Safer Lambeth partnership

Domestic homicide review

Executive summary

Report into the death of Elaine

April 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date: November 2019

Though nothing can bring back the hour
Of splendour in the grass, of glory in the flower;
We will grieve not, rather find
Strength in what remains behind;
In the primal sympathy
Which having been must ever be.

Ode: Intimations of Immortality from Recollections of Early Childhood
By William Wordsworth

Included in the Eulogy read by Isabel and Charles at Elaine's funeral

Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Lambeth Review Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Elaine[1], a resident of the London Borough of Lambeth (hereafter 'Lambeth').

1.1.2 Elaine (38) was killed by her nephew, Aiden[2] (21), in the home she shared with him and a number of other family members. The Review Panel has framed its considerations of the contact between Elaine and Aiden in the context of fatal Adult Family Violence (AFV)[3], which is a form of domestic abuse.

1.1.3 Aiden was convicted of manslaughter by diminished responsibility in March 2019. However, sentencing was delayed for psychiatric reports. In November 2019 Aiden was sentenced to an indefinite period at a secure hospital under Section 37 Mental Health Act 1993 with a section 41 restriction. The murder charge has been left to lie on file.

1.1.4 Additionally, this DHR has considered reported incidents of violence and abuse by Aiden towards his mother (Rachel) and former partner (Mia). Given these reported incidents, the Review Panel thought it appropriate to consider whether Aiden had a propensity for violence against women. This added an additional layer of complexity to the review process and the Review Panel has sought to understand these contacts in their own right. The Review Panel has framed its considerations of the contact between Rachel and Mia as potential examples of child to parent violence (CPV)[4] and Intimate Partner Violence (IPV) respectively, with these both being forms of domestic abuse.

1.1.5 This broadened scope has drawn attention to some of Aiden's other behaviours, and in doing so has brought the role of different agencies into focus. The Review Panel feels this broadened scope is in keeping with the spirit of the DHR process, which is about learning and prevention. At the same time, the Review Panel would like to acknowledge the challenges this has presented, including the difficulties of defining different types of domestic violence and abuse and, critically, ensuring that Elaine remained central to the DHR. These issues are explored more fully in the Overview Report.

1.1.6 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of any children have been removed (with anonymity further enhanced by Elaine's child being referred to as Child A, and Aiden's child being referred to as Child B). Only the Independent Chair (hereafter 'the chair') and Review Panel members are named.

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

[1] Not her real name.

[2] Not his real name.

[3] Fatal AFV is generally accepted to involve a homicide between family members aged 16 years and older.

[4] CPV is a pattern of violence and abuse from a child to a parent.

Name	Relationship to Elaine	Relationship to Aiden
Elaine	n/a	Aunt
Aiden	Nephew	n/a
Luke	Husband	Uncle
Isabel	Mother	n/a
Charles	Father	n/a
Hazel	Mother-in-law	Grandmother
Rachel	Former Sister-in-law	Mother
Jacob	Brother-in-law	Father
Mia	n/a	Former partner
Child A	Child	Cousin
Child B	Great nibling	Child

1.1.8 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Lambeth Partnership – commissioned this DHR. Having received notification from the Metropolitan Police Service (MPS) in late April 2018, a decision was made to conduct a DHR in consultation with the Safer Lambeth Partnership Co-Chairs and the Chairs of the Lambeth Safeguarding Adults Board (LSAB) and Lambeth Safeguarding Children Partnership (LSCP). Subsequently, the Home Office was notified of the decision in writing in May 2018.

1.1.9 Standing Together Against Domestic Violence (STADV) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in June 2018. The completed report was handed to the Safer Lambeth Partnership in November 2019. In February 2020, it was tabled at a meeting of the Safer Lambeth Executive and signed off, before being submitted to the Home Office Quality Assurance Panel in April 2020. In August 2020, the completed report was considered by the Home Office Quality Assurance Panel. In September 2020, the Safer Lambeth Partnership received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2 Contributors to the Review

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

1.2.2 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. This included both Elaine and Aiden, but also Aiden's mother (Rachel) and his former partner (Mia) and Child B, given reports of other domestic abuse incidents. A total of 28 agencies were contacted to check for involvement with the parties concerned with this Review. Of these: five agencies had limited contact and submitted a Summary of

