



SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary Report into the death of Adult J

July 2017

Independent Chair and Author of Report: Mark Yexley

Associate Standing Together Against Domestic Violence

Date of Final Version: December 2019



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1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Croydon Partnership Domestic Homicide Review (DHR) panel in reviewing the homicide of Adult J who was a resident in their area.

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

The victim: Adult J - Aged 36 at time of her death, a white Romanian woman

The perpetrator and housemate of victim: Adult K - Aged 34 at time of homicide, a white Romanian man

Niece of the victim: Adult X

Nephew of the victim: Adult Y

1.1.3 Criminal proceedings were completed in March 2018. Adult K pleaded guilty to the murder of Adult J. He was sentenced to Life Imprisonment, with a recommendation that he serve at least 20 years. There was no additional penalty in relation to the separate counts of assault on Adult J's niece and nephew.

1.1.4 The process began with an initial meeting of the Community Safety Partnership when the decision to hold a domestic homicide review was agreed. The Home Office were informed of the decision on 18 August 2017. All agencies that potentially had contact with victim/perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.2 Contributors to the Review

1.2.1 This Review has followed the statutory guidance for Domestic Homicide Reviews 2016 issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. An initial meeting was held to discuss the findings of the agencies. There was very limited information known to local agencies. There were no previous concerns that any party had been subject to any reports of safeguarding or domestic abuse concerns. Guided by the CSP requirement to have a tightly focused review, the panel decided that it was not proportionate to request Individual Management Reviews (IMRs) from the agencies. A total of 12 agencies were contacted to check for involvement with the parties concerned with this review. Nine agencies returned a nil contact, and three agencies provided chronologies only, due to

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the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

- 1.2.1 The following agencies had contact with either the victim and/or perpetrator and their contributions to this Review are:

Agency	Contribution
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	Chronology
Croydon Health Services (CHS)	Chronology
Metropolitan Police Service (MPS)	Case Summary and Chronology
UK Border Force	None (MPS Records show that this agency had at least two contacts during the period under review)

1.3 The Review Panel Members

- 1.3.1 The Review Panel Members were:

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

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

Mark Yexley	Independent Chair	Standing Together Against Domestic Violence
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- 1.3.2 *Independence and expertise:* Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy, and were independent of the case.
- 1.3.1 The Review Panel met on three occasions, with the first meeting of the Review Panel on the 20 February 2018. There was a panel meeting to review the Overview Report on 6 February 2019. There was a final panel meeting to review CSP comments on the Overview Report on 6 November 2019.
- 1.3.2 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

- 1.4.1 The chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 14 DHRs. Mark is a former Detective Chief Inspector with 34 years' experience of dealing with domestic abuse and was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent reviews of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.
- 1.4.1 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

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

1.5 Timescales

- 1.5.1 The Safer Croydon Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified of the decision in writing on 18 August 2017.
- 1.5.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent Chair for this DHR in November 2017. The completed report was handed to the Safer Croydon Community Safety Partnership in December 2019.
- 1.5.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Initially there was a delay in the commissioning of the review chair. Further delays took place due to the criminal trial process, time taken to liaise with family in Romania, the use of translation services and attempts to interview the perpetrator in prison. The chair also took steps to interview colleagues and friends of Adult J in order to gain a better understanding of her life. Whilst there was limited contact with agencies, the final chronology was not completed until June 2018. The police chronology indicated that the UK Border Force had conducted an investigation into packages of drugs being sent to Adult K. Several months were spent trying to obtain information from the UK Border Force concerning the investigation and they were unable to provide any information to review. The panel also believed it would assist the process to include experts who could provide advice on the impact of domestic abuse on Eastern European women. The chair requested that the CSP commissioned support from Refuge Eastern European Gender Violence Advocacy Service. This was not agreed until 2019. The process was delayed in order to allow Refuge to advise on the final report and recommendations. The final delays to the process was due to objections raised by the CSP on the wording of the draft of the report approved by other panel members in July 2019. The chair suggested that the comments of the CSP should be considered by all of the panel and requested authority to hold a further meeting. This authority for that meeting was granted in October 2019 and the meeting was held in November 2019, when this Overview Report was agreed by all of the panel and CSP representatives.

