father MDL. On police arrival, Khloemae sat on a roof and only came down

¹⁷ made under the Anti-Social Behaviour, Crime and Policing Act of 2014

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after 30 minutes and was subsequently arrested. A search of Khloemae's handbag revealed a bag of cannabis. Khloemae was arrested for threats to kill, assault, and possession of cannabis. In a police interview Khloemae stated she had dreamed of using the knife to kill her mother. In a statement made by Khloemae's mother, her mother stated that Khloemae's mental health was deteriorating. The officers noted nothing in Khloemae's behaviour that would suggest that poor mental health was a factor. When Khloemae was booked into the custody suite she answered "no" to all the standard risk assessment questions regarding mental health and she was remanded in custody. Khloemae was referred to SLaM criminal justice liaison team at Croydon police station after being arrested for assaulting her mother. No signs of mental illness requiring secondary care services were found at that time. Khloemae subsequently served a short prison sentence for assaulting her mother. This was followed by a three-year Restraining Order which limited her contact with her mother, and this was due to expire in August 2020.

- June 2017 – a DASH assessment was undertaken with Khloemae, and the DASH score of 16 indicated that the risk to Khloemae by the perpetrator was high, resulting in a referral to the IDVA Service and the Croydon MARAC. She was also provided with general safety planning advice and a referral was made to the Croydon Young Peoples service at the Turnaround Centre for advice on accessing benefits and employment.
- Khloemae was diagnosed with a formal mental illness during her contacts between 2018 and 2020. It was thought in November 2018 that she may have some traits of emotionally unstable personality disorder¹⁸ (EUPD), but no signs of mental illness requiring secondary care mental health services were found at the time. She was thought to be responding to significant life stressors in the previous year, including a prison stay, verbal and physical abuse from an ex-partner, and changing accommodation and jobs. She was prescribed antidepressants by her GP for depression.
- Khloemae was murdered by the perpetrator when she was aged 23 years old.

17 b - The Perpetrator:

17.4 The panel was able to gather very little information about the perpetrator beyond agency records and reports accessed on behalf of the panel by the chair indicating that, at the point of murdering Khloemae, he was 39 years of age and had a significant

¹⁸ <https://healthmanagement.co.uk/our-insights/articles/emotionally-unstable-personality-disorder/#:~:text=The%20diagnosis%20is%20usually%20made,Difficulty%20in%20maintaining%20stable%20relationships> Formerly known as borderline personality disorder (BPD), EUPD is part of a group of psychiatric conditions known as personality disorders – where someone's personality can interfere with their function, perceptions, behaviour and relationships with others. EUPD commonly presents in adolescence/early childhood and is often experienced along with other mental health conditions. Symptoms vary, but typically include intense and fluctuating emotions and moods, instability in relationships, recurrent thoughts regarding self-harm and/or suicide and using self-harm as a way of managing emotional distress.

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history of offending since childhood, including violent and sexually violent offences.

- 2001 – The perpetrator was arrested for the kidnap and two rapes of an ex-partner (referred to later in this report as female 5) and was sentenced to 6 years imprisonment.
- October 2013 – Information from Croydon Children’s Social Care were notified by the police that the perpetrator was in an “on/off relationship” with a female, Female 2, who was pregnant with his child. The concern documented that the perpetrator was a convicted sex offender following his conviction for two rapes of a previous partner (Female 1) and there were concerns regarding his involvement with Female 2 and her family. An assessment was conducted which identified that Female 2 was not intending to have further contact with the perpetrator and that any contact he had with the child would be supervised by the maternal family. On this basis, the case was closed. At some point in 2014, a police notification was received that Female 2 was considering renewing their relationship but that this had not worked out and she sought police to remove him from her property. The records indicate that there was no report of violence during this incident and no consideration appears to have been given to a previous concern regarding the perpetrator being a sexual offender. The assessment was closed.
- 2015 – The perpetrator reported to the police that Female 1 had stabbed him. She was arrested and placed on bail, and in 2016 was found not guilty by the court.
- April 2015 – Female 2 called the police advising that she needed their assistance because the perpetrator was refusing to leave her address. She explained to the responding officers that the couple had been in an on/off relationship for two years and had a 16-month-old child together. They had slept together the previous evening, but she had decided that morning that she did not wish to see him any longer. When police arrived all parties were calm, and no offences were alleged or apparent. A Domestic Abuse, Stalking and Harassment and ‘Honour Based Violence’ (DASH, 2009¹⁹) Risk Assessment Checklist ²⁰was completed with Female 2 and she answered “no” to all questions. Intelligence was analysed and noted that the perpetrator, who was using an alias, had an extensive offending history. As Female 2 had not alleged any offences the DASH assessment was graded as “Standard” risk, and no further action (NFA) was taken beyond the information being shared with Children’s Social Care.
- October 2015 - The perpetrator, using the same alias as per the previous incident, attended Female 2’s home once again, wanting to visit his child. Police and Children’s Social Care records indicate that she informed professionals that although Female 2 did not want him in her home, she was intimidated by him so allowed him access. Whilst inside he barred her exit from a room and insisted on

¹⁹ https://safelives.org.uk/sites/default/files/resources/Dash%20for%20DVAs%20FINAL_0.pdf

²⁰ which is standard for all allegations of domestic abuse (see appendix F)

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interrogating her mobile phone. When she denied him her phone, he stated that he would kill her with a knife unless she obeyed. She handed over the phone and he deleted several messages, then threw it on the floor causing damage. He then threatened to blow up her mother's house as well as her own. After he had left the address, Female 2 called the police. The perpetrator was swiftly identified and arrested for the offence of "threats to kill", charged, detained in custody, and recalled to prison in order to minimise any further risk to Female 2. The police undertook a Domestic Violence Disclosure to Female 1, who was recorded on police records as a previous partner of the perpetrator.

- **2016 – Khloemae and the perpetrator meet, and an intimate relationship is 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.
- May 2016 – Khloemae's friend contacted the police as she was worried that she had not come home following a planned meeting with her ex-boyfriend (now known to be the perpetrator). Although Khloemae had never stated that she had been assaulted to her friend she did mention that he had been violent to previous partners. Intelligence checks carried out by officers linked the perpetrator to the alias he previously used when the police were called to incidents by a previous intimate partner. Police undertook efforts to locate Khloemae, her parents were consulted, and another friend eventually contacted the police to confirm that Khloemae was safe and well and staying with her. Several further efforts to establish her safety proved fruitless until her father was spoken to the next morning, and he stated that Khloemae had returned home. As no allegation of a crime was made the report was closed as intelligence only.
- January 2016 - The perpetrator called the police to state he had killed his partner, Female 1. Police attended an emergency call made by the perpetrator in which he stated that he had killed his partner at a London address. When the police arrived at the property, he refused them entry stating he had a knife, and that he was intoxicated and violent. He was subsequently dealt with by specialist officers from the Territorial Support Group (TSG) and arrested on suspicion of murder as there was no sign of Female 1 at the address. Their two young sons were taken to their grandmother's address. The children told officers that their parents constantly argued. Female 1 was treated as a high-risk missing person and eventually traced to the Princess Royal University Hospital where she was awaiting treatment for bruising, advising clinicians that she had been punched by the perpetrator that evening after a verbal argument, where he had threatened to tell the police that she was breaking her bail conditions (regarding the stabbing). The perpetrator was charged with assault occasioning actual bodily harm (ABH) and Affray.

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- June 2016 - The 13-year-old daughter (Female 4) of the perpetrator's new girlfriend, Female 3, alleged that he had raped her on two occasions, 3 weeks apart, first in her bedroom at her home, and a second time at another address in London. When sharing information about the first alleged rape, she stated that the perpetrator had taken cocaine in front of the children, and whilst their mother slept, he entered the room of Female 4, which she shared with her 11-year-old sister. She stated the perpetrator told her sister to leave the room and when she did, he raped her. The appropriate forensic samples were obtained from Female 4, were taken, and appropriate steps undertaken to provide Female 4 with ongoing support in relation to her sexual health and well-being. The perpetrator was located, arrested, and, in a police interview, denied the offences stating that the girls were sexually attracted to him and would be inappropriate towards him, not the other way around. He was subsequently charged with two counts of penetrative sexual activity with a girl aged 13-15 and remanded in custody to appear at the Magistrate's court in June 2016. Children's Social Care records documented a number of previous concerns about the family of Female 3 and her children, and a strategy meeting was undertaken around this time to assess the needs of the children and Female 3. The panel agreed that the investigating officer (IO) undertook a diligent investigation and obtained vast amounts of physical and forensic evidence. During the two-week criminal trial, the officer introduced "bad character" evidence, which was refused by the judge as prejudicial, a jury found the perpetrator not guilty.
- January 2017 – A MARAC²¹ meeting discussion recorded the perpetrator as a victim of domestic abuse, perpetrated by Female 1. The minutes indicate that the Family Justice Centre (FJC) received a referral from them which documented that the perpetrator and Female 1 met in 2010 at a party and began a casual relationship, and the perpetrator was unaware that, at this time, Female 1 did not have settled immigration status in the UK. The couple subsequently learned that Female 1 was pregnant, and the perpetrator supported Female 1 to obtain leave to remain in the UK. The perpetrator is recorded as stating that his relationship with Female 1 was "on and off" but, when Female 1 became aware that he had commenced a relationship with someone else and returned to the relationship with Female 1, Female 1 "went a bit mad" and attacked him, and during the attack, stabbed him. His account also stated that Female 1 was arrested and bailed but continued to harass and stalk him, and this included her making threats to kill him. The perpetrator reported that he had mobility issues and that his children were in the care of his parents. It was reported that The FJC would continue to support the perpetrator. A Domestic Violence Disclosure was made to Khloemae by the Police, and her father was present when the disclosure was made.

²¹ <https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf> defines a MARAC as a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors

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- July 2017 –The perpetrator was staying at the home address of a 52-year-old male (Male 1) when an argument broke out. The perpetrator accused Male 1 of stealing his property in order to sell it. The perpetrator attacked Male 1 with a machete causing a laceration to his head. Male 1 fought his way out of the flat and made his way outside where he called police and was subsequently treated by the London Ambulance Service (LAS) and conveyed to a local hospital for treatment. The perpetrator remained at the address and was drinking alcohol when the police arrived. He was arrested for assault and taken to a local police station. The flat was forensically examined as there were obvious signs of disturbance and visible blood markings. In the police interview, the perpetrator stated that Male 1 was an alcoholic, had first assaulted the perpetrator as Male 1 had no money for alcohol, and the perpetrator had merely hugged him to stop Male 1 from further assaulting the perpetrator. The perpetrator denied all knowledge of an assault by a knife or machete and pointed out a black eye and scratches allegedly caused by Male 1. The perpetrator was subsequently charged with assault occasioning actual bodily harm (ABH) and kept in police custody to attend court.
- April 2017 –The perpetrator contacted an ex-partner, Female 5, who was the victim of rape and kidnapping by the perpetrator in 2001, for which he received a 6-year sentence of imprisonment. In this report to the police, Female 5 alleged that the perpetrator was harassing her via Facebook. Female 5 explained that the perpetrator messaged her in January 2016, and she did not respond. He repeated contact 15 months later with a full stop, at which point he blocked her account, whereupon she reported this to the police. Female 5 then set up a new Facebook profile and the perpetrator posted on her new profile “Hi, how you doing” on her account. This allegation was assigned to a detective within the CSU, who sought guidance from a supervising officer as Female 5 was the victim of serious previous offences that the perpetrator subjected her to and, although the contact did not constitute an overt threat in its content, it may have been designed to cause Female 5 distress. The OIC contacted the Croydon Jigsaw unit who stated that this did not constitute a breach of the perpetrator’s current conditions. Support and advice were offered to Female 5, and completed by an IDVA, and after a face-to-face discussion with Female 5, officers concluded that NFA would be her preferred outcome as issuing a first-instance harassment warning (FIHW) may have caused an escalation of the suspects’ behaviour. The case was then closed with NFA.
- July 2017 – Female 4, now a 15-year-old, who had been the subject of a rape allegation back in June 2016, attended the front office at her local police station to report that the perpetrator had approached her twice in two days in two different locations in London, and said to her that she had made his life a misery and he was going to do the same to her. Female 4 explained to the reporting officer that she had been the victim of sexual assault by the perpetrator, and she was very concerned because of the words used by the suspect. The reporting officer completed a MERLIN which was graded as “GREEN” by the MASH police

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supervisor and passed to Children's Social Care. Initial supervision of the CRIS identified this as a possible offence of intimidating a witness, which, if proved, would be a more serious offence than harassment. Liaison with the OIC for the 2016 offence revealed that a protection from harassment order had been served on the perpetrator at the conclusion of the trial, and this expired in August 2021. The Detective Inspector in charge of the CAIT team decided that as it was not a live CAIT investigation it should be screened back to Borough policing to deal with. An appointment was made with Female 4 and her father to complete a statement but neither attended the police station, and her father stated her mother now wished to attend. Several further attempts at contact were made but Female 4's mother stated that now she did not wish to attend with her daughter. As an appropriate adult was required in order to obtain a statement from a child the OIC attempted several other options including attending Female 4's school, but ultimately this failed because of Female 4's school attendance was described as "unpredictable and poor". After 3 ½ months of aborted attempts to obtain a statement from Female 4, the OIC and her supervisor concluded that Female 4 did not wish to have contact with the police and closed the investigation as NFA.

18. Narrative Chronology and Overview of Agency Involvement

18.1 The following information is provided as a narrative chronology of agency involvement within the time frame of this review:

18.2 January 2017 – Khloemae was arrested for being drunk and disorderly and for being in possession of cannabis. Whilst in custody she stated that her boyfriend, the perpetrator would kill her on her release. She explained they had met in 2014 and started a relationship, but he was very controlling and constantly accused her of cheating with other men. She had broken up with the perpetrator when he was in prison and started a relationship with another man, however, the perpetrator had contacted her, and they had once more entered a relationship. He then started verbally abusing her, damaging her things, and had now become physical with her, punching her in the face and ribs. The previous week the perpetrator had texted her that he would petrol bomb her house. Khloemae refused to provide an evidential statement as she was scared to do so. Intelligence checks were completed and showed that the perpetrator was on bail for assaulting another partner and was an RSO. Khloemae was offered a place in a domestic abuse (DA) refuge but declined this. She also refused a lift home following her release and declined further contact with the police, whom she did not want to attend her address. The Investigating Officer (IO) placed an alert warning on the home address (known as "special schemes") and discussed the case with a supervisor who stated that without the support from the victim, the arrest of the perpetrator might inflame the situation. (The IO continued to try and contact Khloemae. The perpetrator was arrested for this offence and others when he assaulted Khloemae again in February 2017). The matter was referred to the Crown Prosecution Service (CPS) for consideration of an evidence-based prosecution,

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however, they refused to charge for this allegation due to the evidence being insufficient.

18.3 Beginning February 2017 - Police were called to a disturbance in the street by a concerned member of the public. On their arrival, an informant stated that he had seen a woman assaulted and thrown into a large rubbish bin. On searching some blood was discovered in a bin, and enquiries led to a flat nearby, where Khloemae stated she had been assaulted by the perpetrator causing an injury to her head. The perpetrator was arrested and taken into custody, whilst Khloemae who was under the influence of alcohol was taken to Croydon University Hospital for treatment under police escort. Once there she became violent, assaulted a nurse kicking her in the stomach, further assaulting the accompanying officers, and was subsequently charged with assaulting a constable and common assault on the nurse. Khloemae later provided a short evidential statement stating that the perpetrator had punched her and thrown her hard into the bin which had broken glass in it. Prior to her arrest, clinical examination documents that Khloemae had a 1cm laceration to the back of her head, but clinical examination did not identify signs of a fracture. The wound was assessed, documented, and appropriately treated. Due to the level of violence displayed by Khloemae toward ED staff, they were unable to fully assess her. Khloemae was later brought back to the ED by the police, as she had been picking at her head wound. No new trauma was diagnosed, and the wound was cleaned and treated. Khloemae was then discharged back into police custody. The perpetrator was interviewed by the police and stated that Khloemae had drunk six bottles of wine and had fallen over both outside and in the flat. The perpetrator was detained in police custody and was subsequently charged and arrested with assault occasioning actual bodily harm (ABH), authorised by the CPS subsequently for this incident and previous assaults of Khloemae. (Khloemae's family advised the panel that the perpetrator, prior to putting Khloemae in the bin, also set her alight. They believe this was a credible threat to Khloemae's life, and the panel do not disagree although it noted that Khloemae did mention to professionals that he had set her alight.)

18.4 Mid-February 2017 - Khloemae self-referred to the FJC following an assault by her partner, the perpetrator, and was referred to the Croydon MARAC.

18.5 End February 2017 – Khloemae was sentenced to a Community Order, with an unpaid work requirement, a curfew order with an address tag (her parent's address) and she was also ordered to pay compensation to the victims of the assaults on the officers and nurse.

18.6 Beginning March 2017 - Khloemae received a 12-month conditional discharge with costs regarding possession of cannabis in January 2017 and was found not guilty of theft.

18.7 March 2017 - Khloemae's parents called the police for assistance, advising that Khloemae was "going crazy" following an argument about her being drunk and playing

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loud music, during which Khloemae assaulted her parents. An officer attended and Khloemae was booked into the custody suite but was described in the custody suite log as being too intoxicated to sign to say she understood her rights. She was placed in a cell until sober where she was booked out for an interview and admitted to assaulting her parents, she stated that no one was helping her but did not elaborate as to what help she needed. The matter was referred to the CPS for charging advice, and the CPS decided no further action (NFA) should be taken.

18.8 The following week, in March 2017, Khloemae's mother called the police following a verbal argument about Khloemae watching the television with the volume too loud whilst she was intoxicated. The attending officers recorded Mrs Loy's concerns regarding her daughter stating that her behaviour had deteriorated recently, that she was drinking too much, and had been affected by the recent death of her Nan. In addition, her violent boyfriend, the perpetrator, had a bail hearing the next day, and if he was granted bail, Khloemae feared retribution. The reporting officer noted from intelligence that Khloemae had been previously arrested for assaulting her parents but could find no CRIS to contact the appointed IO. A DASH risk assessment was completed and determined as "standard". The CRIS report was submitted to a Community Support Unit (CSU) for their information and closed as no crime had been alleged. FJC IDVA records indicate that Khloemae was being supported by them at this time, and her housing options were discussed with her, but Khloemae felt she could stay with her family safely at this time. Khloemae was 'reluctant to engage' with FJC then received support and advice in relation to her housing options and was referred to CAYSH by the IDVA, who was also liaising with the police in relation to the perpetrator's pending bail hearing and possible bail conditions. CAYSH records indicate that they received the referral in relation to Khloemae's housing needs, but that Khloemae did not engage with them.

18.9 End March 2017 – The perpetrator was sentenced to 20 weeks imprisonment for the most recent assault on Khloemae, and a restraining order was also imposed. Khloemae was arrested for causing a disturbance in McDonald's, Croydon involving staff and other customers – during which she assaulted a staff member. She was also in breach of a conditional discharge. In April 2017, magistrates sentenced Khloemae to a Community Order, with a 20-day rehabilitation activity requirement and ordered her to pay costs and compensation.

18.10 April 2017 - Khloemae was reported as missing from home by her father. He stated he hadn't seen or spoken to her since 06/04/2017, and this was out of character. The police created a MERLIN missing person's report, grading it as "Medium", due to Khloemae being deemed vulnerable whilst intoxicated. Local enquiries were carried out, and she returned home of her own volition. A missing persons debrief was undertaken with her, but Khloemae stated she had been out with friends and had come to no harm. A vulnerable adult coming to notice MERLIN report was completed and assessed as "BLUE" by the MASH police supervisor.

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18.11 The following day, in April 2017, Khloemae attended the ED Croydon University Hospital with a history of injury to her left hand/wrist and soft tissue tenderness. Upon further examination, that there was no acute bone injury, full movement was present, and joint spaces maintained. During the consultation in ED, it is documented that Khloemae gave different versions of how she had sustained the injuries (that she flicked her hand five days earlier, she fell when was intoxicated, she hit her forearm on the back of her friend four days earlier and that she could not recall the events when she sustained the injury.). Khloemae was discharged later that day for GP follow-up. Her clinical notes do not indicate that Khloemae disclosed any history of domestic violence to ED staff, and there is no record to suggest that ED staff suspected assault or asked Khloemae if she was assaulted. No police involvement was recorded. There was no further exploration of her alcohol use during this interaction.