Engagement; four agencies submitted Short Reports due to the brevity of their involvement; and 10 agencies were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.2.1 The following agencies made contributions to this DHR:

Agency	Contribution
Clapham Family Practice (which took over Dr Santamaria's Medical Practice on 1st July 2018) – General Practitioner (GP) for Aiden from August 2016 until April 2018)[5]	IMR and Chronology (with support from the Lambeth Clinical Commissioning Group, CCG)
Guys and St Thomas Hospital NHS Foundation Trust (GSTT) / Evelina London – provider of children's health services	Short Report
Hetherington Group Practice – GP for Aiden prior to August 2016 and from April 2018	IMR and Chronology (with support from the Lambeth CCG)
Kings College Hospital NHS Foundation Trust (KCH)	Short Report
MPS	IMR and Chronology / addendum relating to the 31st March 2019
Refuge[6]	Summary of Engagement
South London and Maudsley NHS Foundation Trust (SLaM) - Mental Health	IMR and Chronology
Victim Support	Summary of Engagement
Surrey Police	Short Report

1.2.2 Agencies in other areas also contributed to this DHR:

Lewisham

Agency	Contribution
Harris Academy Beckenham	Summary of Engagement
Lewisham and Greenwich NHS Trust (LGT) – Health visiting services	IMR and Chronology
Lewisham Council – Children's Social Care	IMR and Chronology

[5] Dr Santamaria's Medical Practice was a comprised of only one GP partner. The practice closed with their Dr Santamaria's retirement prior to this DHR commencing. The patient list (which included Aiden) was transferred to the Clapham Family Practice, which has cooperated with the Lambeth CCG to prepare an IMR. In the chronology itself, reference is made to Dr Santamaria's Medical Practice although the analysis addresses the Clapham Family Practice.

[6] This related to contact with Refuge services provided in areas outside Lambeth.

Lewisham Council – Youth Offending Service (YOS)[7]	IMR and Chronology
Lewisham Council – Single Homeless Intervention and Prevention (SHIP)[8] Service	IMR and Chronology

Buckinghamshire

Agency	Contribution
Buckinghamshire Children's Social Care	Summary of Engagement
Buckinghamshire Healthcare Trust – Hospital / community nursing	Summary of Engagement
Medical Centre – GP for Elaine[9]	IMR and Chronology
Oxford Health NHS Foundation Trust – Mental Health	IMR and Chronology
Local Authority District Council – Housing[10]	Short Report

1.2.3 *Independence and Quality of IMRs*: The IMRs and Short Reports were written by authors independent of case management or delivery of the service concerned. They were largely of good standard and enabled the Review Panel to analyse the contact with Elaine and/or Aiden, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. This included asking the MPS to provide an addendum to their IMR, expanding on their contact with Aiden on the 31st March 2019. This was because Aiden's mother (Rachel) told the chair that her family had provided information about Aiden's mental health to the MPS on this date.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Agency	Role	Agency
Alice Wu	Clinical Adult Safeguarding Lead	Lambeth CCG
Angela Middleton	Patient Safety Lead, Mental Health	NHS England (NHSE)
Charlene Noel	Violence against Women and Girls (VAWG) Programme and Strategy Manager	Lewisham Council Community Safety / Link to local CSP

[7] Works with the community and local agencies such as the police and schools, to help keep young people aged 10-17 out of trouble. For more information, go to the Lewisham Youth Offending Service page.

[8] Responsible for preventing homelessness and placing vulnerable single homeless people with support needs into supported accommodation. For more information, go to the LB Lewisham - Single Homeless Intervention and Prevention Team page.

[9] The Medical Centre is not identified to enhance anonymity.

[10] The local authority is not identified to enhance anonymity.