1.6 Equality and Diversity

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

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- 1.6.2 Adult J was a 36 year old heterosexual white woman. Adult K was a heterosexual white man and was 34 years old at the time of Adult J's death. They were not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was disabled, was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs. Adult J was not pregnant. The DHR Panel provided special consideration to race, age, or marital or civil partnership status throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.
- 1.6.3 **Race:** Adult J and Adult K were both Romanian nationals. It is known that Adult J entered the UK six years prior to her death. The Review Panel gave special consideration to the nationality of both parties and whether their status, as migrant workers, in the UK affected contact with agencies.
- 1.6.4 **Sex:** Sex should always require special consideration. Recent analysis of Domestic Homicide Reviews; reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.¹ This characteristic is therefore relevant for this case, the victim of the homicide was female and perpetrator of the homicide was male.
- 1.6.5 In considering the impact of crimes on women from Eastern Europe there are other specific considerations. Refuge have found that Eastern European women are at particularly high risk of abuse compared to victims in other Refuge services. Victims can be more isolated than most and require specialist services who are aware of cultural and language needs.

1.7 Terms of Reference for the Review

- 1.7.1 At the first meeting, the DHR panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from January 2010 to the date of the homicide. It was established that Adult J came to the UK in 2010 and there had been very limited contact with agencies over the years. It was decided that all agencies could check records back to 2010 without additional demands on resources.
- 1.7.2 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the following case specific issues:

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

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

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

1.7.3 As a result of identifying these key lines of enquiry, other agencies were invited to be part of the review due to their expertise in stalking, personal safety and additional barriers faced by East European women. These agencies had not been previously aware of the individuals involved. There were no local options available to consider the aspects of stalking and Eastern European women. The local statutory substance misuse service was included on the panel.

1.7.4 In relation to Eastern European input, Standing Together proposed that the domestic abuse charity Refuge be approached. Refuge provide expertise in the provision of services to Eastern European women experiencing abuse. It was agreed that Refuge would be commissioned by the CSP to review the Overview Report. Refuge were also able to provide expertise on the stalking aspects of the case.

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

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

1.8.2 Consideration was initially given to approach the brother of Adult J. He was the nominated member of the family dealing with the police investigation.

1.8.3 Initial contact, on behalf of the chair, was made through the police FLO and a police interpreter. Letters of introduction and explanation of the DHR process were provided through the FLO and the interpreter translated those face to face with Adult J's brother in February 2018. The initial letter outlined the services of Advocacy After Fatal Domestic Abuse (AAFDA) and offered the services of the Victim Support Homicide Service, but the family declined this support.

1.8.4 Adult J's brother agreed with the FLO that he could be contacted directly by the chair through email. Croydon CSP provided translation services for all correspondence. In April 2018, a letter of introduction and a copy of the Home Office DHR leaflet for families was translated into Romanian and sent by email to Adult J's brother. There was no response from Adult J's brother. A further email, in Romanian, was sent to Adult J's brother in September 2018. There was no response to that email. In October 2018 the chair contacted the FLO and asked that the police interpreter, known to have a good relationship with Adult J's brother, would send a further email

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to the brother. The email would ask Adult J's brother, whether he wished to talk to the chair by phone or whether he did not want contact. To date there has been no response from Adult J's brother.

- 1.8.5 Consideration was also given to contacting the niece and nephew of Adult J, children of her brother. Nephew Y indicated that he did not want any contact after the incident. However, his sister Niece X was willing for her details to be passed to the Chair of the Review.
- 1.8.6 The chair attempted contact with Niece X May 2018 and June 2018. Niece X responded to the text message, stating that she would be happy for the chair to send her information about the DHR process by email. The chair then sent a letter of introduction to Niece X. The letter included reference to the support offered by AAFDA. The chair also sent a copy of the Home Office DHR leaflet for families. The letter confirmed that the chair would attempt contact if he had not heard from Niece X after 30 days. A follow up call was made to Niece X and there was no reply. At the end of August 2018 a further email was sent to Niece X by the chair, there was no reply to the email. Enquiries were made with the FLO and they confirmed that they had not had any contact with the niece and nephew since the sentencing of Adult K earlier in 2018.
- 1.8.7 To date there have been no interviews with the family. In all correspondence with the family they are informed that supporting a DHR is a voluntary matter and they are not obliged to become involved in the process. The panel respect the wishes of the family.
- 1.8.8 The FLO was able to provide details of Adult J's employer. Adult J was a junior school teacher working in Croydon. The chair contacted Adult J's Head Teacher who was willing to support the review and she was interviewed face to face in October 2018. The panel would like to express their thanks to the Head Teacher and the FLO for their support of this review.