18.12 End April 2017 – Khloemae was reported as missing from home by her father. He stated he hadn't seen or spoken to her since the previous day, and this was out of character. The police created a MERLIN missing person's report, grading it as "Medium" due to Khloemae's level of vulnerability whilst intoxicated. Local enquiries were undertaken and, when she returned home under her own volition, a missing persons debrief was undertaken with her by the officers. Khloemae stated she had been out with friends, had come to no harm, was an adult, and felt it was unnecessary for her parents to report her missing to the police when she was out enjoying herself. A vulnerable adult coming to notice MERLIN report was completed and assessed as "BLUE" by the MASH police supervisor, and checks undertaken by the police noted that Khloemae resided at her parent's address but was subject to a 3-year Restraining Order issued by Croydon Crown Court which prohibited her contact with her mother and attending this address.

18.13 Beginning May 2017 - Police were called to the flat of Khloemae's new boyfriend who she had been going out with for a month. Neighbours had heard breaking glass late at night and called 999. On police arrival, Khloemae was alone inside the flat cleaning up the broken glass with recent bleeding cuts to her hands and was observed by the officers to be under the influence of alcohol. She informed officers that she had been invited over by her boyfriend, had found the window broken, and gained access. She was arrested on suspicion of criminal damage and taken into custody. Police were unable to trace her boyfriend but carried out an interview where Khloemae admitted she had broken the window. When the police did trace and speak with her boyfriend, he confirmed he did not wish to press charges, and Khloemae was released with NFA taken.

18.14 The following week, Khloemae appeared before the magistrates and was sentenced for Failing to Comply with a Community Order, imposed for offences committed between 22/02/2017 and 12/04/2017 (resulting from her February 2017 conviction and sentence). She received 20 hours unpaid community service requirement; costs and the original order was to continue.

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18.15 September 2017 - Khloemae was a witness to her cousin CC being a victim of Malicious Communication, namely the receipt of multiple calls from the perpetrator. Information shared with the panel indicated that the perpetrator had assaulted Khloemae's cousin two weeks previously, and the perpetrator was made subject to an injunction which prohibited his contact with Khloemae's cousin, although he was subsequently found not guilty in respect of the assault allegation.

18.16 October 2017 – The Probation Service undertook a MARAC referral that records regarding the perpetrator and a different victim.

18.17 November 2017 - The perpetrator appeared at Croydon Crown Court for the offence that occurred in January 2016 in relation to Female 1. There appear not to have been any presentence reports ordered by the court and was sentenced without input from the Probation Service.

18.18 IDVA records indicate that Khloemae moved to an address in another area in London that was not covered by the FJC IDVA and the case was closed to the FJC.

18.19 Mid–November 2017 – Khloemae was a witness to her cousin being a victim of a second breach of a non-molestation order, as she was present when the perpetrator (who was subject to an injunction against him for assaulting the cousin). The perpetrator had left the scene prior to police arrival, the officers noted that both Khloemae and her cousin were under the influence of alcohol and were arguing over her cousin's lost mobile phone. The matter was ultimately closed with NFA as the cousin did not wish to complete a statement.

18.20 February 2018 - A friend of the perpetrator rang the police, claiming he was the landlord of the perpetrator's home address, and a man was kicking the door of the perpetrator's property. The friend also stated that they were staying at the property while the perpetrator was away. No suspect was identified, and the friend was advised to tell the perpetrator to report the damage to police upon his return - NFA was taken.

18.21 Mid-April 2018 - Khloemae called the Police via 999 in the late evening. She advised that she had been assaulted by the perpetrator the previous week, and on this evening, he had made threats to kill her and her family members. She refused the offer made by the call handler to make an appointment to see her and stated she wished to see the police now. The call handler advised Kloe Mae that as such there would be a considerable delay to this call as they had graded the call as "E" for extended, and the receiving local dispatcher noted that there were lengthy delays in comparison to the "I" immediate calls. Police attended Khloemae's address the next morning, and as there was no reply, a note was made for the re-attendance of a unit later, and a "skeleton" CRIS was placed on the system with the minimal details available from the original call. The Initial investigating officer (IIO) noted the background intelligence, linked the named suspect as the perpetrator and created a CRIMINT for the attention of MARAC as Khloemae was an identified repeat victim.

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18.22 The CRIS was screened by the CSU, and a supervisor noted the history and contacted Khloemae, who stated that she did want to make any allegation. She was offered uniform or plain clothes officers to attend but Khloemae declined further police assistance the case was subsequently closed with NFA.

18.23 Early May 2018 - Khloemae alleged to police that she had been at a friend's house with the perpetrator when he had become argumentative, scratching, and punching her in the face. He then calmed down but about an hour later assaulted her again, whereupon she had rolled in a ball crying. The perpetrator then attempted to comfort her, but when this failed, he left the address. She had contacted her father, who agreed to pick her up, and together they reported the matter to the police. Khloemae provided basic details in a statement and her injuries were recorded on the officer's body-worn video (BWV). She provided the perpetrator's details by his alias's first name and was not to provide an address for him. Officers completed a DASH which they graded as "medium" as Khloemae described the perpetrator's behaviour as escalating in violence and control. Intelligence checks revealed the perpetrator's background of violence towards Khloemae and others, as well as other offences. Initial arrest enquiries proved negative. The case was screened to the CSU where it was supervised and allocated with instructions to trace the suspect. The perpetrator's nomadic lifestyle frustrated attempts to locate him, and he was quickly circulated as "wanted" on the police national computer (PNC). Several other techniques were deployed by the investigating officer in order to identify his whereabouts. In June 2018, he was arrested for another unconnected matter and was subsequently interviewed regarding this assault and other offences, and was bailed on the instruction of the CPS, who after the completion of their action plan decided that NFA should be taken.

18.24 Late May 2018 - Khloemae attended Croydon police station and alleged that the perpetrator had threatened her to make her stay in a tent with him in a local park in Norbury two weeks earlier. She stated that she met him to celebrate her birthday on that day and things between them became amicable, the perpetrator had grabbed her around the waist hugging her outside a train station and walked with her saying he wanted to be with her once more. They went to a bar in Croydon, and after a few cocktails began arguing but then went on to a friend's house where they had more alcohol. Khloemae stated that she ended the evening by sleeping at a cousin's house, and then received a text from the perpetrator threatening a family member unless she went and stayed with him in his tent. She presented at the Police Station with burn marks to her neck, face, and head, bruising to her left forearm, and had lost a fingernail. Khloemae said she had no idea how the injuries had occurred as the week she was kept in the tent was like a "blur". She eventually escaped when the perpetrator left to charge his phone. The police referred Khloemae to St George's hospital for treatment whereupon staff stated to police that Khloemae would be referred to adult social services as she was vulnerable. The attended officer also completed a MERLIN as she was a vulnerable adult and was assessed as "AMBER" by the MASH decision maker and passed to Adult Social Care. A DASH was completed with Khloemae, and the escalation of the perpetrator's abuse was noted. The risk posed to Khloemae was

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graded medium. Patrol officers immediately attended Norbury Woods and conducted a search but found no tents or rough sleeping activity, and their discussions with regular parkgoers suggested they had not seen any tents. Officers then circulated the perpetrator as wanted on the PNC (in addition to the offence at the beginning of May 2018). The crime report was allocated to the officer who was investigating the earlier allegation. The officer ensured Khloemae was safe at an address far from the perpetrator's sphere of influence and referred to partners via the FJC, and MARAC for consideration. The BWV of Khloemae's initial approach to the police in relation to this incident was secured and the officer also obtained medical evidence from St George's hospital, in addition to completing a range of activities in order to secure the suspect's arrest. In early June, the perpetrator was seen and chased by officers, but he escaped despite being hit by an officer-deployed Taser by running along the railway line and narrowly missed being struck by a train. The officer was then contacted by Khloemae's father who stated he suspected that Khloemae's behaviour was subversive, and he believed that she had resumed contact with the perpetrator. Attempts by the officer to contact Khloemae were unsuccessful as her phone was switched off. By mid-June, Khloemae's father advised that she had returned home with bruising but stated she had been in a fight with an unknown girl in a pub. The officer immediately attended at the father's home address and spoke with Khloemae. She was offered further support by the officer, and Khloemae denied having any knowledge or contact with the perpetrator, confirming she still wished him prosecuted for the events in May. The perpetrator was subsequently arrested on a historic allegation of rape from 2006 and this assault. In a police interview, he presented Facebook messages from Khloemae where she had stated that she had "*said bullshit to the police*" and blamed her self-harming injuries as being assaults committed by the perpetrator. The CPS created an action plan which was completed by the officer, including house-to-house enquiries around the park. This resulted in a witness being traced, who confirmed seeing a tent but had heard no disturbances from it. The CPS eventually decided not to pursue any charges against the perpetrator and the case was closed with NFA taken.

18.25 A week later (late May 2018), the FJC IDVA received a call from Khloemae's mother, alleging Khloemae had suffered domestic abuse by the perpetrator. A DASH risk assessment was undertaken by the IDVA with Khloemae, and the score of this assessment was 17, Khloemae was referred to Croydon MARAC as a repeat referral. The IDVA also gave Khloemae general safety planning advice and undertook a housing referral to Croydon Turnaround Centre (housing for young people) on Khloemae's behalf. During the following week, housing records confirmed that Khloemae had made a homeless application to SHS.

18.26 At the end of May 2018, Khloemae was arrested for being drunk and disorderly at a train station and advised that she had been evicted from temporary accommodation following a domestic incident with a different male partner and concerns that she was taking drugs and bringing in guests at various times of the night. Khloemae was understood by the police to have been under the care of Croydon Council and Mental Health Services during that time.

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18.27 A week after this arrest, Khloemae presented at the ED at Croydon University Hospital with facial burns. There was swelling of the left index finger and possible blood collection around the nailbed. An x-ray showed an underlying comminuted distal phalanx fracture²². Khloemae could not be certain on how long ago she had sustained the injury. Clinician notes indicated that the burns were already healing and did not require any medical intervention. There was no recording relating to the cause of the burns. Khole Mae later disclosed that she injured herself the previous week whilst being held hostage by an individual known to her and that the Police were investigating the incident. The ED submitted a referral for Khloemae to be seen by the Department of Plastics and Surgery Reconstruction at St Georges Hospital for Specialist input. The ED plan recorded the need to escalate the concerns raised by Khole Mae's repeated presentations following assaults with the ED Matron, but there is no record to indicate that the discussion with the ED Matron took place. However, records do show that a referral was made to Croydon Social Care with a reference number that indicates this was completed. Mental Health records also reference Khloemae's attendance at the ED with a reference to her being intoxicated but with injuries consistent with being burned on her face and neck and that she was seen by the Croydon Council Safeguarding Triage team. The records also indicate Khloemae described an on/off relationship with the perpetrator over the previous three years; that the burns had been caused by him he had kept her 'hostage' after stalking her. She disclosed that she had been out with friends, and believed he had some sort of tracking device on her as he waited for her and coerced her to go with him, keeping her in a tent in Kent for approximately eight days. The Safeguarding Triage worker tried to contact the Croydon assessment and liaison team to request that she be seen but could not make phone contact. There was no recorded acknowledgement of this referral back to the Croydon Council Safeguarding Triage team. Khloemae consented to a safeguarding investigation; a safeguarding referral was made alongside a referral to an Independent Domestic Violence Advocate (IDVA).¹⁷ A MARAC referral had been made by a sexual violence crisis support service. A follow-up call made by the Triage worker ascertained that Khloemae wanted:

- The perpetrator to be arrested for assault and coercion.
- To move out of the borough for her safety.
- To feel safe and settled with a job and accommodation.

18.28 The following day, Khloemae presented to Croydon Council as homeless with visible scars on her face, neck, and a bandaged finger and was seen by a CAYSH worker within the Early Help Service. At this time, she was staying temporarily with an aunt who lived in the Croydon area despite it being unsafe for her to remain in Croydon. Khloemae advised that the FJC had assessed her as at High risk, her ex-partner had assaulted her on numerous occasions. In an interview, she referred to the perpetrator being sent to prison in 2017 for assaulting her and the recent incident in May during which he had kidnapped her for 1 week and broke her finger. Khloemae

²² Multiple fractures in her wrist

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also expressed concern that the perpetrator's network of friends was also a threat to her. She also reported that she could not stay with her mother as there was a restraining order against her from returning home as a result of a previous conviction for assault by her on her mother and that she had been sofa surfing since leaving remand for this offence. Khloemae was placed in emergency Bed and Breakfast accommodation whilst further investigations regarding her housing position were explored.

18.29 In May 2018, Adult Social Care²³ were very briefly involved in this case. Upon receipt of a Police Merlin report from the Metropolitan Police Service (MPS) the referral onto LAS passing information to an advanced social worker for assessment and risk rating. A social worker embarked on gathering information and uploading information on the database as per policy and procedure. A Safeguarding Assessment was completed, and the worker contacted the Croydon Housing worker, Croydon Substance Misuse Service, Turning Point, and Croydon Family Justice Centre worker IDVA to refer Khloemae to their respective services. A safeguarding referral was made to the CHMT younger adults service, and the safeguarding leads were copied into the referral.

18.30 Beginning of June 2018 – Heath and Social Care records indicate that a letter was sent to the Croydon Assessment and Liaison Team in June 2018, advising that Khole Mae had been referred to MARAC, and inviting their attendance. This correspondence was subsequent to the safeguarding referral made to Croydon Council by Croydon Hospital's ED after Khole Mae attended in May 2018. This communication was received after the risks were triaged by the London Borough of Croydon Safeguarding Team who forwarded the safeguarding concern to the SLaM Assessment and Liaison Team to undertake a safeguarding enquiry under Section 42 of the Care Act 2014. This communication and request to undertake an enquiry was never acknowledged nor acted upon. This team was also alerted that Khloemae was due to be discussed at a forthcoming MARAC panel. Mental Health records indicate that they were invited to attend a MARAC meeting. There is no information about any response from SLaM to this in the clinical records, and there was no action taken.

18.31 At the June MARAC meeting, the IDVA presented Khloemae to the Croydon MARAC in relation to the incident at the beginning of May 2018, from which Khloemae escaped and went to Croydon University Hospital. The IDVA presenting the case advised MARAC partners that Khloemae had informed the IDVA supporting her that

²³ Excerpt from the Adult social care IMR: Adult social care is the support provided to adults with either physical or learning disabilities, or physical or mental illnesses. The support provided could be for personal care such as eating, cleaning and getting dressed or for domestic routines such as going to the shops. The service is responsible for assessment and intervention under the Care Act for section 42 adult safeguarding enquiries. If a MERLIN report is raised regarding a domestic abuse incident involving an adult in receipt of social and /or health care it will be passed to the Central Duty Team for assessment and processing. If a person is known the community mental health team a safeguarding referral is forwarded to them for processing. South London and Maudsley (SLAM) Community Mental Health Team CMHT is the service provider who Croydon Adult Social Care Central Duty Team would pass referral to.

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the perpetrator was accused of cheating on her, and physically assaulted her. Khloemae thought that the perpetrator had knocked her out as she could recall very little in relation to the injuries she sustained during her ordeal, including her broken finger, but she believed the burns to her face were caused by the perpetrator using an aerosol and lighter. She also stated to the IDVA that the perpetrator would not allow her to leave the tent (he was also homeless) for a week, saying she could not go back home until things between the couple had healed. From the MARAC a referral was made to Adult Social Care for support in relation to her mental health. A week after the case was discussed at MARAC, Housing records indicate that a reciprocal housing placement had been requested of another Local Authority and this was agreed. A MARAC-to-MARAC transfer was then undertaken as Khloemae had been allocated emergency accommodation in West Kent. Toward the end of June, the FJC IDVA closed Khloemae's case with them as it was felt Khloemae needed support around Domestic Abuse, and her case with Early Help and Housing was also closed.

18.32 During the last week in June 2018, information shared by the Police with the panel indicated that Khloemae was discussed as a victim of the perpetrator at the Bexley (in Kent) MARAC, and this discussion identified the risk posed by the perpetrator's increased violent coercive control toward her and highlighted her vulnerabilities due to her mental health.

18.33 July 2018 - Between the beginning of to mid-July Housing records indicate that Khloemae returned to interim accommodation but there was a disagreement on the suitable long-term accommodation option for Khloemae – the FJC IDVA felt that she would be better suited to supported housing, in line with Khloemae's wishes, but housing colleagues disagreed, stating refuge provision would be more appropriate for her. Housing records indicate that Khloemae was moved again, and a further MARAC transfer was made to Richmond and Wandsworth.

18.34 Mid-July 2018 - Khloemae contacted the police to state that she had, the day before making the report, received a text from a withheld number stating, "Hey Renee you are ok sexy?" Khloemae said that the perpetrator had mentioned Renee to her before and this is what led her to believe the text was from him. She went on to receive two more texts from the withheld number that were derogatory. Intelligence checks were completed by the police, and these highlighted the history of domestic abuse that Khloemae had suffered from the perpetrator and the investigation was allocated to the same officer dealing with the connected matters. There was no evidence linking the messages to the perpetrator the allegation was closed with NFA.

18.35 Around this time, the police were called to a Croydon Railway Station following reports that a male, who was later identified as the perpetrator, possibly under the influence of drugs, was acting aggressively. On arrival, the perpetrator was approached by police who found him to be aggressive and unpredictable in his manner – his actions ranged from lying on the ground shouting "Don't shoot me", to shouting

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and threatening the officers. He was encouraged to leave the station, and he eventually complied.

18.36 At the end of July 2018, Khloemae, who was now residing in a domestic abuse refuge in Wandsworth, called the police and stated that she had been assaulted by someone in the house she lives in. On arrival Khloemae was in her room with her parents and described by the officers as being very intoxicated. Initially, she refused to speak to the responding officers stating that she had not called them, however on them reading the contents of the call to police she said that the perpetrator had slapped her face and bottom earlier that evening in Croydon. Officers attempted to complete the DASH risk assessment with her, and Khloemae refused to answer all the questions and became aggressive with them. She subsequently refused to interact any further with them, or supply details of any offences, shouting that they needed to leave. Khloemae then sat on the window ledge that led to the roof area and stayed there for 25 minutes until coaxed back into her room by her father. Khloemae refused the officer's offer of an assessment by the LAS. Her mother and father outlined the relationship history to the officers which the officers confirmed through research, and, being concerned about Khloemae's behaviour and the information her parents shared with them, they completed a MERLIN report requesting an assessment. This referral indicated that Khloemae had been diagnosed as suffering from severe depression, had stopped taking her anti-depressant medication, and had recently self-harmed, and the referral was shared with Wandsworth Adult Social Care by the local MASH. The CRIS was allocated to a CSU officer who contacted Khloemae, who stated that she had not been assaulted, and did not wish police assistance. The case was subsequently closed with NFA. Housing records also indicate that Khloemae had been issued with a final warning from the accommodation provider in Wandsworth, and this cited alcohol-related antisocial behaviour. A Housing Needs Officer (HNO) sent an update to Khloemae's allocated Probation Officer and, noting that the FJC referred Khloemae's case to the Wandsworth Domestic Violence Services who had not picked up the case, requested that the FJC follow up their referral to the Wandsworth Domestic Violence Services. The email exchange from the Probation Officer indicated that Khloemae did not wish to engage with services in relation to her mental health and alcohol use. Housing records then indicated to the panel that Khloemae had attempted to access supported housing in LB Greenwich, but this service had a long waiting list of their own with 16/17s and care leavers being prioritised. The FJC also confirmed in an email to the HNO that Khloemae's case was closed to FJC following MARAC-to-MARAC transfer and referral to local DV services.

18.37 Mental Health records also note that at the end of July 2018, SWLStG Wandsworth Single Point of Access (SPA) Duty team received a police report that Khloemae had called the emergency services stating she had been assaulted by her boyfriend. The police Merlin report noted that police had attended her accommodation, which was a 'safe house', and her parents were present when the police attended, Khloemae appeared to be under the influence of alcohol and had made numerous cuts to her arms and legs which resulted in her being seen by the ambulance service

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but she refused to be taken to ED. The police left her with her father as she would not engage any further with the police.