David Rowley	Adult Safeguarding Lead	Lambeth CCG
Elaine Rumble	Head of Nursing Quality Lambeth	Mental Health (SLaM)
Eleanor Hargadon-Lowe	Child Protection Conference Chair	Lewisham Council Children's Social Care
Ella Pollock	Senior VAWG Project Officer	Lambeth Council Integrated Children's Commissioning and Community Safety
Graeme Gwyn	Review Officer	Metropolitan Police Specialist Crime Review Group (SCRG)
Matthew Edom	Area Manager, South West London	Community Rehabilitation Company
Mick Collins	Borough Lead	Lambeth Addictions (SLaM)
Moira McGrath	Director of Integrated Commissioning	Lambeth CCG
Naeema Sarkar	Assistant Director (Quality Assurance)	Lambeth Council Children's Services
Rachel Nicholas[11]	Head of Service – Domestic Abuse	Victim Support
Richard Sparkes	Assistant Director	Lambeth Council Adult Social Care
Rose Parker[12]	VAWG Programme and Commissioning Manager	Lambeth Council Integrated Children's Commissioning and Community Safety
[redacted]	Community Safety Team Leader	Local Authority District Council in Buckinghamshire / Link to local CSP[13]
Sharon Erdman	Head of Operations	Refuge
Sophie Bartle	Contracts & Partnerships Manager – South West Area	Community Rehabilitation Company

1.3.2 Surrey Police participated electronically but a representative (Jane Lord, the manager of the Surrey & Sussex Crime Review Team) attended the final Review Panel meeting.

[11] Succeeded Hannah Norgate on the Review Panel in October 2019.

[12] Succeeded Sophie Taylor on the Review Panel in July 2019.

[13] The local authority name, and that of the local representative, are not identified to enhance anonymity.

1.3.3 Black Thrive[14] acted as a critical friend and provided comment and feedback on the report during drafting[15]. The chair and Review Panel are grateful for their time and input. Black Thrive has in particular, provided feedback that has helped shape this report in relation to both the experience of Aiden as a young, Black Caribbean man and his access to mental health services. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge in the course of a DHR.

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

1.3.5 The Review Panel met a total of four times, and the first meeting was on the 19th September 2018. There were further meetings on the 19th January 2019, the 5th April 2019 and the 3rd July 2019. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft by email during September and signing off the final report in November 2019. Following feedback from the Home Office Quality Assurance Panel, the Review Panel also commented on and then agreed revisions to the final report by email in October and November 2020 (this is discussed fully in section five of the Overview Report).

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

1.4 Chair of the DHR and Author of the Overview Report

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

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

1.4.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.4.4 *Independence:* James has chaired one previous DHR in Lambeth. However, he has no other current connection with the local area or any of the agencies involved. James has had some contact with

[14] Black Thrive operates in Lambeth and is working to reduce mental health inequalities and improve support for Black communities and service users in relation to mental wellbeing. For more information, go to the black thrive website.

[15] The Safer Lambeth Partnership facilitated the approach to Black Thrive. It was agreed that Black Thrive would act as a 'critical friend' (rather than joining the Review Panel) given the organisation's capacity and the time commitment associated with Review Panel membership.

Lambeth prior to 2013 in a former role, when he was a Multi Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)[16]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the subjects of the DHR, and as a result, established that the time period to be reviewed would be from 1st January 2016 (the year Elaine moved to London and began living at the same property as Aiden) to the date of the homicide (in mid-April 2018). The Review Panel also agreed to consider contact/involvement with Aiden from 2011 (when he first came into contact with services). Where there was agency involvement with any subject prior to these dates, agencies were asked to summarise this, and review any issues pertinent to the DHR.

1.5.2 Additionally, because there were reported incidents of domestic violence and abuse by Aiden involving Aiden's mother (Rachel) and former partner (Mia), the Review Panel sought to identify any relevant information about these contacts.

1.5.3 It was established that both the Elaine and Aiden had contact with agencies in other parts of the country, including Buckinghamshire, the London Borough of Lewisham (hereafter 'Lewisham') and Surrey. Information and / or participation from agencies in these areas was secured during the course of the DHR (see sections 1.2.2 above).

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

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

[16] For more information, go to the SafeLives website.

- Specific consideration to the following issues: AFV; Substance Misuse; Mental Health; and Youth Crime and Child Criminal Exploitation[17,18]; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.6 Summary of Chronology

Elaine

1.6.1 Elaine had contact with a number of agencies in Buckinghamshire between 2014 and 2016. Her contact with all of these agencies had been concluded for some years by the time of her death. The Review Panel concluded that there was no evidence to indicate that any of this contact had any bearing on the homicide. It was agreed that it was neither appropriate nor proportionate to include specific details of this contact in the DHR.