1.9 Summary of Chronology

- 1.9.1 Adult J and Adult K were not, and have never been, in an intimate relationship. They were not related. The case was reviewed under the DHR Guidelines as they were both members of the same household. Adult K and Adult J had been living together, as friends, in shared accommodation for around 6 years. They lived together with Adult J's adult niece and nephew in a privately rented terraced house. The four people had been living in the house for 15 months before the homicide.
- 1.9.2 Adult J was single at the time of her death. She was a qualified teacher in Romania. After entering the UK in 2010, Adult J trained to gain UK qualification to work as a primary school teacher. In 2016 Adult J started work as a teacher in a Croydon junior school teaching eight and nine year olds. It should be noted that Adult J's Head Teacher was extremely supportive to the review.

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- 1.9.3 Adult K was known to have worked in a number of jobs, including construction work. At the time of the murder he was employed as a caretaker in a property in central London. In November 2014 and September 2016, the MPS received information from the UK Border Force of seizure of a parcel addressed to Adult K at his home. There is no other information forthcoming from UK Border Force about this investigation.
- 1.9.4 It is believed, by family, that Adult K was infatuated by Adult J. Material discovered on Adult K's computer would support the family view and he was effectively spying on Adult J.
- 1.9.1 On a date in July 2017, from after midnight, Adult K had stayed up and had been watching pornographic films, on his computer. The films included scenes of graphic violence and death. He had been taking cocaine throughout the night, he also had painkillers and Viagra. In the early morning Adult J came down from her room and was attacked by Adult K. After the attack Nephew Y came downstairs from his room. Nephew Y saw Adult J laying on the kitchen floor, at that point Adult K hit him on the head with a hammer. Nephew Y tried to fight off Adult K, Niece X came downstairs and tried to help her brother. Adult K then grabbed Niece X and tried to hit her with the hammer. Niece X then hit Adult K over the head with a wine bottle. They fought with Adult K and managed to get him out of the house. It was the opinion of the police that Niece X's intervention was pivotal in saving her brother's life.
- 1.9.2 Police were called to the house and found Adult J unconscious. She had suffered severe head trauma. She was taken to hospital and never regained consciousness and died three days after the attack.
- 1.9.3 **Clinical Commissioning Group (CCG):** Adult J registered with a new GP service in 2016 and there were no safeguarding issues or any matters of concern for the panel. There were no records of Adult K registering with a GP.
- 1.9.1 **Croydon Health Services (CHS):** In 2013 Adult J attended her local Hospital with two minor medical complaints. There were no safeguarding concerns.
- 1.9.2 **Metropolitan Police Service (MPS):** Police provided information on the homicide and the background of both parties. Checks were conducted on police databases on Adult J and Adult K. There were no known previous incidents of either person coming to the attention of the police. The only record on police databases came from intelligence reports submitted by UK Border Force. The records show that two packages of prescription only drugs, addressed to the perpetrator, were intercepted by the agency before they were due for delivery. No further information was available.

1.10 Conclusions (key issues during this review)

- 1.10.1 There are no typical cases of domestic homicide, all emerge from specific circumstances and are tragic for families and friends. This case is particularly unique in that the relationship between victim and perpetrator falls outside guidelines that statutory agencies dealing with domestic abuse are focussed on. Adult J and Adult K had never been intimate partners and they were not members of the same family. Adult J was victim of stalking behaviours of a housemate and it appears that she was completely unaware of his covert actions. This stalking behaviour does reflect the actions of many men in cases of intimate partner abuse and a DHR is the most appropriate forum to analyse that behaviour and make links to local services supporting women and girls subject to violence.
- 1.10.2 This case has not revealed any concerns on the processes and procedures of statutory agencies who had contact with Adult J. The panel are unable to comment on information held by UK Border Force, because they could not produce any records for the panel.
- 1.10.3 **Services for Eastern European Women.** This case should be examined alongside the DHR reviewing the murder of Victoria, a Polish woman murdered in Croydon in 2016. Examination of both cases together has revealed the lack of services, in Croydon, that are specific to the needs of Eastern European women victims of violence. In setting up both DHR panels the local CSP were unable to suggest any local agencies that could support the panel. The expertise of Refuge was commissioned for both DHRs.
- 1.10.4 It is essential that all partners, working to prevent abuse and support victims, ensure that there are locally commissioned services available for Eastern European women who are vulnerable to abuse. We cannot be sure whether Adult J was aware she was being stalked. We know that she came from a country where there are limited services available for victims of abuse. We know services specific to Eastern European women were not known to the panel or CSP during the review process.
- 1.10.5 **Stalking.** The case has shown how stalking of a person who is a member of the same household can result in a Domestic Homicide. It is appreciated that the main agencies dealing with stalking in the UK are Non-Government Organisations (NGOs). The engagement of organisations dealing with stalking and personal safety have been challenging. One agency did not answer requests for support. When another agency, dealing with personal safety, was approached it was established that the cost of consultation was prohibitive to engagement with the DHR.
- 1.10.6 There is an appreciation of the panel that there is difficulty in accessing specialist services, but stalking should not be considered as a specialist element within domestic abuse services. Stalking and controlling behaviour is at the heart of domestic abuse and all local domestic abuse services should have available skills to support victims of stalking.