18.38 August 2018 – Information from GP (AS) records indicate that Khloemae twice attended the surgery for GP support in relation to symptoms of depression, namely low mood, anxiety, and suicidal ideation, and requested a fit note for universal credit. Mental Health records indicate that Wandsworth SPA made attempts to contact Khloemae to complete an assessment, but she was not contactable by letter or mobile phone, or through her mother, although her mother did respond to a text message that confirmed Khloemae's new mobile phone number. Wandsworth SPA then successfully contacted Khloemae on her new contact number and arranged an assessment appointment.

18.39 Mid-August 2018 - Wandsworth SPA records indicate that Khloemae attended her assessment with them and disclosed that she had been feeling very low in mood and very depressed since she came out of prison in August 2017 and the medication she was prescribed was, she thought, was helping her. Khloemae also stated that she would like help with employment support and therapy for her depression, preferring one-to-one therapy. The following day, in line with her wishes, Khloemae was referred to Wandsworth Improving Access to Psychological Therapies (IAPT)¹⁹ and 'Your Way' for employment support.

18.40 At the end of August 2018, the perpetrator attended Croydon Police Station and stated that he had received threatening messages from a female and male who he thought may be Khloemae and her new partner. He related that he had been previously shot and stabbed and that was what the messages alluded to, however, he did not wish to make a formal statement. A full background check was carried out revealing the level of abuse that the perpetrator had caused Khloemae to suffer, and a decision was made that no further action would be taken due to a lack of evidence connecting the messages to an unidentified suspect and the perpetrator's unwillingness to support a prosecution. Very soon after this allegation was made, the perpetrator was stopped and searched in Richmond Civic Centre by the police after he told council staff he was armed with a knife. No knife was found by the police, and he subsequently left.

18.41 September 2018 - Khloemae called police in the early hours of a mid-September morning, stating she was suicidal. When the police arrived and located Khloemae by a bus stop, it was raining, and she was soaked through and crying. She was noted by the officers to be smelling of intoxicating liquor and had a can of cider in her jacket. Khloemae stated that she wished to go to the hospital for a mental health assessment; that she had gone to St George's earlier that day and had not been seen so was not helped. The officers took her to Charing Cross Hospital where she continued to be erratic and was assessed by staff, referred to the Wandsworth mental health home team, and discharged. As she was scared and upset, the officers took her back to the domestic abuse refuge so she would be safe from any perceived threat from the

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perpetrator, and they completed a MERLIN report which was rated as “AMBER” by the MASH decision maker and shared with Wandsworth Adult Social Care. Mental Health records note this incident but also note that when presented to St George’s Hospital the previous day she threatened to commit suicide if not helped that day. When the police transported her to Charing Cross Hospital, Khloemae was recorded as intoxicated and volatile initially and until the effects of the intoxication had reduced, was seen by Hammersmith and Fulham liaison psychiatry²¹. History was obtained from the SWLStG bed manager, who advised that a transfer of care to Wandsworth & Battersea HTT was in progress, and she had an initial appointment booked on 20 September 2018. Khloemae said that she had called the police as she wanted someone to talk as she was having suicidal thoughts. The next day, Wandsworth HTT called Khloemae to discuss her attendance at Charing Cross ED. Khloemae is recorded as being argumentative and denied she had been there and hung up. An urgent medical review was planned for 18 September 2018 but was cancelled after she declined to attend, and she was referred back to Wandsworth SPA.

18.42 Health and Social Care records received an update following the – assessment undertaken by the Wandsworth SPA and confirmed that a referral was made to ‘Your Way’ for employment support, and to IAPT for psychological help. However, the IAPT referral was refused because of her impulsivity and potential risk to herself²⁴. Khloemae was offered a medical review by a consultant psychiatrist, which was a positive intervention to make a fuller assessment of her mental health issues. This fuller assessment had to be cancelled because she had come under the care of Wandsworth Home Treatment Team (HTT), and she was not engaging with HTT so had been referred to CWWB CMHT for a more detailed assessment. A medical review by CWWB CMHT noted a history of depression diagnosed a year previously but no past psychiatric history. A comprehensive personal medical and social history was taken. The plan was to Refer to ‘Your Way’ for support for employment and housing (referral made in August 2018); her medication was to be increased, and the GP would be asked to arrange this. A medical review was scheduled in 4-6 weeks to monitor mental health, as well as accommodation and employment situation. A referral for psychology assessment by CWWB CMHT team was also confirmed as being undertaken.

18.43 Health and Social Care records also confirm that a risk assessment was conducted by Wandsworth SPA in September 2018 as part of their clinical assessment of Khloemae. This identified the following risk information:

- Risk of self-harm: Khloemae denied any current thoughts of harming herself by cutting or overdosing, although it was noted she had cut herself in January 2018.
- Risk of suicide: Khloemae denied any suicidal thoughts but said that she last had suicidal thoughts yesterday whilst she was at her cousin’s place. She had thoughts

²⁴ The panel understand that IAPT is intended to be a short term cognitive behavioural intervention, which is not suitable for people in crisis or who present as risk to themselves and the investigation undertaken by Niche confirmed this this is line with accepted national guidance.

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of going to the train station and the bridge but said that she didn't go because her ex-partner used to be in that area, and she was scared to go out in case she met him on the street. She reported that when she has suicidal thoughts, she goes to the train station and sits there for about an hour watching the trains go by and imagines that she is jumping in front of the train. She stated that she has never acted on these suicidal thoughts, but she goes to sit at the train station and imagines how she would die. She denied having any current plans or intents of ending her life and said that she is currently able to guarantee her safety.

- Risk of harm to others: Khloemae denied having any current thoughts of harm to others.
- Risk of harm from others: Khloemae reported that she feels at risk from her ex-partner and his friends.

18.44 Mid-September 2018 – records shared by the police document that, over three days, there were 3 incidents of note:

- Day 1: In the early hours of the morning Khloemae was seen by police officers crouching between parked cars in an area of high theft of and from motor vehicles. When spoken to by the officers, she gave no reason for her suspicious actions and was subsequently searched for items that may assist in stealing from a motor vehicle. No items were found, and she was allowed to leave.
- Day 2: In the early hours of the morning Khloemae called police saying she needed help as she was left at Wimbledon Chase railway station on her own. She then said there was a female on the tracks. Officers arrived and found it was Khloemae who had been on the tracks. She was drunk and made the call to get a lift home. She was issued a fixed penalty notice (FPN) for wasting police time and taken home.
- Day 3: Officers were approached in the street by the perpetrator's mother DW. She did not make any allegations against her son but wanted advice as to how to obtain an injunction against him as he had been staying with her up to two weeks ago but had now left. She found her son intimidating because of his size and aggressive nature and they had fallen out over his requirement to look after his dog. The officers probed further but she was adamant that it was not a criminal matter, and that she merely wanted advice which she was provided with.

18.45 Mental Health records also indicate that, around this time, Khloemae:

- Was not engaging with HTT but would accept a referral to a CMHT.
- Was argumentative and hung up on staff from Wandsworth SPA when they contacted by phone to make her aware of the community mental health referral.
- At the end September 2018, the perpetrator attended Croydon Police Station to be interviewed under caution for not completing a required periodic notification under the terms of his sexual offences order. He said he'd made a mistake by completing it a day late. He was written to with a date to attend Croydon Magistrates' Court

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the following month (records indicate that in January 2019 Magistrates found him not guilty).

18.46 Throughout October 2018 – Professionals found it difficult to engage Khloemae who was not attending pre-agreed medical appointments to review her treatment or responding to emails about rent arrears.

18.47 At the end of October 2018, the police received an anonymous call (on a number attributed to Khloemae) from Khloemae alleging she had been assaulted. In the background, however, a male voice could be heard saying “She has stabbed me”. Police arrested Khloemae but there was no sign of any male victim being present. In custody, Khloemae stated she had attempted suicide in the past and was placed in a CCTV equipped cell and placed on 30-minute checks for her safety. Police checks identified a domestic abuse history pertaining to Khloe Ma\le and the perpetrator, and the police visited the perpetrator at his home finding he was fit and well. Khloemae was released on police bail pending investigation and eventually, the matter was concluded with NFA taken, following an extensive investigation that failed to identify any potential male stabbing victim.

18.48 November 2018 – Mental Health and Social Care records document that at the beginning of November, Khloemae attended a treatment review and reported feeling slightly better on increased medication. Her housing situation was described by her leading professionals to record this, as being confused, she was in touch with the Council, and she could not recall any support from ‘Your Way’. Khloemae reported her abusive ex-partner (later established to be the perpetrator) had been trying to contact her through social media and text but was adamant she did not want contact with him. Ongoing referrals were discussed with her and declined a referral to a STEPPS²² group as she did not want to talk in front of people and did not think talking would help; she also declined a referral for psychological support. She agreed to a follow-up appointment the following week which she attended. At this appointment, Khloemae agreed to a plan that enabled her to be discharged back to the care of her GP, who would continue her prescribed medication regime and whom she could ask to re-refer her if she changed her mind about the declined referrals for psychological therapies or if her mood decreased.

18.49 Police were called to an attempted assault at a bar in Croydon in mid-November 2018. Upon arrival Khloemae was pointed out, to the officers, to be in an adjoining venue after having caused a disturbance and trying to punch a staff member. Police officers approached her and noted that she was intoxicated and was described as becoming abusive and volatile. On being handcuffed it is described that she became more violent, kicking out and assaulting officers. When placed in a police vehicle she removed her underwear and urinated on the floor of the van. Once in custody, her risk assessment recorded that she stated she suffered from bipolar disorder, depression, and anxiety and had self-harmed in the past. Khloemae was placed on 30-minute checks for her own safety and given access to a healthcare professional. She was interviewed and subsequently charged with assault on four police officers, criminal damage, being drunk and disorderly and she was bailed from custody. These offences

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were dealt with by the Magistrates Court and Khloemae was sentenced to 10 weeks imprisonment suspended for 24 months, a 30-day rehab activity requirement, and a 6-month drug/alcohol treatment requirement.

18.50 In early December 2018, - Mental Health records indicate that clinicians were considering if Khloemae was experiencing personality difficulties and if a psychiatric assessment would be beneficial or appropriate. When this was explored with the SPA team a referral to IAPT was not progressed on the basis that Khloemae appeared to be reacting to personal and social circumstances, was emotionally unstable, and would not be suited to short cognitive therapy interventions. The plan was to book a routine medical review, clarify a diagnosis, and consider possible secondary care psychology input. By the time this assessment was carried out, she had been seen by the liaison team at Hammersmith and referred to Wandsworth Home Treatment Team (HTT) and was therefore discharged from Wandsworth SPA. A week later, Khloemae was seen by Liaison Psychiatry at St George's Hospital after being found wandering around outside. She was described as well-kempt but under the influence of alcohol or drugs and agitated and volatile. Khloemae refused to be assessed by Liaison Psychiatry and self-discharged by leaving the ED department. Her history was noted, but a formal care plan was not developed, an email was sent to the doctor who planned to see her for a medical review later in the month, and her GP was informed of her presentation. She was then discharged from liaison psychiatry.

18.51 Officers from the JIGSAW unit who monitor RSO's called at the perpetrator's address as part of the regular mandatory checks on residency. As there was no reply, they left a note with contact details in mid-December 2018. He called officers later that day and said that they should not just call around as "man answers the door with arms". When asked exactly what he meant by this the perpetrator refused to reply. The officer felt it was a veiled threat and recorded the information accordingly within CRIMINT.

18.52 January 2019 – Health and Social care records indicate that the GP had referred him to Kingston & Richmond Assessment Team (KRAT²⁵), requesting an urgent review of his mental health. As there was no acute risk, KRAT suggested a referral to Kingston Primary Care Mental Health Team (KPCMHT), who diagnosed complex post-traumatic stress disorder (PTSD) with depression, noting a background of a long history of violent offending. It was felt he would benefit from secondary mental health care, so he was referred back to KRAT. KRAT became aware of his offending and risk history so referred him to the Forensic service. This was not accepted because the service is commissioned only for people discharged from SWLStG forensic inpatient services. Referrals were then made to the Recovery Support Team, the Personality Disorder pathway, then back to KRAT, with no clear pathway for assessment or treatment. His final contact was in May 2020, when his GP referred him to KRAT again. There were no concerns about his mental health, and as he was living outside the borough catchment area, he was closed to KRAT and referred back to his GP. The GP followed advice to prescribe a mood stabiliser.

²⁵ The single point of access for referral to Kingston & Richmond secondary mental health services provided by SWLStG.

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18.53 Khloemae was arrested at Wandsworth Probation Offices in mid-January 2019 after she had entered her parent's address and had set fire to a wardrobe and clothing. This incident placed her in breach of a protection from harassment restraining order issued in 2017. Khloemae's sibling was in bed at the time and was woken by the smoke alarm. He found Khloemae hiding in the house, but she ran off after stealing some items. She had videoed herself whilst inside the premises, taunting her mother remotely via social media. The crime was allocated to a CSU officer who assessed it as "High" risk given the nature of the allegation, the potential of harm to Khloemae's sibling, Khloemae's mental health history and vulnerabilities. Officers made a number of unsuccessful attempts and arranged to arrest at a pre-arranged probation meeting. She was also arrested for failing to appear at Croydon magistrates' court in relation to the incident in November 2018. Whilst in custody Khloemae stated within her risk assessment that she had self-harmed in the past and was assigned 30-minute checks and a visit to the health care professional. In addition, the IO requested an MH assessment whilst in custody due to her issues with addiction and depression. She was deemed fit to be interviewed by a custody nurse and provided a no-comment interview. Khloemae was charged with arson, breaching a criminal behaviour order, and burglary. She pleaded guilty to Arson and the breach however the burglary charge was not proceeded with at court.

18.54 At this time, it was also noted by the panel that Housing records documented that Khloemae remained on what is described in the records as a "significantly long" waiting list to be considered for Greenwich-supported housing but was unlikely to be given priority ahead of Greenwich clients.

18.55 February 2019 – Khloemae was assessed by SLAM addictions services for her suitability for an alcohol treatment order from court.

18.56 GP records note the receipt of correspondence from Kingston and Richmond Mental Health services in February 2019, requesting a referral to local mental health services to be made as the perpetrator was known to local mental health services in the past. In the letter, the psychiatric team stated that he was unclear of diagnosis, ongoing mood and behaviour problems and had advised clinicians that prescribed medication was not helping. As a follow-up the GP Practice wrote to the perpetrator but due to homelessness alternative ways of contacting him such as by text or telephone would have been more suited as the address on the system was an old address.

18.57 March 2019 - Khloemae's mother successfully applied for a restraining order against Khloemae at the Croydon Family Court.

18.58 April 2019 - Khloemae appeared at South London Magistrates' Court and was sentenced to 26 weeks imprisonment suspended for 18 months, with a 40-day rehabilitation activity requirement (alcohol treatment), 3 months curfew with a tag, and 12 months exclusion requirement not to enter the road where her parents resided.

18.59 Probation records indicate that Khloemae was allocated within 24 hours to a Probation Officer in line with policy and procedures and she attended her initial

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appointment within 24 hours of sentencing. In line with nationally agreed standards at the time, her case was then Probation Practitioner (OM1) in the former Community Rehabilitation Company (CRC). During the induction meeting with OM1, Khloemae discussed her engagement with the Alcohol Treatment providers Wandsworth Consortium Drug and Alcohol Service (WCDAS) and there was a discussion around her mental health for which she was prescribed medication. She explained to OM1 that she was upset about being arrested by the Police due to outstanding warrants for Criminal Damage, Arson, and Breach of Restraining Order against her mother. Khloemae also disclosed that she had been a victim of domestic violence, and checks undertaken by OM1 established that the perpetrator's identity, that he was known to the Probation Service by several names and one alias, and he had registered different addresses. OM1 also explored safeguarding concerns, and KHLOEMAE's relationship with her mother and other family members. Following this session, the officer liaised with the Police to enquire about the pending matters. It was also recorded that the perpetrator was discussed at a MARAC meeting in 2017 (for a different victim), and this suggested to OM1 that the perpetrator had a known history of abuse as a domestic abuse perpetrator.

18.60 Housing records recorded that a Housing Needs Officer to access Homefinder out of borough accommodation for Khloemae.

18.61 Throughout March and April 2019 Probation records indicate that Khloemae was engaging with alcohol treatment at Wandsworth Consortium Drug and Alcohol Service (WCDAS). OM1 continually liaised with WCDAS and ensured that sessions were being attended it appears her attendance with Probation sessions and WCDAS appointments were sporadic. In this time period, there was a CRC risk assessment undertaken called OMNIA, additionally, there were also safeguarding checks and BIU checks undertaken.

18.62 Given that there was a further Court appearance, a progress report had been requested regarding Khloemae engagement to inform the Court report. (Khloemae was discharged from SLaM in July 2019 as she did not complete the requirement to engage with the alcohol treatment plan).

18.63 In early April 2019, Female 6 contacted Hampshire police and alleged that she and the perpetrator had been seeing each other since November 2018, but Female 6 officially ended their relationship in March 2019 and the perpetrator had exerted an overbearing controlling influence during their relationship. She informed officers that the perpetrator had punched her in the face and knocked her to the ground in January (leaving her with still visible scarring around the eye). Female 6 didn't initially report the assault but felt compelled to when the perpetrator began sending her texts and calling her after she had ended the relationship and she had asked him to stop contacting her. However, he continued to call her and send abusive messages. The allegation was assessed as "High" risk due to his RSO status and offending history. Several unsuccessful arrest attempts were made at his home address before he handed himself in at Kingston Police Station a week after Female 6 reported this to the police. In a police interview, the perpetrator gave a prepared statement denying

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assaulting Female 6 or sending her malicious messages. Apart from a small outburst during the questioning that followed, he made no comment. He was bailed with conditions after his address was searched for outstanding phones. The matter was eventually concluded with a police decision to take NFA due to a lack of evidence to provide a realistic prospect of conviction, and the 6-month time scale for a common assault had elapsed.

18.64 Khloemae breached her curfew and was arrested at her hostel. Whilst in custody she stated in her risk assessment she was depressed and was subsequently seen by a healthcare professional and placed on 30-minute checks. Khloemae was kept in custody for just less than 4 hours and produced to the next available court sitting and released by the Court.

18.65 Four days later, police were called to Khloemae's hostel and found Khloemae to be distressed and intoxicated. She informed the officers that she and her boyfriend, Male 1 (believed not to be the perpetrator), had been in a relationship for a year. She alleged that during an argument Male 1 had choked her and taken her mobile phone, she had no injuries and did not lose consciousness. Khloemae did not wish to make a formal complaint and refused to complete a statement. Officers completed a DASH and noted that Male 1 was jealous and controlling. Later the same day, Khloemae was evicted from the premises after a number of issues that contravened hostel rules. She was subsequently contacted by officers from the local safeguarding team and said the incident was a one-off, and she'd since seen Male 1 and he had returned her phone. She declined further police action and declined to give her consent for referrals to supporting agencies. Despite Khloemae not wishing to make a statement, arrest enquiry continued and Male 1 attended Kingston police station for an interview under caution during which he made no comment. The investigation was then assessed by an Evidential Review Officer (ERO) and closed with NFA taken.

18.66 The next day, Khloemae called the police to inform them she had been evicted from her bail address. She said she had been given emergency accommodation.

18.67 At the end of April/beginning of May, Khloemae was sentenced for breaching the orders she was sentenced to in February 2019 in relation to the offences she committed in January 2019. She received 36 weeks custody suspended for 18 months with a Suspended Sentence Order, that had three requirements: Electronic Curfew GPS Monitoring from 7pm - 7am, 40 days Rehabilitation Activity Requirement and 12 months Exclusion from parents' address. Following this sentence, Khloemae was instructed to report to Lewisham Probation Office and the management of her order commenced in Lewisham. There was a slight delay in the allocation of her case, but she was eventually allocated to the duty officer who initially saw Khloemae, who attended as instructed after her sentence hearing. This provided some consistency. The induction process followed all consent and disclosure forms. were signed, including an equality monitoring form and the officers followed established recording convention which covers all aspects of Probation sessions.