1.6.2 While Elaine's parents (Isabel and Charles) understood and agreed with this decision, they felt that this might mean it was hard to 'hear' and 'see' Elaine as part of this DHR. To help address this, extracts from both a Victim Impact Statement, as well as the Eulogy that Isabel and Charles read at Elaine's funeral, have been included at the beginning of the Overview Report. This Executive Summary begins with some lines from a poem that Isabel and Charles included in the Eulogy.

Aiden

1.6.3 Aiden had contact with a range of agencies. This included contact with the police because of periods when he was missing from home, and later in relation to reports of carrying and supplying drugs. This contact was with both the MPS and, from 2013, Surrey Police. These reports began in 2011 (when he was 15/16) and continued until 2014 (when he was aged 18/19).

1.6.4 From 2011, Aiden also came to the attention of Lewisham Council – Children's Social Care in relation to concerns about the periods he was missing from home, as well as charges relating to drug supply and assault. In 2011, because Aiden had been bailed to Lambeth, Lewisham Council – Children's Social Care referred his case to Lambeth Council - Children's Social Care. There is no evidence that there was any consideration of the length of Aiden's bail or record of the outcomes of the referral. Furthermore, Lambeth Council – Children's Social Care has no records of a referral being received.

1.6.5 Although the assault charge was discontinued, Aiden was sentenced in relation to drug supply. He was ordered to engage with Lewisham Council – YOS and, during this time, he was deemed to be compliant and no issues were identified with his engagement. However, at the same time, Aiden was

[17] At the start of the DHR, the Review Panel identified included 'Youth Crime' in the Terms of Reference because of contact with Aiden in relation to youth offending. During the course of the DHR, the Review Panel agreed to amend this to 'Youth Crime and Child Criminal Exploitation' because there were periods when Aiden was missing from home, as well as contact with the MPS relating to the carrying or supply of drugs, largely when he was under the age of 18. The Review Panel therefore felt was appropriate to consider the potential of Child Criminal Exploitation.

[18] HM Government defines Child Criminal Exploitation as occurring where "*occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology*". For more information, visit the GOV.UK page, Criminal exploitation of children and vulnerable adults: county lines.

frequently coming to the attention of the police. Because there were no processes in place to share this information (as he was not charged with any new offences), this information was not known to YOS.

1.6.6 In 2013, Lambeth Council – Children's Social Care received a police notification relating to Aiden but took no further action.

1.6.7 Aiden also presented to the Lewisham Council – SHIP Service. He said he was living with friends because his mother (Rachel) had excluded him from her home after an argument. Although SHIP identified that an assessment was required, a considerable delay meant that by the time Aiden's application was processed, he had made alternative arrangements. During this time, it is unknown where he was staying.

1.6.8 The MPS, Surrey Police, both Children Social Care departments, YOS and SHIP have all acknowledged that their practice with Aiden was not joined up and was insufficient. Since the period when Aiden was in contact with services (during which he was for the most part under 18 and therefore still a child), there is an acknowledgement that there should have been a more robust assessment of his risks and needs. This should have included considering whether he was at risk of Child Criminal Exploitation. All of these agencies have described changes to policy and practice since this contact which would have enabled more robust information sharing and assessment of need. As a result, the Review Panel did not make further recommendations.

1.6.9 Aiden also came to the attention of the MPS in relation to reports of violence and abuse, including incidents involving his mother (Rachel) and then partner (Mia). These contacts are discussed below with reference to Rachel and Mia respectively.

1.6.10 Aiden had a range of contact with health services, including two different general practices. This contact was often related to other physical issues, but significantly some contacts involved disclosures relating to his anger, relationship and use of cannabis, as well as his mental health. Broadly, these issues were addressed appropriately in individual consultations. However, each response was specific to a particular consultation and there was not any broader consideration which brought these issues together, particularly in relation to the possible risk of domestic violence and abuse. The Review Panel has not made recommendations in relation to these issues as the local CCG is already progressing actions in relation to GP awareness and response as a result of a previous DHR.

1.6.11 In relation to Aiden's mental health, Aiden had contact with GPs, the MPS and SLaM.

1.6.12 Considering GP contact, the Review Panel has identified that there is a lack of awareness of mental health referral pathways in Lambeth, with two different GPs making referrals outside of the recommended route. One of these referrals was 'lost' and the GP in question did not follow up with Aiden about whether he had accessed mental health services. While the second referral was mis-directed, it did trigger an assessment by SLaM. Recommendations have been made to the CCG to ensure professionals are aware of the local mental health referral pathway.