- 1.10.7 **Tech Abuse.** Adult J's death has brought to light the use, by Adult K, of recent technology to intrude into the private life of his female housemate using spyware on home computers to monitor private communication and hidden devices to watch her shower. The use of Tech Abuse by perpetrators has become more prevalent as computers and mobile devices are used constantly in our everyday lives. The abusive partner who would previously intercept mail or follow their victim can now use more covert means to stalk and exert control.
- 1.10.8 Advice for victims of Tech Abuse has often been for them to stop using mobile devices. This has the potential to isolate victims even more, increasing vulnerability. Local domestic abuse services need to be in position to support potential victims of Tech Abuse, increasing personal safety wherever possible.
- 1.10.9 **UK Border Force and Substance Misuse.** It is known that Adult K was under the influence of controlled drugs when he murdered Adult J. Whilst Adult K had not previously been arrested, there was UK Border Force intelligence available to suggest that he was to be the recipient of controlled drugs. Whilst there is evidence that the Border Force passed intelligence to the local force, there is no evidence that any action was taken to investigate potential criminal offences or engage with local substance misuse services. This case has shown that there has been a systems failure in the management of investigation and information.

1.11 Lessons To Be Learnt

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

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

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

At the point of publication of this DHR, the Domestic Abuse Bill 2019-21 is being debated which will encompass abusive behaviour conducted using technology. The UK Government has also published

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an Online Harms White Paper, which outlines proposals to establish a duty of care for internet companies that will make clear their responsibilities to keep users safe. These are welcomed steps towards addressing this learning point.

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

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

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

The circumstances of this case of a woman being stalked and abused in a shared household, by a man known to her show that she should be given the same access to services as someone in an intimate relationship. Local services should promote that they have the flexibility to support the needs of a victim, rather than defining a person by their relationship status.

Lesson 5. National Law Enforcement and Domestic Homicide Reviews. In order to conduct effective DHRs, the panel needs to be in possession of all relevant information. In many cases, crucial information on immigration, major crimes including substance misuse will be held by National Agencies. These agencies are not subject to mandatory attendance at DHRs and yet are under the umbrella of the Home Office. In this case it was clear that the perpetrator was under the influence of a controlled drug at the time Adult J was murdered, and yet the panel could not access information held by a National Agency who intercepted drugs being delivered to the perpetrator.

If this information is not available for a Government prescribed review process, then it is hard to see how those National Agencies can help support victims of abuse on a daily basis.

1.12 Single agency recommendations

1.12.1 There are no single agency recommendations.

1.13 Overview Report Recommendations

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

National Recommendations

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

1.13.3 **Recommendation 2** That the Home Office establish that information sharing protocols between the UK Border Force and police service are robust and auditable process for recording information and disseminating information.

Local Recommendations

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

1.13.5 **Recommendation 4** That Safer Croydon Community Safety Partnership reviews local commissioned VAWG services, to ensure that they provide language and culturally specific services, which reflect the demographics of the community it services, including Romanian/Eastern European women.

1.13.6 **Recommendation 5** That London Borough of Croydon Education Department considers a reflective practice event on the good work of the MPS Homicide Investigation Team and London Borough of Croydon Education Department in managing the death of Adult J. This should demonstrate the importance of having a domestic abuse lead within education settings.

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