18.68 Health and Social Care records indicate that the perpetrator's GP saw him at KPCMHT, requesting an assessment to confirm a diagnosis for possible bipolar

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affective disorder and the provision of clinical management advice to his GP. The GP letter noted it had taken the perpetrator some time to bring a psychiatric report (prepared by his legal team for a court appearance) into the surgery and that the perpetrator had redacted areas of the report, which caused a delay in the referral being made. He was very reluctant to discuss his past medical history but said that he suffered from PTSD from a previous assault and stabbing.

18.69 Mid-May 2019 – Housing records confirm that the Local Authority had a duty to provide Khloemae with accommodation and Temporary Accommodation (TA) was requested. In line with policy at the time, this ended HNO's involvement with Khloemae, and her case was transferred to Housing Initiatives & TA colleagues.

18.70 Also, at the end of May, the perpetrator was arrested near Barnes Train Station for a public order offence, assaulting a police officer, and drunkenness after he told a train guard he had a gun and threatened to 'cut' him. He was detained and searched, but no firearm was found. He was taken to Kingston Police Station to be dealt with by BTP officers.

18.71 June 2019 – Information from Maudsley Hospital records indicate that the Criminal Justice Mental Health Team were requested to assess Khloemae whilst she was in police custody due to flags on police records which indicated historical self-harm. Khloemae did not wish to engage in the assessment, but the worker recorded that she appeared orientated in time and place and that there was no evidence of significant mental health issues. The assessment found no reason to request a mental health disposal and it was recommended that the Criminal Justice process be followed.

18.72 End June 2019 - Probation records noted that Khloemae attended a supervision session, but a period of non-compliance followed although her absences from supervision sessions were deemed acceptable because Khloemae submitted satisfactory medical certification. She also provided a Statutory sick pay form that indicated she was diagnosed with Bipolar, an injured lower back, and a trapped nerve. Due to the health issues, a Senior Probation Officer (SPO) contacted Khloemae to explore how her future reporting could progress. It was agreed that the next contact would be via telephone and the frequency of reporting would be arranged monthly. The SPO also documented that should Khloemae's health concerns deteriorate further the order would be returned to Court as unworkable. This was in line with organisational expectations. Khloemae was assessed as posing a low level of risk to members of the public and, due to no risk concerns being disclosed, she was reduced monthly contact.

18.73 July 2019 – Information from Niche after their review of the mental health care records showed that the perpetrator was seen by a KPCMHT psychiatrist in July 2019, who diagnosed complex PTSD with depression, with a background risk history of violent offending. The perpetrator reported being constantly hypervigilant, having difficulty sleeping, and social isolation. At that time, he advised that he was on bail for assaulting someone with a knife. The KPCMHT psychiatrist did not support the suggested diagnosis of bipolar disorder although it was noted that this could not be

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completely excluded. The plan was to continue the prescription of a mood stabiliser to reduce his levels of arousal and mood swings, and the GP prescribed sodium valproate¹⁰ on this recommendation. In addition, it was thought he would benefit from secondary mental health care, so was referred back to KRAT.

18.74 July 2019 - Information from Mental Health records indicate that Khloemae was discharged from SLaM's addictions group in July 2019 for non-engagement.

18.75 August 2019 – Information from a second referral to KRAT in August 2019 in relation to the perpetrator by his GP and information was requested from the police about his offending history. When this was received, the perpetrator was referred to the Forensic Outreach Team because of the team's concerns about the risk he posed to others. The Forensic Outreach Team declined to assess the perpetrator because, at this time, the service was commissioned only for people discharged from SWLStG forensic inpatient services. However, there is a consultancy service within the forensic service, and the psychiatrist responsible for this service contacted KRAT to make them aware that the perpetrator could be assessed by this service if he had a named consultant and was under the care of a team in the community. It was suggested he be referred by KRAT to the Recovery Support Team (RST) for a consultant review, who could then re-refer him to the forensic service for consultancy.

18.76 The perpetrator called the police to ask why officers had attended the previous day and left a note at the beginning of August. When told it was a regular visit, he said he would not talk to the officers and so there was no point in them coming to his home. He said if officers wanted to come to his address knowing he would arm himself, then that was not his fault. He said he had a 16" knife by the front door and if officers felt comfortable being in a room where he had such easy access to a knife, they were welcome to come over as he would plead not guilty due to his mental health. Officers noted within the MERLIN that he was diagnosed as bipolar, and experienced paranoia and depression. The MASH decision maker graded the report as "GREEN" and passed the information to adult social care.

18.77 Between October 2019 to February 2020, Probation records document that Khloemae was complying with her Community Order and was reporting face-to-face on a monthly basis. The interventions undertaken with OM2 included monitoring Khloemae's current circumstances, her relationships, and mental health and exploring positive links to the community. It is evident that Khloemae described difficult relationships with family members and described being in a new relationship. There were no concerns raised around her new relationship and her new partner's family were described as supportive by Khloemae. This was followed up by OM2 as little information was known about Khloemae's new partner. This was a missed opportunity to take a more investigative approach and enquire with her and other partners such as the housing advice support workers and the MARAC team about details of this new relationship.

18.78 November 2019 – Information from a document that the perpetrator was assessed in November 2019 by a locum consultant for KRAT. Following the perpetrator reporting that he felt paranoid and depressed. During this assessment, the

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perpetrator described being in and out of prison for various reasons but was not willing to elaborate on these and said he had been accused of sexual crimes he did not commit. It was noted that he expressed that he felt he was the victim rather than the perpetrator and blamed services for abandoning him. The perpetrator spoke of becoming hypervigilant as a result of being shot and stabbed. As a consequence, he stated that he had taken to wearing a bulletproof vest and placing CCTV cameras in his flat. He described a longstanding history of mood fluctuations. He reported periods of elated mood, high energy levels, racing thoughts, talkativeness, impulsiveness and having less need for sleep. These could last a few hours to a couple of days, followed by a sudden crash with depressive mood, self-neglect, self-isolation and suicidal thoughts. He explained that he used alcohol or drugs to contain his fluctuating mood. The clinical impression following this assessment was a complex history of PTSD, emotionally instability and possible antisocial personality disorder. The proposed plan was for referral to the Recovery Support Team for regular follow-up and rehabilitation in the community to reduce his high risk of aggression and recidivism.

18.79 In mid-November 2019, an off-duty JIGSAW officer was approached by the perpetrator in a train station and grabbed the officer's arm. The perpetrator said, 'I told you I'd catch you', but was not aggressive however the officer was concerned given threats the perpetrator had recently made against other JIGSAW officers. The officer recorded that the perpetrator watched the officer board the train and then left the scene as the train doors closed.

18.80 December 2019 – After an internal audit of open safeguarding cases, Mental Health records document that it was noted that a safeguarding referral, which originated in May 2018, remained open. This prompted the Croydon Assessment & Liaison Team to try to make contact with Khloemae, who did not respond to any of the attempts to contact her. After a joint discussion between safeguarding teams at the London Borough of Croydon and SLaM, Khloemae was discharged in December 2019, and a letter advising her of this was posted to her. This was returned by Royal Mail in February 2020 as 'unable to deliver'.

18.81 February 2020 - Owing to the Covid pandemic restrictions, the London CRC implemented an exceptional delivery model, signed off as part of the contractual agreement with the MoJ2, which resulted in more service users being engaged remotely. Probation records document that Khloemae submitted a medical certificate that stated she had been diagnosed as bipolar and experiencing depression. OM2 contacted Khloemae via telephone, and she reported that her GP had been assisting her with her mental health issues. The next contact was undertaken a week later, and Khloemae reported that she was no longer in a relationship with her partner, but it was not recorded who the partner was.

18.82 GP records document that Khloemae reported to her GP that she had stopped drinking, had no self-harm or suicidal thoughts, and was planning to have a baby.

18.83 Around the same time, a neighbour reported a loud disturbance between a male and female at the perpetrator's flat, with a male shouting "Shut the fuck up", and a female screaming "get off me, get off me", and a loud bang. The 999 operator graded

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this as an Immediate attendance call. Police attended but heard no disturbance. They knocked on the door repeatedly however received no reply, but a male eventually came to the window and spoke to officers followed shortly by a female. They concluded that there was no evidence of any disturbance or assault apparent. Their music was playing very loudly, and the officer thought it could be a malicious call by the neighbour due to the noise rather than any actual disturbance. The identity of the female was not recorded.

18.84 March 2020 – In mid-March, the perpetrator called the police to tell them he would not be attending the Police Station due to the Covid 19 pandemic restrictions. He stated that he was unable to contact his GP to get his repeat prescription and planned to attend the practice later. He also asked if he would be shot if he became a terrorist and added he wasn't surprised people go crazy and kill others, then ended the conversation. The officer who he contacted created a CRIMINT for officer safety, and a MERLIN which was graded as "GREEN" and passed to Kingston Adult Social Care noting his diagnosed Mental Health issues.

18.85 April 2020 – Toward the middle of April, police were called to a noisy house party at the perpetrator's address. On arrival, the perpetrator is described within police records as starting to goad the officers and had to be restrained by some of the other partygoers. Police stayed on the scene until the music was turned down and left with no further action. Officer safety concerns were placed on the CRIMINT system because of his offending history and aggressive nature.

18.86 May 2020 – A number of concerns were documented within agency records in May 2020. These primarily focused on the perpetrator:

- Health and Social Care records document that the perpetrator's final contact with them took place in May 2020, when his GP re-referred him to KRAT. By the time KRAT acted on the referral, KRAT had no concerns about his mental health, and as he was living outside the borough catchment area, he was closed to KRAT and referred back to his GP.
- A regular JIGSAW visit was conducted by police at the perpetrator's address. The door was open, and he was pacing up and down on the phone, trying to get a prescription for his anti-psychotic medication as it had run out. Having finished his call, he became extremely angry and aggressive and swore at the officers. He demanded they leave, puffing out his chest and trying to intimidate them. He refused to properly engage with the officers and appeared to be suffering from mental health issues exacerbated by the lack of medication. The MASH decision maker graded the report as "GREEN" and passed the information on to Kingston Adult Social Care. SWLStG community mental health services document two contacts with the perpetrator, following his presentation to his local police station saying his life was at risk. Police requested he was seen by Street Triage as they believed he was hearing voices by way of a Merlin report made by the police after attending his flat, in which it was reported the perpetrator had been angry and aggressive in his interaction with the police and asking for medication. When seen by Street Triage, the perpetrator denied hearing voices but had genuine

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concerns about accommodation and risk of harm from others. He refused to say where he was but said he was carrying a knife to protect himself.

- Health and Social Care records indicate that a female attended the ED and the female's notes document that the female had been assaulted by the assailant but refused to give her name to clinicians. KRAT were unable to raise a safeguarding alert for the female (now believed to be Khloemae) as they did not know her name. KRAT contacted the police who advised this had not been reported to them, and the service asked Jigsaw to consider whether a safeguarding/MARAC referral was necessary for the female. Police records indicate that the Jigsaw team did undertake a MARAC referral.
- Soon after this incident, the perpetrator was arrested at Victoria railway Station by BTP officers for travelling on a train without paying the fare. He was also arrested for threatening behaviour and possessing an 8" knife. He was charged with the offences, but the matters were still outstanding by the time he was arrested for murder.

18.87 Probation records indicate that, by mid-May 2020, a risk and needs assessment linked to Khloemae's case was reviewed and she was assessed as posing a medium risk of harm to members of the public and of re-offending.

18.88 Over the following week, in the middle of May 2020, the police responded to 4 calls:

- I. The perpetrator called the police in the early hours of the morning as he felt threatened. Police attended the perpetrator's address as he stated he was being threatened by his neighbours. On arrival he was extremely paranoid saying that he could hear voices through the walls calling him a "nonce" and a "wrong un", and that fellow residents had discovered he was an RSO, and now intended to petrol bomb his address and rob him. He added that if anyone attempted this, he would murder them due to his MH and Post Traumatic Stress Disorder (PTSD). The perpetrator was wearing a stab-proof vest, had several items around the flat with which to arm himself, and swung between being scared to doing push-ups and weights whilst the officers were present. Khloemae and another unknown male (the male was sleeping) were present during the visit. Officers were concerned that the perpetrator clearly had mental health issues. The perpetrator stayed within his address, and the officers were unable to utilise powers under section 136 of the Mental Health Act. Officers completed a MERLIN report, which was supervised and added to by the duty Inspector who concluded the report; The MASH supervisor reinforced that message and graded the report "RED" – this indicated the most urgent response was required when it was subsequently shared with Adult Social Care.
- II. The perpetrator called the police in the early hours, saying he was frightened as he could hear someone saying they were coming to finish him off. Officers attended his address. On arrival, there was no reply, but after the officers left the scene he called the police once more, and when officers attended, he eventually answered the door. After entering the premises officers noted that also present was a female under the influence of something (possibly Khloemae). After talking to the perpetrator for a while, he became agitated and accused them of preparing to deploy a Taser on him. He then required them to leave, slammed the door on them, and appeared to put a large object

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behind it to act as a barricade. The officers recorded the incident on MERLIN because of the perpetrator's erratic behaviour. The Kingston MASH supervisor graded the incident as "AMBER" and shared information on the attendance with adult social care.

- III. The perpetrator called the police in the early evening as he had just moved into a new address and that within an hour of arriving at the property, he could hear people planning to kill him and he did not feel safe. Police attended and found him in an aggressive mood, during which he expressed his willingness to fight the officers and spoke of his access to machetes and weapons. He stated that he suffered from schizophrenia, PTSD and had attended the Teddington health centre but he did not feel they had been helpful. He agreed to accompany officers to Kingston Police Station as a place of safety as he refused to be taken to Kingston Hospital for a MH assessment. Whilst at the police station, officers contacted the local authority to arrange new accommodation. A MERLIN was completed; however, this was read in conjunction with 20PAC114004 by the MASH supervisor and graded as "BLUE" therefore the information was not shared.
- IV. The perpetrator called the police in the early hours saying that he felt threatened by his neighbours. Police attended his address following a call from him stating he was being threatened. On arrival, he was extremely paranoid saying that he could hear voices through the walls calling him a "nonce" and a "wrong un". He claimed that fellow residents had discovered he was a registered sex offender, and intended to petrol bomb his address and rob him. He added that if anyone attempted this, he would murder them due to his mental health and Post Traumatic Stress Disorder (PTSD). The perpetrator was wearing a stab-proof vest, had several items around the flat with which to arm himself, and swung between being scared to doing push-ups and weights whilst the officers were present. Khloemae and another unknown sleeping male were present during the visit. Officers were concerned regarding his clear mental health issues, however, he stayed within his address, and as such they were unable to utilise powers under section 136 of the Mental Health Act²⁶. Officers completed a MERLIN report, which was supervised and added to by the duty Inspector who concluded the report; The MASH supervisor reinforced that message and graded the report as the most urgent "RED". The perpetrator called the police at 0355hrs, who attended his address as he claimed he was frightened as he could hear someone saying they were coming to finish him off. On arrival there was no reply, however after officers left the scene he called once more, and he finally answered the door. After entering the premises officers noted that also present was a female under the influence of something (possibly Khloemae). After talking to the perpetrator for a while, he became agitated and accused them of preparing to deploy a Taser on him. He then required

²⁶ <https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/#:~:text=Section%20136%20allows%20the%20police,household%20has%20access%20to%2C%20AND.> MIND clarifies that Mental Health Act 1983, section 136 "allows the police to take you to (or keep you at) a [place of safety](#). They can do this without a warrant if:

- you appear to have a [mental disorder](#), AND
- you are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, AND
- you are "in need of [immediate care or control](#)" (meaning the police think it is necessary to keep you or others safe)."

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them to leave, slammed the door on them, and appeared to put a large object behind it to act as a barricade. The officers recorded the incident on MERLIN because of The perpetrator's erratic behaviour. The Kingston MASH supervisor graded the incident as "AMBER" and shared information of the attendance with adult social care.

18.89 The day after this last call to the police, the perpetrator presented at Kingston Hospital ED and insisted on being assessed by the Psychiatric Liaison Team, which is provided by SWLStG. During the assessment, he is recorded as being volatile and belligerent. The Psychiatric Liaison Team did not identify any acute mental disorder (i.e. psychosis or mood disorder). After the assessment was completed, he was discharged, and Kingston Hospital ED staff informed Kingston psychiatric liaison team staff that he had punched the woman who was with him as he was leaving. The police were outside when the patient was leaving with the woman walking behind him. It later transpired that this was Khloemae. It is unclear whether the police were called by the patient or by staff in the Mental Health Assessment Unit as he was refusing to leave. The police were unaware of the perpetrator punching the female. (The panel were also advised the perpetrator punched Khloemae repeatedly on their way to the hospital although this was not known to professionals at the time). The SWLStG internal report noted the KRAT staff explained that they were unable to raise a safeguarding alert for the female as they did not know her name at the time, they witnessed the perpetrator punching her, but they asked Jigsaw to consider whether a safeguarding/MARAC referral was necessary for her. The Jigsaw team made a referral to MARAC in relation to this incident.

18.90 Later that day, the perpetrator and Khloemae attended at the Kingston police station. Noting that they had been sitting in Kingston Police Station's front reception area since the early hours, an officer spoke to them. The perpetrator said that he had to leave his previous address as he felt threatened by people there. He said he had spoken to social services in order to arrange a further address. The officer rang social services and they confirmed they had spoken to him and had arranged for him and Khloemae to stay at a hotel. During this interaction, the perpetrator produced a letter from the Kingston Liaison Psychiatry team, dated the same date, stating that the perpetrator had been assessed that day, and *"during this assessment, he did not present with acute mental disorder to warrant admission or input from the home treatment team"*. As he was a VISOR subject, the officer facilitated the perpetrator completing a temporary residency address form in order to comply with his Registered Sex Offender status. Upon completion, they both left, and the officer completed a MERLIN stating the perpetrator appeared to be suffering from paranoia and recorded the contents of the letter from Kingston Hospital. The MERLIN which was graded as "AMBER" by the MASH decision maker and was passed to adult social care.

18.91 The following day, in the early hours of the morning, the perpetrator called the police from Waterloo railway station claiming he was being followed. BTP officers spoke to him, and checks revealed he was on the sex offenders register. He told the officers he was homeless, and therefore it appeared he had breached his notification requirements. He was subsequently arrested and conveyed to Brixton police station.

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Whilst in custody it was discovered that he had until midnight to officially register as homeless, which he was encouraged to complete once released with NFA taken.

18.92 The next day, the perpetrator approached officers around midday, requiring assistance. He stated he had been sleeping rough at the railway station the previous few nights, but now had nowhere to stay. He had been to the council offices, but they were closed. He said he would potentially cut himself with a knife if he wasn't provided with housing. The officer invited him into the station, and he followed but became agitated when he was spoken to by JIGSAW officers. The officers deemed that he was not suitable for sectioning under 136 of the Mental Health Act as the threat to cut himself was conditional and he was lucid and compliant. Throughout the day the perpetrator became more agitated and paranoid, suggesting that others were out to get him. He had apparently previously refused offers of accommodation due to their locations and stated he was involved with a number of Mental Health professionals. Officers ascertained that the perpetrator was diagnosed with emotionally unstable personality disorder, and another healthcare professional believed he was abusing anti-depressants. In the early evening, the perpetrator phoned the JIGSAW Team claiming armed men were trying to kill him. Officers spoke to him outside the police station observing that he was erratic and agitated but could not provide any detail of a threat. He was given housing advice, but as he walked off angrily officers watched as he threw a hard object several times at a parked police car, then pulled a windscreen wiper off and tried to rip off the blue lights. He was detained, violently struggled, and was subsequently booked into custody and charged with criminal damage to a police vehicle. Two MERLIN reports were completed highlighting the issues with the perpetrator which were both graded as "AMBER" and passed to adult social care. Following the arrest of the perpetrator, Khloemae contacted police for advice on how to obtain her items that were stored by the perpetrator within a unit, as he had been arrested and she did not know his whereabouts. She stated that the storage firm had asked her to obtain a form from the police to complete in order to gain access. She was advised that this was not a matter the police could assist her with.