1.6.13 The MPS also had contact with Aiden in March 2018, shortly before Elaine's homicide. Significantly, during this contact, his family shared their concerns about Aiden's mental health. Aiden was seen by

a Health Care Practitioner (HCP) when he was in custody, but it is unclear whether his family's concerns where shared. As a result, a vulnerability assessment was not completed. Although a recommendation has not been made, this issue is discussed further in the analysis.

1.6.14 Concerning Aiden's contact with the police, the Review Panel has recognised that as a young, Black Caribbean man, he may have faced personal and / or structural barriers or discrimination. This possibility is evident given his mother's (Rachel) expressed distrust of the police, as well as his early experiences of being stopped and searched, and during his last contact with the MPS in March 2018. However, the Review Panel did not feel it was able to make any specific finding(s) or recommendation(s) about these considerations (the rationale for this is set out in section five of the Overview Report). Instead, it endorsed a single agency recommendation made by the Safer Lambeth Partnership, which will use the learning from this DHR to work with the MPS to identify how to improve relationships between Black communities and the police.

1.6.15 Finally, Aiden attended an assessment with SLaM before the homicide. While the assessment was arranged promptly, the Review Panel (and to its credit, SLaM) has identified significant weaknesses in the response. This included issues relating to Aiden and his family (there was a limited family history taken, his father was asked about possible risk in front of Aiden and there was no information provided to Aiden's father about care) and with the assessment itself (this was not recorded properly, and it was not clear which team in SLaM was responsible for Aiden's case). SLaM has made a number of recommendations to address these issues, which the Review Panel has accepted. The Review Panel has also considered Aiden's experience of this assessment, including with reference to wider health inequalities experienced by people of Black Caribbean descent. A recommendation has been made to consider the learning from this case as a result.

Rachel

1.6.16 Rachel reported two incidents to the MPS but told the chair that she called the police to manage a specific issue at the time and did not experience any violence and abuse from Aiden. During the course of the DHR, the Review Panel determined that it was not able to reach a conclusion on this matter and could therefore not consider it further.

1.6.17 However, Rachel did identify the significance of the contact by the MPS with Aiden relating to mental health shortly before the homicide. This has been discussed above.

Mia

1.6.18 Mia was Aiden's former partner. They have a child together. During their relationship, Mia had contact with GSTT Health Visiting and LGT. It is positive that GSTT was able to demonstrate that they undertook routine enquiry about domestic violence and abuse with Mia (who did not make any disclosures). However, while LGT considered making an enquiry, they did not do so. While this was a reasonable decision (Mia was in the company of a friend), practice at the time meant there was no follow up and therefore no way to ask at a future date. Since this time the clinical supervision form in LGT has been changed to monitor how incidents like this are followed up. That would mean that, in similar circumstances, a further contact attempt would be made in order to safely enquire about domestic abuse. The Review Panel accepted this and made no further recommendations.

1.6.19 There were a number of other contacts where the response from the MPS was inadequate. This included issues with the quality of risk assessment in contact with Mia, as well as the timeliness of the MPS response both to Mia as a victim and in pursuing Aiden as an alleged perpetrator. Recommendations have been made to address these issues.

1.6.20 Lewisham Council – Children's Social Care has also acknowledged that its contact with Mia (when it received information about a serious incident of domestic violence and abuse) should have triggered an assessment. Lewisham Council – Children's Social Care have described changes to policy and practice since this contact which would have enabled more robust information sharing and assessment of need. This includes having an Independent Domestic Violence Advisor (IDVA) in the boroughs Multi-Agency Safeguarding Hub (MASH)[19]. This is good practice, as it ensures there is specialist, independent expertise around domestic violence and abuse during this process. As a result, the Review Panel did not make further recommendations.

Analysis

1.6.21 Elaine was the victim of a fatal act of domestic homicide, with this perpetrated by her nephew, Aiden. It occurred when Elaine (in the company of her husband, Luke) had returned briefly to London, where they had been living before returning to Buckinghamshire. In this context, Elaine's homicide can be understood as a fatal case of AFV. However, beyond this fatal act, this DHR has not identified any previous history of domestic violence and abuse by Aiden towards Elaine. While Elaine and Aiden lived in the same house between 2016 and 2018, there are no reports of any ongoing violence, abuse or coercive control by Aiden towards Elaine.