18.93 By the end of May 2020, the perpetrator was subject to MAPPA level 2²⁷.

18.94 A MAPPA meeting took place at the beginning of July 2020, following which the couple were offered accommodation in the Thames Valley area but two days later the perpetrator was again complaining (to Thames Valley Police) that he did not feel safe. The couple moved to a hotel in Westminster. Two nights before he murdered Khloemae, the perpetrator made seven calls to police from the hotel saying he did not feel safe. Police attended following the first call but not thereafter. They concluded that he was 'erratic' and that his mental health was deteriorating but they found no cause to section him because he was not an immediate threat to himself or others. They noted that he was wearing a stab-proof vest. The couple then moved to the Holiday Inn in Greenwich via Lewisham police station, where he reported to register

²⁷ <https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance> MAPPA Level 2 – A local multi-agency management for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2 there will be regular multi-agency public protection (MAPP) meetings about the offender to develop a coordinated plan.

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his address as an RSO. This was the last contact police had with him before the murder in the hotel at around 10 am the following day. He had stabbed Khloemae in the neck with a knife reportedly bought for his own protection. Khloemae's family remain concerned that although the perpetrator was a MAPPA nominal and known by the Police to be a violent sex offender, there was no safeguarding in relation Khloemae when the couple were placed in hotels and his presence in Greenwich was not confirmed to Housing colleagues until after he murdered Khloemae.

18.95 Although reflected in the above information, the panel were aided by the following summary of MARAC involvement with Khloemae:

- February 2017 - Khloemae self-referred to FJC after an alleged assault by her then partner by the perpetrator and supported by the IDVA and referred to MARAC.
- End October 2017 - FJC referred to MARAC
- Khloemae was moved by Housing to Bromley in November 2017. The case was closed to FJC.
- May 2018 - FJC referred to Croydon MARAC following receipt of a call from her mother alleging domestic abuse by the perpetrator.
- June 2018 - FJC referred to Croydon MARAC and a MARAC-to-MARAC transfer made to Kent.
- July 2018 – MARAC-to-MARAC transfer made to Richmond and Wandsworth.

19. Analysis Against the terms of reference

19.1 There now follows an analysis against the terms of reference agreed by the panel for this review, which also explores the impact of the Pandemic in relation to Khloemae, specifically around isolation and access to services.

19.2 The panel noted that not all IMRs fully analysed their agency involvement alongside the terms of reference and did not fully enable the panel to identify learning from them. Where this was the case, the panel considered what Khloemae's perspective may have been, alongside relevant research and national developments to identify learning and potential areas for development in the way the victims of domestic abuse are responded to.

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.*

19.3 A recommendation is made to address this learning.

19.4 The panel noted that Khloemae was murdered during the period of the Covid 19 Pandemic²⁸. It considered that agency involvement with Khloemae had, by this time, reduced to contact with the Probation Service and Mental Health Services. The

²⁸ <https://www.instituteforgovernment.org.uk/sites/default/files/2022-12/timeline-coronavirus-lockdown-december-2021.pdf>

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Probation Service advised the panel that it contacted Khloemae in line with the expectations and standards at the time and this contact took place by telephone. It acknowledged that this review highlighted Khloemae's level of vulnerability and that she had made them aware of her relationship with the perpetrator (though she also said this was not a current feature of her life). In view of this, it is acknowledged that the contact with Khloemae should have been increased. The panel also noted that, despite the pandemic restrictions, many services ensured that contact with Khloemae occurred in line with clinical guidelines, including in-person contact with her. The panel concluded that Khloemae was isolated from her personal support networks, and any access to these networks and professional and/or clinical support, was most likely caused by the pattern of coercive control she was suffering at the hands of the perpetrator. The panel were mindful of the concerns raised by Khloemae's family. Whilst the panel hope that the pandemic restrictions were an extra-ordinary event that will not to be replicated in the future, after consideration of the evidence available to it during this review, it was not assured that if there was a replication of similar restrictions in the future, that all agencies would ensure that victims of abuse can access the support they need support in a person centric manner.

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).*

19.5 The panel were mindful that Khloemae was significantly younger than the perpetrator and the abuse she suffered would most likely have had a significant impact on a victim's emotional, psychological, and mental wellbeing and there was evidence available to the panel that strongly suggested that Khloemae developed a dependency on the perpetrator. Due to the lack of analysis within some IMRs, the panel could not definitively conclude, but had little doubt, that, on the balance of probabilities, Khloemae's day to day life was affected by trying to manage the abuse, and this led to her experiencing increased anxiety and a focus on adapting her behaviour to appease the perpetrator²⁹, but the panel could not meaningfully assess the extent of the impact this had in terms of Khloemae questioning or doubting her experiences, developing low self-esteem or how far she adopted the perspective of the perpetrator and starting to blame herself for the abuse³⁰. Similarly, although there was a strong suggestion with the evidence available to the panel that the perpetrator ensured Khloemae presented with him as a homeless couple, the extent of how this impacted on her economically could not be fully assessed by the panel but it had no doubt that this impacted on Khloemae's ability to acquire, use or maintain money or other property, or to obtain goods or services³¹. The panel determined that this reflected how the perpetrator's

²⁹ Kelly, L (1999). Domestic Violence Matters: an evaluation of a development project, pp.35-37

³⁰ See Women's Aid. Women's Aid responds to Prime Minister's commitment to toughen laws on gaslighting: 2018.

³¹ See Adams, AE, Sullivan, CM, Bybee, D, Greeson, MR. Development of the Scale of Economic Abuse: Violence Against Women: 2008: 14(5):563-588.

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coercively controlling behaviours included restriction, exploitation and sabotage of Khloemae's access to settled and safe accommodation and that this was a form of economic abuse. In the periods where Khloemae ended her relationship with the perpetrator, she was subjected to his abuse, and she told professionals that she was unable to leave the perpetrator. The panel had little difficulty in determining that the perpetrator's abuse of her resulted in her staying with him and fatal abuse as a result. Toward the end of her life, this included his creation of an environment where she lacked economic instability, essentials, and a severe form of deprivation, namely homelessness, and his ensuring their presentation as a homeless couple resulted in her being economically dependent on the perpetrator, thereby limiting her ability to escape and access safety.

19.6 The MAPPA review, and this panel, also noted that the perpetrator claimed to be homeless but found, on the evidence available to it, his reported homelessness was more apparent than real. Monitoring and interacting with Khloemae and the perpetrator were complicated by his unwillingness to stay put at one address because of his repeatedly reported fears that unspecified others would find out that he was a sex offender and cause him harm. When he approached housing colleagues claiming to be homeless and requesting their support enquiries established that he had an assured shorthold tenancy and was not under a notice to quit, even though he was reporting threats from neighbours. HOS liaised with the police but found no evidence of the alleged threats. He was not therefore deemed to be homeless and was notified of this in writing. The perpetrator then gave up his tenancy and, with legal support, managed to persuade the council to make the pragmatic decision was taken to house Khloemae and the perpetrator without formal evidence of the relationship. Housing records indicate that emergency accommodation was provided for the couple on five separate occasions, but the perpetrator repeatedly left it, saying he felt unsafe, and Khloemae left with him – whether this was through choice or under duress the panel could not determine based on the evidence available to it. He never resided at the fifth property. There was also uncertainty, at times, about where he was living and his claims that he had been rehoused by the out-of-hours housing team are not supported by records.

19.7 This was a theme identified within the MAPPA review which, whilst recognising a need to avoid hindsight bias, documented that Khloemae and the risk the perpetrator posed to her should have been noted by those managing the perpetrator as being a particular risk. This was a specific concern raised by her family after Khloemae was murdered, who also stated their concern that the Probation Service did not apparently recognise the perpetrator as a serious risk to women during their earlier period of indolence with him. The panel noted that the perpetrator was a serial perpetrator and noted that the efficacy of MAPPA arrangements in relation to the offender management of the perpetrator have been reviewed separately and do not make any further findings and supports the recommendations made within the MAPPA review. In relation to training to policing colleagues in relation to domestic abuse the panel noted from the MPS IMR that significant steps have been undertaken to ensure that police officers have been provided with appropriate training and resources for them to give proper

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advice on specialist domestic abuse support services. This includes delivery of DA Matters training package³² between July and September 2021 to its Emergency response officers. The panel also notes that delivery of this training was delayed by the national Covid pandemic restrictions. The training aimed to be delivered to 8000 officers but hit 7000+ due to absence reasons including Covid.

19.8 In addition to this training, the MPS have also commissioned additional 'Micro Teach' computer-based learning for first responders which seeks to provide:

- An improved understanding of the 15 High Risk Factors within DASH risk assessment and 'cluster of risk'.
- Better use of professional judgement, defensible decision making and recording of rationale when completing the DASH risk assessment³³.

19.9 The panel noted, as did the MAAPA review, that there were occasions where the perpetrator attempted to manipulate professionals – in August 2018 he alleged Khloemae had sent him threatening messages, and that she had stabbed him. These allegations were investigated, and no further action was identified. The panel noted that on these occasions (and others he made in relation to previous partners) he was treated as a victim without consideration or assessment as to this being the reality or an attempt to manipulate professionals. The panel understands that current training to officers now covers this and make no recommendation in relation to the MPS training package to address this learning.

19.10 The panel agreed that there is never any justification for perpetrating domestic abuse and all perpetrators are responsible for their behaviour and should be held accountable for it. However, it also noted that domestic abuse perpetrators can be particularly adept at manipulating professionals, agencies and systems and may use a range of tactics to perpetuate contact with, and exert control over, the victim, and this can include their minimising of allegations made by the victim, a deflection of responsibility for their abuse and attempts to normalise the abusive behaviour and discredit or make exaggerated reports of abuse. The panel agreed this was the case in relation to the perpetrator who seemed readily willing to portray himself as a victim of domestic abuse by his partners, including Khloemae and sought to deflect and responsibility for his behaviour, as was the case when he was accused of the rape of

³² DA Matters training is a programme of classroom based learning designed specifically for UK police first responders. A one-day interactive learning package was delivered to improve the MPS response to DA by increasing awareness of coercive and controlling behaviour in intimate relationships and its impact on victims and their willingness to engage with the police. The training used real-life footage, case studies and exercises to demonstrate how to identify and gather evidence of coercive controlling behaviour, recognise perpetrator tactics and understand the dynamics of domestic abuse. It also aimed to cover the following topics: responding to vulnerable people, honour based violence, child protection and adult abuse as well as how to deal robustly with perpetrators.

³³ This bespoke MPS teaching package demonstrates the factors which can make an abuser, and the situation overall, higher risk than it may at first appear. It seeks to increase officer's confidence in identifying the more nuanced and harder to articulate experiences of victims, when completing the DASH risk assessment. It is hoped that this input will improve the quality of the risk assessments undertaken, record a clearer rationale of risk and ensure victim safety and satisfaction.

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a child. There was also a level of selectivity as to when and who was present when concerns emerged about his mental wellbeing and the panel noted that Khloemae identified this as a factor which prevented her leaving him – this warranted further exploration with her by the IDVA to enable partners to fully understand how best to support Khloemae to feel able and confident to leave the perpetrator. The panel also noted the physical presentation of the perpetrator was imposing and the perpetrator would use this to intimidate others, including the police, and how this may have been a ploy to evade deflection and scrutiny of the abuse he perpetrated. The perpetrator also admitted use of illicit substances to clinicians, including cannabis, of which long-term usage, can cause paranoia³⁴. Factors such as alcohol and drugs misuse can increase the likelihood and severity of domestic abuse. However, it was clear that research indicates that there is not a causal relationship between substance misuse. Many people believe that alcohol and/or drugs increase aggression and physical violence and therefore perpetrators are likely to use this as an excuse for their abusive behaviour³⁵ despite research being clear that substances can act to disinhibit, rather than act as a cause of violence and abuse. The panel noted the MPS “micro teach” in relation to risk clusters and agreed required further roll out within multi agency domestic abuse training as it would improve:

- Shared understanding of risk and risk clusters.
- Identification of high-risk victims.

19.11 It also agreed that multi agency domestic abuse training needs to be refreshed so that it increases understanding of perpetrator manipulation of professionals and explore safe challenge to perpetrators and the impact that this manipulation can have on its victims. Khloemae’s family also suggested that there needs to be training for young people, perhaps within school curricula to ensure they are aware the indicators of controlling behaviour within relationships, and this is a form of domestic abuse. Whilst the panel do not disagree, it noted that the extensive work undertaken by Education colleagues during the period of this review. This includes:

- The employment by the Local Authority of a specific VAWG education officer since September 2024. This role has helped to improved linked relationships between domestic abuse community and voluntary groups to provide preventative and supportive work with young people. The VAWG education officer is also available for schools to reach out for consultation on concerns they have. Advice and signposting is provided enabling a timely response and package of support.
- There is a programme of training for all schools and colleges in Croydon to increase awareness of domestic abuse.
- There is a new resource available for secondary schools and colleges to deliver with their staff to recognise relationship abuse in young people. This has been circulated for use.

³⁴ <https://www.ox.ac.uk/news/2014-07-16-how-cannabis-causes-paranoia>

³⁵ Guedes, A., Bott, S., Garcia-Moreno, C., Colombini, M., 2016. Global Health Action, 9(1); Capaldi, D. Knoble, N. Shortt, J. Hyon, K., 2012. A systematic review of risk factors for intimate partner violence. Partner Abuse. Volume 2, Issue 3, pp 231-280.

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- Croydon Council funded an education pilot around healthy relationships and healthy masculinity in 10 secondary schools and colleges in Croydon. This is work completed by two carefully selected specialist agencies in their field.
- Tender are also currently working with 10 other schools in Croydon on a separate MOPAC funded project around healthy relationships. This is a mixture of primary and secondary schools. This has included some completing the RE: SET programme which has included working with parents and carers as well as the children and staff and others engaging with the Healthy Relationship Champion Award.
- There is a VAWG Education network meeting for safeguarding leads to attend quarterly. This is facilitated by the VAWG education officer and provides a regular flow of information sharing, resource sharing and links local services.
- ALL schools have a designated safeguarding lead (DSL) with 80% of schools in Croydon having a dedicated DASV Lead. This year launches the first DASV lead training from the VAWG education lead to upskill leads in schools with a deeper understanding of DASV, indicators, how to support victim/survivors and safety planning.
- Croydon Creative Health team have funding to PILOT support for young children (primary age) who have been victims of domestic abuse. The VAWG education Officer has worked closely with the team to develop the relevant policy and procedures, risk assessment and safety planning.

The panel do not make any further recommendations in relation to raising awareness of domestic abuse, including controlling behaviour, within work being undertaken with young people in the area.

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.*

19.12 A recommendation is made to address this learning.

19.13 Having established this context and the learning from it, the panel considered if practitioners involved with the Khloemae and the perpetrator were knowledgeable about potential indicators of domestic violence but not fully cognisant of indicators of other forms of abuse, including coercive control, and so responses did not reflect appropriate action and risk mitigation. The panel noted from the chronology that opportunities for professionals to “routinely enquire” if domestic abuse, including coercive control, was being experienced by Khloemae, but it also accepted that Khloemae often declined to give information and sometimes presented with hostility toward professionals. The panel considered if this was a safety mechanism for Khloemae but there was insufficient evidence available to the panel to enable it to definitively conclude this was the case. As such, it was unable to make a recommendation.

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19.14 The panel considered if there was appropriate consideration of Khloemae's vulnerabilities by agencies involved with Khloemae's accessibility for support, when making decisions in terms of the level and support provided to her. The panel also considered if the relationship between agencies regarding the facets of intersectional factors of 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.

19.15 There was good evidence that some agencies reflected her wishes and feelings in their approach to her circumstances and needs. However, there was also evidence to suggest that process did not align with her expressed wishes, which then became lost in the support afforded to her. It was also unclear to the panel if, at any point, Khloemae's capacity to understand decisions she made, informed by her wishes and feelings and even less clear to what extent this informed her engagement with them. The Care Act (2014) describes an adult at risk as someone who has care and support needs is experiencing, or is at risk of abuse or neglect, and because of those needs is unable to protect themselves against the abuse or neglect or the risk of it. Many agencies contributing to this review were cognisant that Khloemae's housing situation took many months to resolve and that, as a vulnerable young woman she needed stability and support to build resilience and confidence in professionals.

19.16 There was also evidence within the report submitted on behalf of mental health services that indicated Khloemae's support was informed by her wishes and feelings. There was a comprehensive assessment of her circumstances under the headings of risks, forensic history, alcohol/drugs, mood, and social circumstances. This was undertaken by the Croydon Assessment and Liaison Team. Despite the detailed summary of her circumstances and the evidence that the practitioner spent time to discuss possible options for helping her with her anger and stress management, the assessment lacked exploration of the risk of harm from her ex-partner. The consultant psychiatrist also noted that Khloemae was most at risk (of harm to herself) when under the influence of alcohol but does not make any suggestions to her about accessing support for alcohol abuse. It was noted that she declined any input from the team, and the subsequent plan to inform her GP of this and send information about accommodation support were within expected practice. A letter was sent to Croydon Assessment and Liaison Team in June 2018, advising that Khloemae had been referred to MARAC, and invited their attendance. This was subsequent to the safeguarding referral made to Croydon Council by Croydon Hospital ED after Khloemae attended on 21 May 2018. This communication was received from the London Borough of Croydon that Khloemae had presented at ED having incurred serious injuries and being held hostage by her ex-partner. The risks were triaged by the London Borough of Croydon Safeguarding Team who forwarded the safeguarding concern to SLAM Assessment and Liaison Team to undertake a safeguarding enquiry under Section 42 of the Care Act 2014. This communication and request to undertake an enquiry was never acknowledged nor acted upon. The team were also alerted that Khloemae was due to be discussed at a forthcoming MARAC panel. There was no acknowledgement or response to this information, although the safeguarding referral

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remained open until the case was finally closed in December 2019. The panel were advised that the SLAM Safeguarding Adults Policy (v3 June 2020) provides clear definitions of roles and responsibilities when there is a report of abuse, none of which were acted upon in this case. It is not clear from the records why this was overlooked. This was a missed opportunity to conduct an investigation regarding Khloemae's experience of abuse and represents a failure of systems within the Assessment and Liaison Team, and SLAM safeguarding structures, to follow up on an investigation of serious abuse. If the referral had been picked up on time and MARAC was attended, further information would have been highlighted to the team and perhaps discharge would have been delayed until risks were clarified.

19.17 At the end of June, when police attended a flat after a neighbour called stating that a female could be heard screaming as a male was kicking on the door, the officers located Khloemae sitting on a window ledge three levels high and told police she was planning on jumping. The police entered and she came off the ledge into the bedroom. She was described as extremely upset after having an argument with her boyfriend and told the police she attempted to kill herself earlier in the day by going to the train station with plans to jump in front of a train. Khloemae was detained by police under Section 136 MHA. The above chronology documents that when Khloemae arrived at the designated place of safety, clinicians documented that she was still extremely upset and appeared to be under the influence of alcohol, displaying hostility and aggression to the staff. She was breathalysed although the results are not recorded. She gradually became able to settle and spent time looking at her phone and talking to others on her phone, and despite one further episode of unsettled behaviour, eventually fell asleep. Khloemae was assessed by medical staff and assessed to be under the influence of alcohol. She advised that she had four cans of 5% alcohol, had a history of diagnosed depression, and has been on medication for three years. During this assessment, Khloemae explained that she had walked away from the argument she was having with the perpetrator because she was distressed and had been drinking alcohol. She described their relationship of five years as 'strained'. She reported that normally she walked away from arguments and that is what she had done - she moved away from him and was sitting on the window ledge. Khloemae also denied having any suicidal ideation, intent, or plans. She reported that she used to use cannabis but was clear now for over a year, she engaged well in the discussion and had a place to go home to. The management plan was that there was no acute mental health issue identified during the assessment, but she was advised to contact her GP for a review of her antidepressants and self-refer to a drug and alcohol community support team. This was during Covid-19 lockdown and there was some reassurance taken from the fact that the family would be at home with her, and this was confirmed by her parents who were now at the hospital. Records suggest that neither Khloemae or her parents made mention of the restraining order imposed against her which prohibited her attending her parents' address, but Khloemae's parents were clear they were not asked if there was any reason why Khloemae could not return to their address and as a professional was telling them this needed to happen, they felt unable to refuse. Khloemae was regarded as not detainable under the MHA, and not in need of Home Treatment Team input, so was discharged to the care of her parents. Given the prevalence of domestic abuse prior to this assessment and discharge, the panel noted

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that a referral to MARAC was not undertaken given the impact the abuse had on Khloemae, before the police spoke with her, namely that she intended to jump from a height that would most likely cause serious harm or possibly death.