1.6.22 As a result, it does not appear therefore that any professional or agency had grounds to suspect that Elaine was at risk from Aiden. However, the Review Panel felt it was appropriate to consider whether existing processes would have identified and considered the potential for risk to Elaine, particularly as she shared a home with Aiden. This is described more fully in the Overview Report.

1.6.23 While Elaine does not appear to have experienced any violence, abuse or coercive control by Aiden, the Review Panel considered reported incidents of Aiden being previously violent towards women, including Aiden's mother (Rachel) and former partner (Mia). During the course of the DHR, the Review Panel determined that it was not able to reach a conclusion in relation to reports of violence and abuse towards Rachel, but concluded Aiden was violent and abusive towards Mia. The Review Panel has considered these reports, including both how they were managed by agencies at the time and broader learning, and this is described more fully in the Overview Report.

1.7 Conclusions and key issues arising from this DHR

1.7.1 This DHR was triggered by the homicide of Elaine, an action for which Aiden has been convicted of manslaughter. Elaine's death was a tragedy. The extracts from the Witness Impact Statement and Eulogy, re-produced with the permission of her family at the start of the Overview Report, are

[19] For more information, visit the Lewisham Multi-agency Safeguarding Hub (MASH).

testament to both her life and the impact her death. Yet the same extracts also offer an account of Elaine as a person: someone described by her family as "*responsible, generous, ambitious career minded and independent*", as having a beautiful smile and whose child "*meant everything to her*". Her commitment to her child is evidenced by her determination to get a job closer to home after having to move from Buckinghamshire to London for work. That she had secured such a role shortly before her death, enabling her to return to Buckinghamshire as she had hoped, is heart-breaking.

1.7.2 In undertaking this DHR, the Review Panel has looked beyond contact with Elaine alone and has also considered the experience of Rachel and Mia. This has broadened the scope of the DHR and has drawn attention to some of Aiden's other behaviours, and in doing so has brought the role of different agencies into focus.

1.7.3 While the Review Panel agreed to broaden the scope of the DHR, and has considered Aiden's history, it is beyond its purview to address in full his experiences. However, this DHR has noted that during Aiden's adolescence possible Child Criminal Exploitation was not considered and, despite being a child, agencies appeared to have often treated him as an adult. This is not to suggest that these experiences caused his subsequent actions, nor to minimise his responsibility for the killing of Elaine. However, recognising Aiden's experiences is a salutary reminder of the importance and opportunity of early intervention, as well as our shared responsibilities to children and young people.

1.7.4 More broadly, during this DHR, there has been significant learning identified that the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.

1.7.5 The Review Panel would like to acknowledge that some of the questions that Elaine's family have asked, such as why Elaine was targeted by Aiden, remain unanswered. The Review Panel also recognises that Elaine's family have expressed their deep disappointment about the police investigation and the criminal trial outcome. When they reviewed the final report, Elaine's parents (Isabel and Charles) wanted to reiterate their feelings. They have felt, and continue to feel, "*hurt, anger, concern, shock and trauma*". While the Review Panel can neither resolve nor comment on these matters, it can at least provide witness to them and the ongoing impact on Elaine's family.

1.7.6 Finally, the Review Panel is mindful of the impact of this homicide on both Child A and Child B. Child A will tragically grow up without their mother, while Child B's father has been convicted of manslaughter. The Review Panel sadly is unable itself to address this impact, but it has made recommendations for the Safer Lambeth Partnership to take appropriate steps to ensure that Child A and B (and their families) have access to support, including in relation to the publication of this DHR.

1.7.7 The Review Panel extends its sympathy to all those affected by Elaine's death and thanks all those who have participated in the DHR for their contribution.