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.*

19.18 The panel considered the care and service delivery problems identified by the report author and supports all of the recommendations made within the report to improve:

- Improve the recording of all assessments (including breathalysers).
- Policy in relation to risk assessment and who should undertake this, and also to include enquiry into possible domestic abuse or coercive control and recording of domestic abuse as a risk indicator.
- Communications with GPs when patients are discharged as a result of the learning identified by the report author.

19.19 The panel also agreed that a further recommendation needed to be made to ensure MARAC attendance was seen as a priority.

19.20 The IMR provided by housing colleagues indicated that Khloemae moved out of Croydon and then subsequently moved 3 times within 6 weeks to different emergency accommodation, despite her being very clear, and other professionals (e.g. the IDVA) advocating on her behalf, that as young women, she needed supported housing in addition to a refuge space. It was unclear to the panel as to level of consultation with Khloemae, and her views on these moves, was undertaken and responded to. The panel agreed that Khloemae's support network was in Croydon and there should have been more thought and discussion as to whether moving her out of borough was in her best interests. The very helpful report submitted to the panel on behalf of mental health services The panel noted this reflects a lack of understanding within the services that supported Khloemae when she was homeless, and her needs, in relation to the support needs of victims of domestic abuse and the impact that moving them away from their support networks can have on their wellbeing. The panel also considered if adultification³⁶ was a factor in the approach to move her out of Borough, but there was insufficient evidence available to the panel to reach any definitive conclusion on this point. The panel noted that NICE guidelines set the minimum standard of expectations³⁷, and the Domestic Abuse Act 2021 places statutory obligations on services supporting victims of domestic abuse but could see minimal evidence that these were being embedded in practice. The statutory guidance that

³⁶ <https://www.farrer.co.uk/news-and-insights/adultification-bias-of-black-children-qa-with-jahnine-davis/>

³⁷ <https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965>

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supports the implementation of the Domestic Abuse Act³⁸ states that is “vital that housing providers are able to recognise and respond to the signs of domestic abuse. A report by SafeLives identified the risk of misdiagnosing the effects of domestic abuse...professional curiosity is necessary when faced with all cases, even if domestic abuse is not immediately suspected, Housing officers should recognise the impact...”and “in such instances and consider safety planning and specialist support for the victim if action is taken against the perpetrator”. Noting that this guidance requires agencies to give due regard to it unless there are cogent reasons not to, the panel noted that there is a review of current provision for people presenting as homeless in Croydon and recommends that the Head of Housing ensures this includes an audit of housing provision in relation to victims of domestic abuse to ensure that these standards and obligations are being embedded and assure itself that there is no need for the Local Authority to commission initiatives (e.g. the Domestic Abuse Housing Alliance) to improve responses to victims of domestic abuse who are homeless. The panel understand that attempts to formalise an initiative initially led by GLA, that would ensure victims of domestic abuse needing to move Boroughs to escape their abuser would receive timely transition of support, have not been progressed but are unclear why.

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 needing priority support when moving out of their locality into a new area.*

19.21 As identified within the IMR for this agency, the panel also agreed that the review it recommends should consider and ensure that this learning is addressed during the review’s progression.

19.22 The panel also agreed that Housing colleagues should review the domestic abuse training provided to their workforce and ensure it reflects the learning from this review and report on the impact of the revised training in relation to housing processes and decisions when supporting victims of domestic abuse.

19.23 In May 2017, a member of the public observed another male (not the perpetrator) punching a tram stop when in the company of Khloemae. The officers completed full intelligence checks whilst on scene, and CCTV enquiries did not find anything that caused this version of events to be doubted. As there was no history of DA between the parties, no injuries or damage caused, as well as no aggravating

³⁸ https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

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factors identified through the DASH process officers decided that NFA bar reporting the matter would be appropriate in line with Khloemae's wishes on the basis that the male had one report of a domestic incident with a differing partner that was non-violent, and that Khloemae had been the victim of assault previously but with a different partner (the perpetrator). The panel agreed with the IMR author's assessment that the decision-making in relation to this incident was appropriate but noted that this incident possibly highlighted Khloemae's level of vulnerability in relation to her susceptibility to abuse in her intimate relationships³⁹.

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.*

19.24 A recommendation is made to address this learning.

19.25 When considering if there was appropriate information sharing between agencies in relation to Khloemae and the perpetrator, some challenges presented that impeded how professionals carried out assessments, due to the referrals, assessments and management plans in relation to Khloemae and the perpetrator catalogued relevant history. The panel noted that at the time of their very brief involvement with Khloemae in May 2018, the referral received by Adult Social Care was incomplete and did not fully document the history of concerns, and this was compounded by Adult Social Care and mental health services used two different service user data bases. This made the sharing of information about Khloemae difficult. The panel noted that partnership working between ASC and SLAM CMHT has progressed since 2018. This includes a service level agreement that now ensures a mental health practitioner member of staff available to look up service user details on mental health data base known as the EPJS, and this enables timely exchange and recording of information. The panel were clear that a victim's mental health problems are not a cause of domestic abuse; however, it can be a risk factor for perpetration and victimisation. Depression has been linked with perpetrating abuse⁴⁰, and mental health issues can lead to an increased risk of being a victim of domestic abuse⁴¹. Throughout this review, the panel noted that Khloemae frequently presented in a vulnerable manner to professionals, with varying levels of distress and intoxication. The panel commends the hospital staff who alerted JIGSAW officers to an assault on Khloemae by the perpetrator that they witnessed, despite not knowing

³⁹ Yael Lahav, PhD (2023) Hyper-Sensitivity to the Perpetrator and the Likelihood of Returning to Abusive Relationships Journal of Interpersonal Violence 2023, Vol. 38(1-2) 1815–1841
<https://journals.sagepub.com/doi/pdf/10.1177/08862605221092075>

⁴⁰ Guedes, A., Bott, S., Garcia-Moreno, C., Colombini, M., 2016. Bridging the gaps: a global review of intersections of violence against women and violence against children. Global Health Action, 9(1); Schumacher, J., Feldbau-Kohn, S., Smith Slep, A., Heyman, R., 2001. Risk factors for male-to-female partner physical abuse. Aggression and Violent Behavior, 6(2–3), pp. 281-352.

⁴¹ Bacchus, L., Ranganathan, M., Watts, C., Devries, K., 2018. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. BMJ Open, 8(7), pp. 1-20. 137 ONS. 2018. Partner abuse in detail – Appendix tables - Office for National Statistics (ons.gov.uk)

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the identity of the female assaulted, which resulted in a further MARAC referral. MPS colleagues were also commended by the panel who approached Khloemae with compassion and took action to prioritise her immediate safety. However, it noted that the recognition of Khloemae being a vulnerable young woman did not always result in the MERLIN referrals that would have ensured that partner agencies received information about her increased vulnerability. It supports the recommendation made by the MPS IMR author in relation to his learning. The MPS IMR also noted that, in 2020, there was a focus on the perpetrator's vulnerability and a lack of consideration for Khloemae's safety when colleagues supported him.

19.26 The perpetrator was a High-Risk Registered Sex Offender (RSO) and from September 2018 to May 2020 he was managed by the Jigsaw Team in two London Boroughs. From May 2020 he was a MAPPA 2 nominal. Over the course of his management, he was not forthcoming with details of sexual partners when questioned about this for risk assessment purposes and the first time he mentioned Khloemae was in May 2020. He was raised to Level 2 management under the Multi-Agency Public Protection Arrangements (MAPPA) at the beginning of June 2020 due to ongoing concerns during the period of high police contact in 2020 officers which repeatedly reported the perpetrator as being paranoid, intoxicated, extremely aggressive, and suffering poor mental health. The police IMR noted, and panel agreed, that whilst officers detailed his vulnerabilities, they did not consider Khloemae, who was present during these interactions, as potentially vulnerable, and in turn did not record any MERLINS regarding her, or consider the risk posed to her by the perpetrator her from a safeguarding perspective. The panel also noted that the evidence available to it during this review established that the information was not made available to the attending officers and agreed that had this been available, this may have triggered thought on the safeguarding of Khloemae.

Learning Point 9 – *We need to take that our focus on the management of perpetrators who pose a significant risk to themselves may cause us to lose sight of the need to 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 be cases where an overlap will occur with MAAPA and MARAC. Where this occurs, we need to ensure improved interface by supporting information sharing that reflects the victim's perspective in meetings.*

19.27 Recommendations are made to address this learning.

19.28 The Panel considered if there were issues pertaining to public confidence that were identified within this review. The Police IMR describes the perpetrator as “a

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physically imposing man, well over 6 foot tall, and of a muscular build, he was a cage fighter by profession and used his physical presence to intimidate partners and those trying to engage with him". When the panel considered the historic information about the perpetrator his behaviour toward previous intimate partners and allegations of rape, the panel noted that there were swift and appropriate responses commensurate with the seriousness of the reported offences, and appropriate decisions were made to share information with members of the public, namely his partners, and this included Khloemae in 2017. The panel agreed this was an appropriate use of "right to know" under the Domestic Violence Disclosure scheme. However, when the perpetrator alleged that he had been stabbed by his then partner in 2015, and then again in 2016 when he reported that he had killed his partner, although there were police-appropriate responses and investigations, there is no reference to a MERLIN report regarding the two children in 2015, and although a MERLIN was shared in 2016, this lacked reflection on any opportunity to undertake joint safeguarding activity. The panel noted that practice, policy, procedure and structures in safeguarding have radically changed in the subsequent 6 years the historic nature of the contact. It does not make a recommendation in response to this observation.

19.29 In April 2017, when a former girlfriend alleged harassment by the perpetrator, there was a reflection of the victim's needs and support, resulting in advice being offered and completed by an Independent Domestic Violence Advocate (IDVA). It agreed this was an example of good practice. The panel noted that the perpetrator was, in line with the victim's wishes, issued a first-instance harassment warning (FIHW) may have caused an escalation of the suspects' behaviour. The Panel were advised that the use of FIHW within the MPS was discontinued In January 2020⁴² and have revised harassment and stalking SOPs. It makes no recommendation to this.

19.30 Throughout agency involvement with Khloemae, the panel noted that there were instances that provided opportunities to assess the risks posed to Khloemae by the perpetrator and to potentially safeguard her that were missed. The panel also noted that incidents of domestic abuse were considered on a single-incident basis and there appeared to be no holistic overview of the pattern of the domestic abuse and the tactics deployed by the perpetrator to leaver coercive control over her and the fear she experienced. There were opportunities to refer Khloemae to MARAC as a repeat referral and this did not happen which resulted in evidence-led approaches, not being undertaken, as set out in the Criminal Justice Act 2003. As such, the statutory guidance for the offence of coercive control does not appear to feature in their responses to the domestic abuse she suffered or the impact of this on her mental well-being.

19.31 The panel noted that when Khloemae was arrested for theft and possession of cannabis in January 2020, whilst in custody she alleged that the perpetrator had assaulted her. Khloemae's family were clear that the criminal justice process did not result in any safeguards for Khloemae and this is discussed further below. The IMR

⁴² Her Majesties Inspectorate of Constabularies had discovered they were ineffective and had some cases led to escalation of domestic homicides and other serious offences.

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author noted that although the police undertook checks and established the perpetrator had a history of domestic abuse and his RSO status, this did not trigger a DASH risk assessment to assess the risk he posed to Khloemae. Had this been undertaken this would have indicated several high-risk indicators alongside Khloemae's evident heightened fear of the perpetrator:

- A fear that the perpetrator would kill her on her release.
- Jealous and controlling behaviour by the perpetrator toward her.
- Recent separation and post-separation harassment by the perpetrator.
- Escalation and severity in relation to the physical abuse she was suffering from the perpetrator.
- Threats to seriously harm her family and fear of repercussions if she made a statement to the police.

Khloemae's family also noted that Khloemae's behaviour was evidence of her fear of the perpetrator and the panel agreed this reflected the need to ensure a trauma informed response to victims of domestic abuse.

19.32 Whilst, on this occasion, there was some consideration of her safety and she was offered a place in a domestic abuse (DA) refuge, a lift home on her release from custody and further contact with officers following her release was offered these measures were refused by Khloemae, who subsequently did not respond to calls from the Investigating Officer (IO), who also placed an alert warning on the home address and discussed the case with a supervisor. The panel noted that the decision taken not to arrest the perpetrator on the basis that "without the support from the victim arrest may enflame the situation" and it agreed that this reflected a significant lack of understanding of the heightened risk a victim of coercive control can be facing and the need for a coordinated response with other professionals to support the victim and reduce the risk of harm posed by the perpetrator. It agreed with the IMR author that arrest would have been "[a] legitimate option under these circumstances, combined with [the perpetrator]'s offending background and that a MARAC referral and Domestic Violence Prevention Orders (DVPO), which the IMR identified were "considered but not decided upon" should have been progressed.

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.*

19.33 The panel supports the IMR author's recommendation in relation to this learning.

19.34 The panel then considered the risk posed to Khloemae by the perpetrator and how this was assessed and responded to by agencies. In February 2017, when the perpetrator was arrested for assaulting Khloemae, the JIGSAW case officer decided to complete a "right to know" disclosure under the Domestic Violence Disclosure Scheme (DVDS) (aka Clare's law). The same IO dealt with this incident and the panel commended the continuity this afforded Khloemae, but noted that, and agree with the IMR author's assessment that "whilst basic investigation techniques were applied (arrest and charge), there is a marked absence of considering any other options to

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deal with the circumstances as a whole, such as a MARAC referral to seek options of assistance from a wider partnership network, or indeed a Domestic Violence Prevention Order (DVPO) to enable further time for support to be offered to Khloemae which may have encouraged her support for prosecution". Similarly, in March 2017, when Khloemae was arrested for assaulting her parents, no further action was taken on CPS advice. On the second occasion, Khloemae's parents stated to the officers that her violent boyfriend [the perpetrator], had a bail hearing the next day, and if he was granted bail, she feared retribution. The panel support the IMR author's finding that a MERLIN ACN reports "could have been considered by the arresting officers to alert partners of the issues identified. This may have encouraged others to recognise the need for a more coordinated response to the victim support that Khloemae needed at this time. It also agreed that the incidents could have "been passed to the CSU officer dealing with her case in order to be more victim-focused and offer support in line with SOPs". As such, the panel supports the recommendations made by the IMR author.

19.35 Throughout the timeframe of this review, Khloemae was reported missing to the police on three occasions. The panel noted that the police response grading was in line with MPS in existence at the time. On each occasion she had come to no harm, and it is evident that the subversive nature of the perpetrator's behaviour did not identify his relationship with Khloemae. The panel noted that the first report that Khloemae was missing specifically stated that Khloemae had a new partner, and the panel could not find any record that the identity of this individual was not explored with her.

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.*

19.36 The panel also noted that the evidence presented to it within this review indicated an escalation in the risk posed to Khloemae by the perpetrator from April 2018, but the single incident focus being deployed by agencies did not identify or ensure an effective response to the escalation through a coordinated response that could have enabled the sharing of information and enabled the use of markers/warnings indicators within agency systems that could have afforded conversations about her safety with Khloemae.

19.37 The panel noted that escalation was most definitely apparent in mid-April 2018, when Khloemae alleged to the police that the perpetrator had threatened to kill her, having assaulted her the previous week. This incident was recognised by the police as crossing the threshold for a repeat referral back to MARAC, although this seems contrary to the information provided and was not in line with the published SOPs on dealing with allegations of domestic abuse. The panel agreed with the police IMR author that a more immediate response was required, and this incident should not have been marked for the attendance of officers the next morning and support the recommendation within the IMR made to support the learning of the policing colleague.

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It noted the context in which the individual was working and that this was an extremely challenging time as workloads increased significantly because of a lack of trained staff, and team numbers 50% below their anticipated capacity. In addition, both supervisors and staff were moved into safeguarding that had never completed the role before, and naturally this was a further challenge. As a result, experienced supervisors were used to screen large quantities of allegations, and if, as in this case, once contacted the victim was clear that they did not want to access services then the case was closed down as NFA. If a complainant was willing to engage then steps would have been taken have completed a range of safeguarding options, including arrest of the suspect, application for a Domestic Violence Protection Order (DVPO), if appropriate, and referral to partners via MARAC and a local service the Family Justice Centre (FJC). The panel, noting that SN CSU officers handle a higher volume of crimes than anywhere else in the MPS, the panel are grateful to the Police IMR author who took steps to reassure the panel that steps have been taken to ensure that allocation of work from the main CSU work file is now more timely and there is a designated risk management team (RMT) that deal with DVPOs MARAC referrals, and Domestic Violence Disclosures which enables investigators and allows for a better response by a dedicated team to the risk associated with non-crimes or when the victim does not wish to engage with police.

Learning Point 14 – *Our responses to domestic abuse must consider patterns of behaviour that interlink 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.*

19.38 The panel do not deem it appropriate to recommend that the MPS consider re-structure or allocation of work streams. It does, however, recommend that the learning of this case is shared within MPS to ensure that the need to have a victim-centric approach that evidences consideration of patterns of abuse, even when victims appear unwilling to engage.

19.39 In May 2018, Khloemae appeared to have resumed contact with the perpetrator, and she reported to the police, with support from her father, that the perpetrator had assaulted her. Her injuries were recorded on the officers' body-worn video (BWV). The officers completed a DASH assessment which they graded as "medium" on the basis of Khloemae describing the perpetrator's violence toward her as escalating in violence and control. He was eventually arrested and interviewed in relation to this assault, subsequently interviewed, and was bailed on the instruction of the CPS, who subsequently decided that NFA should be taken.

19.40 Just two weeks later, Khloemae alleged assault and false imprisonment during the period in which the perpetrator was circulated as "wanted" by the police. She described what the panel agreed would have been a terrifying ordeal for her, which began with the perpetrator threatening to make her stay in a tent with him in a local park, just one day after she attended the police station with her father. The CPS eventually decided not to prefer any charges against the perpetrator with no further

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action taken, and the panel understand this decision was made based solely on the CPS perception of Khloemae as an unreliable witness. The IMR author notes that, at the time of being involved in this case, the OIC was a trainee in an extremely busy environment where asking questions or challenging decisions was not feasible due to the pressures on the team. Khloemae had advised the OIC that the perpetrator had what Khloemae described as “a hold over her” and that Khloemae found the CPS decision very frustrating, and this frustration was shared by the OIC and Khloemae’s family, who were trying to protect her but were frustrated by the evident hold the perpetrator had over Khloemae which resulted in the couple reconciling. Khloemae was vulnerable, experiencing mental health problems and, in the absence of any assessment that indicated her level of fear of the perpetrator, the panel concluded this would have been extreme given the recent incidents of abuse. The OIC triggered referrals that enabled Khloemae to receive support from local agencies, including the FJC, ensured a MERLIN had been submitted to the MASH for onward communication to partners. In addition, a MARAC referral was also made. The panel agreed that the OIC is to be commended for the actions she undertook and her engagement with Khloemae and the members of the family.

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.*

19.41 The panel were aware that, at this point in time, discussions were underway with the CPS to ensure that lawyers received training in relation to the impact of coercive control and invite the Home Office to consider if this case could form the basis of a case study within this training to enable CPS colleagues to understand the dynamics of coercive control require all agencies to be cognisant of the impact on the victim and the need to ensure evidence prosecutions that are not overly reliant on the victim and reflect other forms of evidence. It also recommends that the MPS recirculate its guidance⁴³ on how officers are supported to consider appealing against CPS decisions not to charge perpetrators in similar circumstances.

19.42 When the Bexley MARAC heard Khloemae’s case at the end of June 2018, the risk was identified to Khloemae due to the controlling and violent nature of the perpetrator, and her mental health was noted. The Panel agreed that the FJC IDVA ensured that an appropriate referral to MARAC were undertaken and that they IDVA struggled to engage with Khloemae, who did not always attend appointments arranged with her. The panel noted that there was minimal reflection on why this was the case, and if the service needed to consider alternative methods to engage her. The transparent IMR form the FJC identified that a MARAC-to-MARAC referral did not appear to have been sent to Bromley in November 2017 and this would have resulted in no support being provided to Khloemae from this date to when she then approached FJC again in May 2018. The panel noted that the practice at FJC in terms of MARAC-

⁴³ Officers within the MPS can request a supervisor not below the rank of Inspector to complete a formal appeal against a CPS decision not to charge. This takes the form of an email to the CPS case manager setting out the rationale of appeal. In addition victims themselves have the right to appeal a CPS decision under the Victims Right to Review (VRR).

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to-MARAC transfers has now greatly improved since 2017 but that it remains unclear if undertaking the MARAC-to-MARAC referral is a role for the IDVA, although the FJC IDVA will often undertake the referral being made. A week after the case being represented to MARAC Khloemae alleged malicious communication from an anonymous source, she believed was the perpetrator. SafeLives defines⁴⁴ a MARAC 'repeat' as "any instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC. The individual act of abuse does not need to be 'criminal', violent or threatening but should be viewed within the context of a pattern of coercive and controlling behaviour. Some events that might be considered a 'repeat' incident may include, but are not limited to:

- Unwanted direct or indirect contact from the perpetrator and/or their friends or family
- A breach of police or court bail conditions
- A breach of any civil court order between the victim and perpetrator
- Any dispute between the victim and perpetrator(s) including over child contact, property, divorce/ separation proceedings etc.

19.43 These events could be disclosed to any service or agency."

19.44 The panel could find no evidence to confirm that this incident was referred to the MARAC as a repeat referral. Similarly, when Khloemae reported the perpetrator had assaulted her again in July 2018, and then again in August 2019, the panel noted that follow-up action was seen as a safeguarding issue because Khloemae's mental health was declining and was not referred to MARAC as a repeat referral. The panel also could not establish how the MARAC would review repeat referrals to MARAC in line with SafeLives Guidance. 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.

19.45 The panel, having considered the SafeLives MARAC-to-MARAC guidance⁴⁵ and process map, which is clear that the MARAC coordinator should take responsibility for MARAC-to-MARAC transfers, recommends that the Violence Reduction Unit undertakes a review of its MARAC operating protocol against the SafeLives and ensure this is clarified by way of clearly designating whose responsibility this is within its local MARAC Operating Protocol. The panel supports the recommendation made within its IMR, but rather than an internal discussion, it recommends that this service undertakes a deep dive review to ensure that follow-up work in relation to MARAC-to-MARAC transfers ensures victim support is in place and escalated to the appropriate agency/MARAC when a MARAC-to- MARAC transfer is

⁴⁴ <https://safelives.org.uk/definition-repeat-marac>

⁴⁵ <https://safelives.org.uk/sites/default/files/resources/MARAC%20to%20MARAC%20referral%20process%20FINAL.pdf>

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necessary and that all workers consistently ensure that appropriate referrals are made, accepted and this is clearly recorded on the IDVA case management system. The panel established that on at least three occasions there was the opportunity for a repeat MARAC to be undertaken and could find no evidence of this being undertaken. The MARAC is a systematic multi-agency response to victims assessed to be at high risk of serious harm or homicide. If the process has not been effective or successful in reducing the risks (or the impact of those risks) that the perpetrator poses to the victim, then agencies will need to continue to work together to resolve challenges and barriers preventing effectiveness⁴⁶. This suggests to the Panel that MARAC partners did not “flag & tag” files as expected, which would have provided a mechanism for practitioners to identify when Khloemae accessed their service, that Khloemae had been discussed at a MARAC in the last 12 months. This would have informed the practitioner that she had been assessed to be at high risk of serious harm or homicide by the perpetrator and they could consider whether there were indicators that the abuse was ongoing and/or possibly escalating. It also would have afforded professionals to consider if the definition of “repeat” had been met and re-referred her back to the MARAC. This would have enabled Khloemae to have been offered support from an IDVA or specialist domestic abuse specialist. It also would have enabled the MARAC partners to proactively collaborate on the risks and work to reduce those risks in coordination with whichever agency was engaging with her at the time.

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.*

19.46 The panel recommended that the MARAC protocol was immediately reviewed to ensure this requirement is explicitly stated within the protocol and the Community Safety partnership seek reassurance from its constituent agencies that this is being undertaken. It given the appropriate reassurance and so no recommendation is made in relation to this learning point

19.47 In April 2019, Khloemae alleged Male 1 had assaulted her. This allegation referenced an attempt to choke her but did not result in a referral to MARAC. Given the link⁴⁷ between non-fatal strangulation and domestic homicide, the panel considered if there should be a recommendation in relation to this. However, it also noted, that at the time, knowledge of the impact of non-fatal strangulation was not as fully understood as it is now and so makes no recommendation in relation to learning around non-fatal strangulation. The panel noted that this suggested that the ability to refer Khloemae to MARAC based on professional judgment may not have been fully understood⁴⁸. It also noted that the need to be evidence-led, rather than solely relying on a victim’s account, was learning from this review.

⁴⁶ <https://safelives.org.uk/sites/default/files/resources/Repeat%20Definition%20-%20A%20Briefing%20for%20Maracs%202018.pdf>

⁴⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573025/> Non-fatal strangulation is an important risk factor for homicide of women; Glass N. et al

⁴⁸ https://safelives.org.uk/sites/default/files/resources/FAQs%20about%20Dash%20FINAL_0.pdf

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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 our 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.*

19.48 The panel makes recommendations to address this learning.

The panel was aided in their analysis by the very helpful report submitted on behalf of mental health services. The report also highlighted that there highlighted a variance in the quality of the risk assessments and although the perpetrator had been reviewed several times, there was no risk formulation. It also highlighted that there was, at times, delays in referrals for assessment and a lack of communication between mental health services in relation to the agreed process to be followed to enable the perpetrator to have access to a forensic consultancy:

- **19.49** In January 2019, when the perpetrator requested an appointment for a psychiatric assessment. An administrative error caused by the changes of the GP not being added to his patient record caused a further delay in the perpetrator being assessed by the KPCMHT and this was only actioned after the perpetrator called to ask about its progress. The outcome of this second request by the perpetrator was to request that the GP refer him to KPCMHT because he was not experiencing a crisis and risks to himself were thought to be low. The report submitted on behalf of mental health services confirmed to the panel that, as the perpetrator was not considered to be in need of urgent care, so the suggestion of the KPCMHT referral was appropriate.

19.50 The KRAT team screened and triaged the perpetrator as a non-urgent referral in August 2019, within the expected time frame of 28 days. The KRAT's role is to assess, and if short-term intervention is not indicated, signpost to other services. The suggested referral to the community Forensic Outreach Team was made, and the panel were reassured that this was influenced by the risks he presented. KRAT also requested information from the Police about his previous offending and were informed he was being managed at MAPPA level 1 and was a registered sex offender with many offences of sexual and domestic violence against women. The outcome of the assessment by KPCMHT was the risk of violence to others precluded him from being offered a service.

19.51 The community forensic service appropriately rejected the referral, as their service only provides community treatment for individuals who have been discharged from the inpatient forensic service. There had been no communication by KRAT with the community forensic service to discuss the referral, which would have been helpful both for discussion about the risk concerns and to clarify the role of the team. The forensic service did however provide a liaison service to generic community mental health teams to assist them in accessing the appropriate forensic services for advice and to support local teams in assessing and managing risks that their patients may pose. The forensic service converted the referral into a 'consultancy referral' to the

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wider forensic service, as it provides a borough-based consultancy service to non-forensic mental health services. The report submitted on behalf of mental health services confirmed to the panel that, whilst this was, potentially good practice, for a consultation to take place, an individual would need to have a named community consultant and care coordinator. The consultant forensic psychiatrist informed the KRAT team of this by phone and by email, and it was suggested the perpetrator be referred to the Kingston Recovery and Support Team for the allocation of a community psychiatrist and care coordinator, after assessment by the KRAT team but this information was not shared with the Recovery and Support Team was not informed directly. The perpetrator was referred to the Kingston North Recovery Support Team for further support, but the referral made no mention of the previous plan for him to be reviewed by the forensic service. He was then discharged from KRAT. This resulted in the plan, which was to refer him to Kingston North RST, and then on to the forensic consultancy for an opinion, not being progressed. Kingston North RST felt the level of risk that the perpetrator posed was too high for the team to manage in someone who in their opinion would not engage effectively with the therapeutic offer available. The Kingston North RST was unaware that if a referral is declined, the patient does not return to the KRAT caseload and Operational Policy is silent about the process to be followed if the RST declines a referral. As such, the panel agreed with the report's author that this highlighted there was a lack of collective understanding between the teams at the time about who would hold responsibility for the perpetrator's assessment and any required clinical care. The perpetrator was discharged back to his GP with advice for him to be signposted to services who manage anger and support former prisoners. Due to an administrative oversight, a discharge letter was not sent to the perpetrator or his GP and therefore the GP practice never received this advice.

- **19.52** In October 2019, the KRAT team decided that the perpetrator should be offered a medical review by the KRAT locum consultant psychiatrist. He did not attend this appointment but was offered another appointment for mid-November 2019, which he attended. This was in line with the Trust policy around missed appointments. The clinical impression of the locum consultant psychiatrist was that the perpetrator had a complex history of PTSD, Emotionally Unstable Personality Disorder (EUPD)¹³, and possibly antisocial personality disorder and would need regular follow-up and rehabilitation in the community to reduce his high risk of aggression. It was considered that the personality disorder pathway was unsuitable, due to his presentation and offending behaviour. The report confirmed to the panel that was an appropriate decision.

19.53 At the time, the panel understood that the KRAT received a high volume of Merlin reports from the Police and Local Authorities some of which were inappropriate referrals with inconsistent information. was taken. In May 2020 KRAT made contact with the perpetrator but he would not provide information about his whereabouts. Furthermore, in May 2020 he was discussed at a MAPPA meeting attended by mental health services, and it was stated that KRAT would offer him a further assessment. On receipt of the referral, the RST's discussion focused on the risk that the perpetrator would present to other service users and the team's inability to provide treatment

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which would mitigate the risks. They declined the referral because of the risk he posed to other service users and the opinion that he would not engage therapeutically in any way that would mitigate the risks. This resulted in a high-risk patient in need of a forensic assessment not being managed by any mental health service and the opportunity for a forensic opinion to support risk formulation and management being lost. The panel also agreed with the similar finding made by the MAPPA and authors - considering the perpetrator's mental health needs and the fact that he was homeless a safeguarding referral would possibly have led to a more joined-up approach and better collaboration between services involved.

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

19.54 The panel support the recommendations made within this report and makes no further recommendations in relation to this learning.

19.55 The panel also noted that during the period professionals who had contact with colleagues did not scope the perpetrator's relationship history so there was no opportunity to establish if he was in a relationship at the time of his interactions with them. The panel acknowledged that within the evidence presented to it, the perpetrator was adept in presenting in crisis to professionals. The history documented within the report submitted on behalf of mental health services suggested that there was, at times, a clear focus on his need for clinical treatment, but limited professional curiosity that would have triggered further questioning of the perpetrator to determine if anyone close to him, including his intimate partners, was at risk from him. Whilst it acknowledged that there was very minimal chance of him being transparent about his current relationships, this lack of professional curiosity had the potential to make recommendations that could have placed Khloemae, and other females he was in a relationship with, at risk. For example, the panel agreed that when clinicians referred the perpetrator to services who manage anger when he had a documented history of domestic abuse perpetration may not have been appropriate and does not align with research⁴⁹ and developing domestic abuse best practice.

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.*

19.56 The panel support the recommendations made within this report and make further recommendations in relation to this learning.

⁴⁹ Evan Stark. (2007). *Coercive Control: The Entrapment of Women in Personal Life*. Oxford University Press.; Mandel, D. (2020). *Unraveling the gender paradox at the center of the Safe & Together Model*. https://share.hsforms.com/1m3JU8ITHRBq1fNdKtZXQeA3a1w1?__hstc=156919908.c102e668e7444ef82b099ba245a708cd.1578068180096.1617285449770.1617381414550.766&__hssc=156919908.4.1617381414550&__hsfp=2831251599; David Mandell et al (2020) *How Domestic Violence Perpetrators Manipulate Systems Why Systems & Professionals Are So Vulnerable & 5 Steps to Perpetrator-Proof Your System* https://f.hubspotusercontent00.net/hubfs/5507857/Free%20Downloads/PerpManipulation_4721.pdf

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19.57 The panel also found that there were elements of further good practices not included elsewhere in this report:

- There was evidence of communication between mental health service liaison teams across London when patients from other boroughs presented at ED in need of assessment.
- There is an agreement amongst the London Health Based Places of Safety (HBPoS) that contact can be made to other units to assist if there are no places in the service user's locality. Operational staff pragmatically manage these arrangements.

19.58 The panel considered issues presented in this review that had the potential to locally affect public confidence in the protection of people in vulnerable situations. It considered that, in July 2018, when the perpetrator was suspected of harassing a previous victim of rape when she was a child, the panel were mindful of the challenges experienced by policing colleagues in their attempts to support the victim with the making of a statement and that the officers concerned are no longer employed by the MPS and a full explanation as to the decision making of the time could not be established, or why the perpetrator was not arrested or interviewed in relation to this offence. It agreed with the IMR author that, whilst ordinarily a statement from the victim would be required at the charging stage, one is not required to justify basic investigation steps such as arrest, and as the perpetrator was, at the time, a MAPPA Registered Sex Offender with a history of serious offending this should have been sought as a priority. Whilst this may not have changed the outcome, the panel agreed this would have given a clear message to the perpetrator that his behaviour was being monitored and there could be repercussions if he continued to intimidate his victims.

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 noncompliance and ensure that noncompliance does trigger the processes that reinforce the expectations on them.*

19.59 Recommendations have been made by the relevant agencies to address this learning.

19.60 The panel also noted that there were two separate incidents in September and November 2017 that involved malicious communications from the perpetrator to a cousin of Khloemae, despite the imposition of a non-molestation order by the court that prohibited him making any contact with Khloemae's cousin. The contact in itself the panel to conclude that the perpetrator had no intention of adhering to any court orders imposed on him and held himself to be above the law. The panel also considered if the perpetrator saw Khloemae's cousin as a threat to his control over Khloemae and, as such if the risk he posed to her was transferred to her cousin. The evidence available to the panel did not enable the panel to reach a definitive conclusion on this point but noted that the impact of the contact on Khloemae would

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have eroded her confidence in the legal powers/sanctions that could have afforded her protection from him⁵⁰.

19.61 The panel identified that the following changes have already taken place, but recommends that the action plan that falls from this review monitors the progress of these key developments:

- The panel noted that some agencies did not receive information, and this was compounded by IT systems that were not compatible. To ensure the DV Hub receives referrals the Croydon Violence Reduction Partnership has ceased using CJSM service as this was causing issues with compatibility with the Council Gmail email system. All emails now sent/received are from standard a Gmail MARAC mailbox using [Official Sensitive] encryption services. In addition, a weekly summary of all cases is now sent to the DV Hub to cross-reference with the referrals forwarded to them to identify any missed cases.
- One agency (RBK Housing) advised the panel they were not aware of MARAC's involvement. The panel understands that, during the timeframe of this review, MARAC partners (excluding Police/IDVA that were notified at the time of referral) were only notified of cases due to be heard at the forthcoming MARAC in a case list sent out a week before the MARAC, and in relation to this case, Khloemae had been moved out of Borough at the time the case list was sent. This process has now changed. A new referral notification is sent to all MARAC partners at the time a referral is made. This includes the details of the victim, perpetrator, children, addresses, etc, and a summary of reasons for referral/background to the case including key risks, etc. MARAC partners are then requested to 'flag and tag' these cases upon receipt, so that should their agency have contact with the individuals involved their colleagues are aware that they are a MARAC case and to contact their agency MARAC representative for more information.
- The panel also noted that there was a lack of information sharing for cases (e.g. where the victim moved out of the borough) prior to the MARAC meeting. It understands that when a case is now transferred to another borough prior to being heard at the MARAC all partners are notified of the transfer and requested to still share any relevant information held on the individuals with the MARAC coordination team. This is then collated and supplied to the transferred borough for their information. Although the panel understands that this can contribute to the management of MARAC volume capacity, and has the potential for good practice, it noted that this is not in line with MARAC guidance⁵¹, which is clear that the MARAC meeting should also record all the information known about the victim, perpetrator and any dependents, and formally record that a MARAC-to-MARAC referral is undertaken. The panel recommend that FJC undertake a review of this current practice and ensure that MARAC guidance is adhered to.

⁵⁰ <https://victimscommissioner.org.uk/document/2021-victim-survey/>

⁵¹ <https://safelives.org.uk/practice-support/resources-marac-meetings>

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- The Probation Service noted that there is a need to ensure risk mitigation follows through when cases are transferred internally or to another OM in another borough. It understands that there is a handover between OMs where this is possible, and the receiving OM will document they have reviewed historical records to help aid future risk management. It now also ensures that managerial oversight documents that the completion and/or review of necessary risk assessment and action plan are in place, that they clearly manage the risk posed by an offender and this includes recording that checks have been undertaken to confirm local intervention/support is being accessed.
- The Probation Service also noted, and have taken steps to ensure that, their practitioners evidence professional curiosity within the case recording, by documenting through exploration of concerns surrounding specific risk factors, and that this has been informed by historic case records and assessments, information from external agencies and service user disclosures.

20. Conclusions

20.1 Khloemae is remembered by her loved ones as being beautiful and kind, willing to help anyone in need. She was a vulnerable young women who was susceptible to abuse. 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. 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. The panel had no doubt that the perpetrator developed a friendship with Khloemae and 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 experienced a decline in her mental wellbeing.
- The perpetrator deployed a number of abusive behaviours toward Khloemae and this 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 most likely a means to ensure their safety as well as her own.
- The abuse she endured impacted her mental wellbeing 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.

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- 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 or not 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 was taken 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, but her experience 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.

20.2 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 the further stages:

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Stage 5- The perpetrator led the 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 that no doubt impacted on a rapid but high-level escalation 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 in order to frighten Khloemae further and prevent her engagement with, and possibly further disclosure to, professionals and may have even planned her murder. There was no evidence to support the perpetrator's assertions to professionals 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 life in her final moments of life.

20.3 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. It accepts that this review details the impacts of the domestic abuse and this can be distressing to read, but agreed that it demonstrates the reality of Khloemae's lived experience. It is grateful to Mrs Loy who was insistent that the loss of her daughter's life should enable professionals to ensure that the risk of Khloemae's loss of life has purpose and agreed to this detail remaining within the final report. Mrs Loy was clear

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that Khloemae's experience should inform professionals to recognise that younger women, whose life experience is in its formative year, can be susceptible to sophisticated and manipulative perpetrators of domestic abuse and that they will deploy "behaviour that will keep them safe but can mean others will find them difficult" and that "signposting advice for women in Khloemae's situation can escalate the risk posed to them" if meaningful support to access the support available to them is not provided.

20.4 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.

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

21. Recommendations

21.1 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.

- 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 a 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 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

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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:

- 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.

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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:

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:

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The Safer Croydon Partnership requests that its constituent agencies 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:

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.

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21.2 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.