1.8 Lessons to be learnt

1.8.1 In describing the lessons to be learnt from this DHR, it is important to note that it appears that no single agency's contact could have prevented Elaine's homicide. Nonetheless, this DHR has identified learning that can be grouped across four areas:

1.8.2 The first area relates to health responses. In relation to GPs this concerns the identification of domestic violence and abuse and risk to others. While GP practice was medically appropriate in relation to specific issues, contacts were often approached in isolation. As a result, Aiden's disclosure of anger issues was not explored across appointments, and connections were not made between this disclosure and other issues that might have triggered consideration of domestic violence and abuse. Similarly, while risk to others was considered in some contacts, this was often done in a narrow fashion. Indeed, it is likely that the question of whether there might have been risk to Elaine may not have even been explored if professionals had identified concerns about risks to others. The Review Panel felt that this was because professional understanding is more likely to consider IPV than other forms of domestic violence and abuse like AFV (or CPV).

1.8.3 With reference to mental health, there has been a range of learning.

1.8.4 In terms of local pathways, the local CCG must take note of the lack of awareness of referral routes to its local front door for mental health (the 'Living Well Network Hub'). A front door is meant to simplify referral routes and increase consistency of response. It clearly cannot do this if professionals do not know it exists.

1.8.5 The Review Panel has also identified that there was a missed opportunity by the MPS to consider a vulnerability assessment during contact with Aiden on the 31st March 2019. It is not possible to say whether this would have averted the homicide of Elaine, but it could have triggered a Merlin ACN (Adult Come to Notice)[20] which may have led to earlier contact by mental health services.

1.8.6 More significantly, there has been substantive learning for SLaM around the conduct and recording of its single interaction with Aiden a few days before the homicide. While there were positives around this contact (including timeliness once the referral had been made, and a plan for a home visit), its actual conduct was lacking. It is welcome therefore that SLaM has identified a range of local and trust wide recommendations as a result. The Review Panel has also considered Aiden's encounter with SLaM and noted the wider context of inequalities in relation to mental health and wellbeing for people of Caribbean descent locally. A recommendation has been made in relation to this issue.

1.8.7 The second area relates to the MPS and their response to domestic violence and abuse. There were a number of contacts where the response from the MPS was inadequate. This included issues with the quality of risk assessment in contact with Mia, as well as the timeliness of the MPS response to both Mia as a victim and in pursing Aiden as an alleged perpetrator. The Review Panel has been made aware of a number of significant change programmes in the MPS that will hopefully prevent these issues occurring in the future, nonetheless recommendations have been made to seek assurance that this is so. In this context, the Review Panel also considered whether Aiden may have faced personal and / or structural barriers or discrimination in his contact with the police. This reflected Aidan's mother's expression of distrust in the police in their treatment of young Black men, as well as the broader context (e.g., the well documented concerns about the disproportionate use

[20] A Merlin ACN should be completed by police officers when they encounter a vulnerable adult AND there is a concern of vulnerability AND There is a risk of harm to that person or another person.

of Stop and Search against Black People). While the Review Panel felt it could not make any specific finding(s) or recommendation(s), for reasons explained in section five of the Overview Report, it endorsed a single agency recommendation made by the Safer Lambeth Partnership. This means the Safer Lambeth Partnership will use the learning from this DHR to work with the MPS to identify how to improve relationships between Black communities and the police.

1.8.8 The third area relates to the identification and response to concerns about young people, particularly where there are issues around them being missing, as well as possible Child Criminal Exploitation. Without seeking to minimise Aiden's actions, the Review Panel also felt it appropriate to note that, as a child, he had periods of going missing, was potentially at risk of Child Criminal Exploitation, and had extensive contact with a number of different agencies. In relation to much of this contact, the Review Panel felt that Aiden was seen and treated as an adult, despite being under the age of 18 and therefore still a child until 2014.

1.8.9 The Review Panel has received assurances that practice across a range of agencies has significantly changed since the contact with Aiden in this context. While accepting these assurances, the Review Panel has made a recommendation that Lambeth and Lewisham LSCPs receive this report and consider its findings.

1.8.10 Finally, the Review Panel has – as discussed in the conclusion above – wrestled with issues of definition, particularly around different types of domestic violence and abuse including IPV, AFV and CPV. The Review Panel felt its own struggles with definition and understanding were likely reflective of wider professional understanding in this area. As a result, while there is work ongoing in Lambeth, recommendations have been made for the wider partnership to look at the local response to these issues and develop it for the future. The Review Panel has also recommended the HM Government plays its part in supporting learning in this area.

1.8.11 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Fortunately, Lambeth has a well-developed VAWG strategy. Many of the recommendations made in this review will build on, or add to, the initiatives that are already underway to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

1.9 Single Agency Recommendations:

1.9.1 The following single agency recommendations were made by the agencies in their IMRs:

MPS

1.9.2 It is recommended that South East Basic Command Unit (BCU) Senior Leadership Team (SLT) review systems in place for offender management and the Emerald Warrants Management System (EWMS) as the new BCU forms and goes forward.

Hetherington Group Practice

1.9.3 The Practice Domestic Abuse policy needs to be amended to include how the practice will respond if a perpetrator discloses or is registered with the practice, as well as clarifying details of the Practice Domestic Abuse Lead, the local referral pathway and Domestic Abuse training resources.

Safer Lambeth Partnership

1.9.4 To use the learning from this DHR, as well as other local and national research, to work with the MPS to identify how to improve relationships between Black communities and the police.

SLaM - *Local recommendations*

1.9.5 (LEO) Community Mental Health Team (CMHT)[21] to develop a local protocol to state that once an initial assessment has been done, the outcome of the assessment should be discussed at the next MDT meeting and any plans put in place to address the key issues relevant to risk.

1.9.6 LEO CMHT to develop a protocol to state that relatives and patients are to be given a copy of the treatment care plan on the day of the assessment including crisis contact details.

1.9.7 The LEO CMHT induction package to highlight how to access medical members of the team for advice.

1.9.8 LEO CMHT to develop a consistent approach and framework for conducting assessments including consideration of collateral sources of information.

Trust wide recommendations

1.9.9 A Trust-wide piece of work to be done to share the learning from other domestic homicide cases that have taken place in the Trust.

1.9.10 The Trust should assure itself that all practitioners are sufficiently aware of the need for domestic abuse routine enquiry as part of full needs and risk assessment. The Think Family approach demonstrates that this should not solely focus on service user's vulnerability, but also carers and other family members, if relevant. Staff should also consider the needs of male victims of domestic abuse.

1.9.11 The Trust should assure itself that staff are aware of the MARAC referral processes, local borough arrangements and the standards expected when there are high risk domestic abuse concerns.

1.10 Multi Agency Recommendations:

1.10.1 The Review Panel has made the following recommendations as part of the DHR:

1.10.2 **Recommendation 1:** The Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and satisfy itself that Child A and Child B (as well as their families) are in receipt of trauma informed support to cope with both the aftermath of the homicide and the publication of the DHR.

[21] The LEO Team a specialist team to help people living in Lambeth who are experiencing psychosis for the first time. For more information, go to: the Slam NHS website.

1.10.3 **Recommendation 2:** After publication of this DHR, the Safer Lambeth Partnership should liaise with Buckinghamshire and Lewisham Children's Social Care respectively and ensure that this report is attached to Child A and Child B's records. This is so that, if they wish to read the DHR when they are older, it will be available to them.

1.10.4 **Recommendation 3:** The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV. This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance.

1.10.5 **Recommendation 4:** The Lambeth CCG to further promote the Living Well Network Hub to ensure that all GPs are aware that mental health referrals should be made via this route.

1.10.6 **Recommendation 5:** The MPS to undertake a training needs assessment to identify the skills and training that police officers require to respond to AFV/CPV.

1.10.7 **Recommendation 6:** The MPS to audit the 'Strengthening Local Policing' programme' to ensure it enables a consistent and robust process for the supervision all of domestic abuse incidents / crimes.

1.10.8 **Recommendation 7:** The MPS to identify the root cause of the delay in the response to Mia's report and ensure that this is addressed in its IT 'Changes Project' in order that such excessive delays cannot occur in the future.

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

1.10.10 **Recommendation 9:** Lambeth Together[22] to consider the learning from this DHR in relation to meeting the needs of local communities, including the provision of culturally appropriate services, a diverse workforce and creating opportunities to build trust with communities.

1.10.11 **Recommendation 10:** The Safer Lambeth Partnership to share this DHR with the Lambeth and Lewisham LSCPs with the expectation that they consider the findings in relation to contact with Aiden.

[22] Lambeth Together is run by a single management group called the Strategic Alliance. The Strategic Alliance leads, coordinates and manages health and social care in Lambeth as a single joined-up system with one budget. For more information, go to Lambeth Together.