21.3 In 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.

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| This is continues to be a live document | | | | | | | |
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| No. | Recommendation | Key Action | Evidence | Key Outcomes | Named Officer | Date | Update |
| SCP | | | | | | | |
| 1 | <p>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 DHRs</p> <p>SMART The CSP's require agencies will ensure that at least 90% of their panel members and IMR authors complete appropriate and contemporary training on the conduct of Domestic</p> | <p>Ensure all panel members and IMR authors complete the Home Office's online DHR training modules.</p> <p>Conduct training on effective report writing, focusing on the specific requirements for DHR overview reports and IMRs. This should include guidance on analysing policies, procedures, and organisational structures.</p> <p>promote cultural awareness training to help panel</p> | <p>Emails to be sent to encourage participation and provide links to training.</p> <p>Provide links to available training.</p> | <p>Enhanced understanding of DHR processes, improve inter-agency collaboration, increase accountability, more effective recommendations aimed at preventing future domestic homicides.</p> <p>Enhance understanding and</p> | <p>DHR Lead</p> <p>DHR Lead</p> | <p>December 2024</p> <p>Ongoing</p> | <p>The panel have been provided with the link to the Home Office online module training.</p> |

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| | <p>Homicide Reviews (DHRs) in line with statutory guidance. This training will be provided by certified trainers and will include both online and in-person sessions. The training program will be completed within the next 6 months, and its effectiveness will be reviewed 3 months after completion</p> | <p>members and IMR authors better understand and address issues related to diverse communities, including honor-based violence.</p> <p>Ensure that all panel members and IMR authors are familiar with the local governance structures for monitoring the implementation of DHR action plans.</p> <p>Collaborate with the Police and Crime Commissioner (PCC) and Domestic Abuse Commissioner</p> | <p>Provide DHR Toolkit to all panel members</p> <p>Contact MOPAC and DAC</p> | <p>improve communication, foster better victim care, strengthen organisation dynamics, promote long term behavioural change, contributes to a more inclusive approach in addressing the needs of diverse communities.</p> <p>Increased accountability, clear understanding of roles, enhanced oversight, SMART Action Plans.</p> <p>Evidence based insights, trauma informed approaches, share</p> | <p>DHR Lead</p> <p>DHR Lead</p> | <p>December 2024</p> <p>January 2024</p> | <p>Currently looking at appropriate local training to cover this training for the panel.</p> <p>All panel members have been provided with the toolkit</p> <p>To be completed.</p> |
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| | | <p>(DAC) to incorporate their insights and expertise into training offers and funding.</p> <p>Provide regular refresher training on the latest statutory guidance for conducting DHRs. This should include updates on any changes to policies, procedures, or best practices</p> | | <p>bets practice, policy influence, foster a more effective response to domestic abuse through improved communication, accountability and victim support.</p> | | | |
| CHS/SLaM | | | | | | | |
| | <p>Training to Health colleagues, including Mental Health Clinicians, is to be reviewed and that learning from this review is embedded into to ensuring it supports practitioners to improve responses to domestic abuse.</p> | <p>Identify that health colleagues including SLaM provide trauma informed training to its colleagues.</p> <p>DA training package is to be developed and will be delivered on a monthly basis</p> | <p>SLaM DA package has been developed and once ratified will be available to all staff within the trust.</p> | <p>The DA training package has incorporated the learning from this review as part o the DA package.</p> | | 22/7/25 | <p>SLaM DA Training package is in the review stage and once ratified will be available to all staff within the trust.</p> <p>Safeguarding Childre and Adults training reviewed and a number of</p> |

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| | <p>1.CHS - Project work by DASV Support Worker & IDVA to roll out the following: To provide more specific training to specialist depts. Such as Maternity, Sexual health etc. in September</p> <p>To recruit domestic abuse champions in various dept. across the Trust support identified champions with DV training Training compliance reported to Learning and Development.</p> | <p>which will be made available to all staff within the trust. The DA training package will share the learning from this review as part of the DA package.</p> <p>DASV Champions</p> <p>DASV Training</p> | | | NW, MLW | November 2022 | <p>changes have been completed to incorporate learning from this review to ensure it supports practitioners to improve responses to domestic abuse.</p> <p>Bitsize training delivered to ED and maternity staff</p> <p>DASV Champion training and recruitment completed. Champion badges. This is an ongoing provision.</p> <p>DASV is present in all levels of SG Training. This is also available as a bespoke package for identified areas of need.</p> |
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| | <p>2.Promote understanding of professional curiosity</p> <p>3. The existing training to be developed to include risk assessment, risk escalation, asking questions about domestic abuse in a safe manner and environment.</p> | <p>Raise awareness of professional curiosity, and how to create situations where patients can be spoken to alone.</p> | <p>Incorporate professional curiosity and safe enquiry into training.</p> <p>Training compliance reported to Learning and Development.</p> <p>To include the professional curiosity in the Trust Safeguarding Newsletter, 7 minutes briefings.</p> <p>Review training programme, policies, guidance and supervision to include reference to professional curiosity.</p> <p>Review and update the current training slides to include exploration around the SafeLives risk assessment</p> <p>Current relevant documentation and training programmes reviewed and</p> | | | <p>November 2022</p> | <p>Domestic abuse Champions have been identified in Adult ED, and other departments.</p> <p>Bespoke training delivered to ED.</p> <p>All levels of SG training include professional curiosity. SGA and SGC policies reviewed.</p> <p>7 minute brief completed</p> <p>Training updated.</p> |
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| | Promote understanding of the impact of ACEs and support better awareness of trauma informed practice | | amended/updated as required Trauma informed practice to be included in safeguarding training, policies, guidelines and supervision processes. | | | | |
| | (SMART) Conduct a comprehensive review of domestic abuse response training for all Health colleagues, including Mental Health Clinicians, and implement at least three evidence-based improvements to the training curriculum. These improvements should result in a 20% increase in practitioner confidence in responding to domestic abuse cases, as measured by pre- and post-training surveys | SLaM are currently developing a bespoke DA training package which will be available to all staff within the trust which will delivered alongside a longitudinal survey to assess how this intervention has impacted staff members confidence and preparedness to respond to DA in their practice. | SLaM DA package has been developed and once ratified will be available to all staff within the trust. | The DA training package has incorporated the learning from this review as part o the DA package. | | 22/7/25 | Training package is in the review stage and once ratified will be available to all staff within the trust. Once the ratification process has been completed, this will be delivered alongside a longitudinal survey to assess how this intervention has impacted staff members confidence and preparedness to respond to DA in their practice. |
| Croydon Housing: | | | | | | | |

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| <i>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</i> | | | | | | | |
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| | Embedded compliance with the standards and obligations as set out in the Domestic Abuse Act | <p>Develop a comprehensive domestic abuse policy that aligns with the statutory definition of domestic abuse provided in the Act. This policy should cover how Croydon housing will identify, respond to, and support victims of domestic abuse.</p> <p>Review and update Croydon's homelessness services to reflect the Act's changes, including the new priority need category for domestic abuse victims.</p> <p>Provide specialised training for staff and managers to</p> | The housing policy will be published on the council website | The policy remain at DRAFT stage whilst a consultation with the public is completed. The report is also being shared with survivors with lived experience | | | |

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| | | help them understand domestic abuse, recognise signs, respond sensitively, and conduct risk assessments. This training should cover the various forms of abuse outlined in the Act, including physical, sexual, emotional, economic, and controlling/coercive behaviour. | | | | | |
| | Initiatives to improve responses to victims of domestic abuse who are homeless are appropriately commissioned and require no improvement | Fund the Domestic Abuse Housing Alliance (DAHA). | Email to DAHA | improve Croydon's response to domestic abuse through the adoption of standards and best practice. | DHR Lead | Ongoing | Croydon is in the process of working towards DAHA accreditation. Two leads have been identified, one from housing and one from the councils DA service. This will take between 12-18 months to achieve accreditation. |

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| | Reciprocal housing arrangements with other Local Authorities are formalised and reflect proportionate intersectional responses to those with vulnerabilities and/or multiple needs. | | | | | | The Pan-London Housing Reciprocal is already an example of a formalised reciprocal arrangement. It is a voluntary collaboration between London local authorities and registered housing providers designed to support social housing tenants at risk of violence who need to move to a safer borough. |
| | The Director of Housing is to commission a review of the domestic abuse training provided to their workforce | Evaluate existing domestic abuse training programs, including content, frequency, and delivery methods. Research current best practices in domestic abuse | | | | | |

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| | | <p>training for housing providers</p> <p>Consider implementing post-training surveys and follow-up assessments</p> | | | | | |
| | <p>The Director of Housing is to commission a thematic analysis of domestic abuse case management.</p> | <p>Analyse how housing works with other agencies to manage complex DA cases.</p> <p>The impact of the high risk victim housing panel meetings and its effectiveness</p> <p>Evaluate the effectiveness of information sharing processes between housing and other services.</p> | | | | | |
| MPS | | | | | | | |
| | <p>The MPS recirculate its guidance on how officers are supported to consider appealing against CPS decisions</p> | |  <p>ops notice - appealing CPS decisio</p> | <p>Information raising completed, along with relevant links to legislation and policy.</p> | <p>Lead responsible officer for DA – D/Supt</p> | <p>14/10/2024</p> | <p>Completed.</p> |

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| | not to charge perpetrators where the professional judgement of the officers can support evidence led prosecutions | | | | Andrew Wadey | | |
| FJS | | | | | | | |
| | The FJS undertakes a review of MARAC that provides reassurance that MARAC function and delivery is in line with Safelives Guidance and appropriate tool kits. | Review the number of cases discussed at MARAC meetings. SafeLives recommends a benchmark of 40 cases per 10,000 adult female population. Compare our MARAC's quarterly data against this expected level to ensure we are addressing an appropriate number of high-risk cases. Ensure that all relevant agencies are represented at MARAC meetings. SafeLives provides a | Croydon MARAC exceeds the 40 per month referrals as bench marked by Safelives. Typically MARAC hears a minimum of 80 cases per month and MARAC is held weekly to manage the demand. There is a MARAC induction pack which is available to new MARAC members. This ensures that new members understand the process and their agency responsibility/accountability within MARAC. Croydon has a good attendance of both statutory and non-statutory partners. Where there have been poor/non-attendance of a partner, this is | High levels of MARAC referrals is not necessarily a negative as the more high harm, high risk V/S referred means that more V/S are accessing support. | Alison Kennedy | Ongoing | MOPAC are currently undertaking a pan London piece of work to ensure that the MARAC process is robust and consistent across all London boroughs |

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| | | <p>toolkit for MARAC representatives that outlines their roles and responsibilities.</p> <p>Check that each representative understands their role and actively participates in information sharing and action planning</p> | escalated to the Safer Croydon Partnership | | | | |
| | <p>The Safer Croydon Partnership leads a review of locally available multi agency domestic abuse training so that is reflects:</p> <ul style="list-style-type: none"> • Shared understanding of risk and risk clusters. • Identification of high-risk victims. • Increases understanding of perpetrator manipulation of professionals, the impact that this | <p>Form a multi-agency working group to oversee review process including victim/survivors.</p> <p>Conduct an audit of existing training materials and identify gaps.</p> <p>Develop updated training modules that address the specified requirements.</p> | Evaluation framework, surveys and questionnaires, focus groups including the new expert by experience panel. | <p>Enhanced risk assessment, consistent approach to identifying risk factors, improved assessments of potential dangers faced by victims.</p> <p>Improve safe challenging techniques. And empowering professionals to act without escalating risks for victims</p> | DHR Lead | Ongoing | <p>Contact has been made with a local authority who were awarded funding to create there own domestic abuse training. Staff members have attended the training to observe its practice and suitability for Croydon.</p> <p>Funding is to be sourced to commit to the</p> |

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| | manipulation can have on its victims and explores safe challenge to perpetrators. | <p>Pilot the new training with a diverse group of professionals.</p> <p>Establish a regular review process to keep the training current and effective.</p> <p>Consult with domestic abuse specialists and survivors to gather insights.</p> | | <p>Improved outcomes for victims including better support and protection.</p> <p>Contribute to ongoing efforts within the Safer Croydon Partnership to enhance services related to domestic abuse and violence against women and girls.</p> | | | <p>train the trainer process.</p> <p>The expert by experience panel will be reviewing the councils training offer currently which is delivered by staff at the council domestic abuse service.</p> |
| SLaM | | | | | | | |
| | SLaM to review current domestic | DA training package is to be developed | SLaM DA package has been developed and once ratified | SLaM DA package has been | | 22/07/25 | Safeguarding Childre and Adults |

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| | <p>abuse training available to its workforce to ensure that it embeds:</p> <ul style="list-style-type: none"> •The use of indirect questions about domestic abuse, risk assessment and risk escalation •Safe domestic abuse enquiry in a trauma informed manner and safe environment, •Following up on contacts when it has been unsafe to ask and gathering information on significant others. | <p>and will be delivered on a monthly basis which will be made available to all staff within the trust. The DA training package will share the learning from this review as part of the DA package. This will incorporate:</p> <p>The use of indirect questions about domestic abuse, risk assessment and risk escalation</p> <ul style="list-style-type: none"> •Safe domestic abuse enquiry in a trauma informed manner and safe environment, •Following up on contacts when it has been unsafe to ask and gathering information on significant others | <p>will be available to all staff within the trust.</p> | <p>developed and once ratified will be available to all staff within the trust. The DA training includes how to create a conducive environment when asking questions surrounding domestic abuse, how to complete a DASH risk assessment, the rationale as to why questions are required to be asked as part of the DASH risk assessment and the importance of escalation including when using professional judgement.</p> | | | <p>training reviewed and a number of changes have been completed to incorporate learning from this review to ensure it supports practitioners to improve responses to domestic abuse.</p> <p>In addition to this, changes have been made to the patient electronic records to alert and remind staff to ensure they have asked a survivor of DA for a safe contact including of a trusted person they have as an alternative way to try to obtain contact with them.</p> |
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| | <p>Review current supervision guidance and practice, ensuring this emphasises the need to use professional judgement and/or curiosity when a disclosure from, or presentation suggests that, a patient is experiencing domestic abuse.</p> | <p>SLaM to complete a review of the current safeguarding supervision to ensure the use of professional judgement is embedded within the context of DA, including when a disclosure from, or presentation suggests that, a patient is experiencing domestic abuse.</p> | <p>Safeguarding policies and DA Policy reviewed and shared.</p> | <p>Safeguarding policy states: Clinical supervision should always incorporate thinking around client risk and safeguarding. Clinical supervision should incorporate thinking around the trust values of trauma-informed care and anti-racism.</p> <p>The DA policy states: Consideration of domestic abuse should form part of directorate or service one-to one supervision, or group supervision, as a matter of routine business.</p> <p>If a victim does not consent to a referral:</p> | | 22/7/25 | Action completed |
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| | | | | <ul style="list-style-type: none"> Use professional judgement and/or seek consultation with the safeguarding teams. | | | |
| | <p>SLaM to review safeguarding/DASV support to ED staff to ensure that practitioners are confident in their practice. This should include:</p> <ul style="list-style-type: none"> •Provision and delivery of safeguarding supervision •Consideration of the impact of ACE's. | <p>SLaM to complete this as part of the Safeguarding and training review.</p> | <p>Safeguarding supervision policy and safeguarding children and adult training reviewed</p> | <p>Safeguarding supervision policy reviewed and states- Staff are responsible for ensuring that their competence in safeguarding is up to date and in line with requirements set out in the Intercollegiate documents and professional revalidation requirements. They should access training and supervision available to them. It is a requirement that all clinical staff, irrespective of role, receive 1:1</p> | | 22/7/25 | Action completed |

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| | | | | <p>supervision at least monthly. Clinical support workers will also receive supervision to at least the minimum required by the policy for clinical staff, and include time to reflect on clinical work.</p> <p>In addition to this, all staff are required to complete safeguarding children and adult training.</p> | | | |
| | Review the addictions service's risk assessment tool and provide assurance that this includes risk of domestic abuse. | Full review of risk assessment tool will be completed | Full review ongoing | | | 22/7/25 | Action ongoing |
| Southwest London and St George's Mental Health NHS Trust (SWLStG) | | | | | | | |
| | Provide assurance that the planned learning event took place for the Kingston and Richmond Teams | | | | | | Awaiting response |

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| | to discuss the learning arising from its contact with Khloe Mae | | | | | | |
| | Develop and disseminate clear criteria for escalation patients with multiple needs to a multi-agency professionals meeting. | | | | | | |
| | <p>SWLStG to undertake a deep dive review within its functions and provide assurance that there are:</p> <ul style="list-style-type: none"> •Improved processes that clarify the different pathways of care within SWLStG to its workforce •Improved communication between SWLStG teams when referrals were being made, rejected and referred back | | | | | | |
| Oxleas NHS Foundation Trust | | | | | | | |
| | Review its procedures and provide | | | Following the interview with the | | | Completed |

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| | assurance that there is a system to notify a patient's GP on discharge and there is now established communication with the patient's GP on discharge. | | | <p>Investigators in 2022, GP Discharge Notifications are now completed and sent to patients' GPs.</p> <p>Admin staff coordinates a weekly list of patients discharged back to Community for the attention of HBPOS Doctor to write a GP Discharge Notifications which the Admin then forward to the GPs.</p> | | | |
| Lewisham Probation Service | | | | | | | |
| | Brief the Head of Service for this PDU on the specific learning for this case so that learning from it can be used to inform development of tailored learning plans are in place and feed into Continual Professional Development Days. | <p>1. Case Review and Analysis: A comprehensive review of the case was conducted, focusing on decision-making processes, inter-agency collaboration, and adherence to</p> | <p>1. Case Review Report dated February 2021 detailing findings and recommendations.</p> <p>2. Reflective Practice Discussions from staff involved in the case.</p> <p>3. Meeting Minutes from the multi-agency learning session held.</p> | <p>1. Learning Plans: Development of learning plans for staff involved, focusing on risk assessment, communication, and escalation procedures.</p> <p>2. CPD Integration:</p> | Head of Service | Ongoing | |

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| | | <p>safeguarding protocols.</p> <p>2. All details have been shared with the Head of Service and further discussions have taken place to ensure that the learning is captured in the future L&D plan. Sem of which has been covered in the practice learning sessions.</p> | | <p>Key themes from the case have been scheduled for inclusion in the next CPD Day, including a workshop on effective multi-agency working.</p> <p>3. Improved Practice: Early indicators show improved confidence among staff in applying escalation protocols, as evidenced in recent supervision records.</p> | | | |
| | <p>Cascade learning from this case through a learning event to its practitioners, and give clear reminders that when supervising offenders</p> | <p>1. Staff Engagement: Feedback was gathered from involved practitioners through reflective sessions to understand challenges and identify practical improvements.</p> | <p>1. Case Review Report dated February 2021 detailing findings and recommendations.</p> <p>2. Reflective Practice Discussions from staff involved in the case</p> <p>3. Meeting Minutes from the multi-agency learning session held.</p> | <p>1. Learning Plans: Development of learning plans for staff involved, focusing on risk assessment, communication, and escalation procedures.</p> <p>2. CPD Integration:</p> | <p>Head of Service</p> | <p>Ongoing</p> | |

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| | | <p>2. Learning & development - Findings were shared with the to begin shaping bespoke learning modules aligned with the identified gaps.</p> <p>3. Quality Development Officer – who has recently come on board will be supporting with the roll out of ongoing learning.</p> | | <p>Key themes from the case have been scheduled for inclusion in the next CPD Day, including a workshop on effective multi-agency working.</p> <p>3. Improved Practice: Early indicators show improved confidence among staff in applying escalation protocols, as evidenced in recent supervision records.</p> | | | |
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Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

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

Ciara Goodwin
Domestic Abuse and Sexual Violence Coordinator
Culture & Community Safety
Regeneration & Economic Recovery Department
8 Mint Walk, Croydon
CR0 1EA

21st May 2025

Dear Ciara,

Thank you for submitting the Domestic Homicide Review (DHR) report (Khloemae Loy) for Croydon Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered in May 2025. I apologise for the delay in responding to you.

It was noted that the review has done well to identify relevant learning and important recommendations given that there was minimal agency involvement with both the victim and the perpetrator. The chair has also very sensitively expressed gratitude to the victim's mother for her engagement and contributions to the review.

There is good use of the Domestic Homicide Timeline alongside the Leaving Cycle to emphasise the issues identified in this case. Research has been used appropriately throughout the report and referenced at the point of mention to support findings.

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

Areas for final development:

- The front title page is currently incomplete as it is missing the date and year of the death, the name of the CSP and the date the report was completed by the author.
- There is limited information on dates in this report, for example the month and year of the murder incident, the date the police notified the CSP of the victim's death, the date the

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second Chair was appointed and the date the review was completed and sent to the CSP. This information should be added.

- Further detail of the Chair's career history should be included.
- There does not appear to be any representation from the voluntary sector with domestic abuse expertise on the Panel. The CSP should consider this for any future reviews undertaken.
- Section 10 'Media Coverage' is somewhat confusing as it states that 'the published report was anonymised through changing the names of the individuals' when the report has already explained that the family wishes were agreed, and the victim's real name was used. This requires clarification.
- The last paragraph of page 7 (in relation to the retrial) requires updating prior to publication.
- The report would benefit from the use of paragraph numbers. Please include these prior to publication.

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

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

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at

DHR@domesticabusecommissioner.independent.gov.uk

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

Yours sincerely,

Home Office DHR Team