



SAFER LAMBETH PARTNERSHIP DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the murder of Isabella

December 2020

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Abuse

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Dedication from Isabella's mother

Isabella was my first daughter out of four. She was a loving and caring person, not only to her family but to strangers. After she passed her friends met two homeless people who told them Isabella gave them money whenever she saw them. Isabella was compassionate and empathetic, exactly like me and the way I raised her to be.

Isabella was a birthday person, it did not matter whose birthday it was she would take charge of the cake and the party planning.

Isabella loved cake. Isabella loved cats. Isabella loved people. Isabella loved her friends. Isabella loved her family and we loved her.

Isabella has three younger siblings. I miss the Fridays when they would all get together at my flat when I would cook for them. We would fall asleep together and talk about our lives. Our lives are so different now. I do not know from day to day, minute to minute how I will feel or how they will feel and Friday nights no longer exist.

What happened to Isabella has devastated us. It has affected me tremendously in all aspects of my life, not least my mental and physical health which has deteriorated significantly since Isabella's death.

The disappointment in the events that led to this tragedy and the way this has affected us is unexplainable by words. I do not believe we will ever get over the way that Isabella was taken from us. We have a lot of anger concerning what surrounded her death and the agencies that could have helped her. It was unfair to expect my daughter to take on the responsibilities that she was handling every day. Isabella loved someone who took her from us.

I had to attend court every day which was scary and I cried all the time. I had no inclination of what I would be facing and the things that I had to hear that my daughter went through I will never forget.

It has never just been about me, the loss of Isabella has been so vast and felt by many. It hurts me knowing that my other daughters have to grow up without her and that Isabella's only niece has to grow up not knowing her as she was only four months old when she passed.

I would never wish this on any other family, all I have in my head are numbers. Isabella was 26 years old. Isabella was stabbed 96 times. How are we supposed to deal with or even understand this loss when such a kind and loving person has been taken from us? I would not wish this kind of grief and pain even on a fly.

I would be out marching if I could against domestic abuse, as I know Isabella would have too if she was able to. Things need to change.

We think about her every day and not a day goes past that we do not talk about her or think about her. Isabella will be missed by everyone that knew her and even those that did not get the chance to meet her.

Thoughts of Isabella's friends

She was a lovely person, with a heart of gold. Everything she done was out of love. Isabella liked music and I remember her playing old reggae when she was cooking on a Sunday.

Isabella was a loving friend. Isabella adored children and adored animals and cats. She had a warm heart. She was quiet and shy, she did not like attention. She kept herself to herself always avoided bad company.

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Executive Summary

1. Preface

1.1 The Review Process

- 1.1.1 This summary outlines the process undertaken by the Safer Lambeth Partnership Domestic Homicide Review (DHR) panel in reviewing the homicide of Isabella, who was a resident in their area.
- 1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

The Principal People Referred to in this Report						
Referred to in report as	Relationship to the victim	Age at time of victim's murder	Ethnic Origin	Faith	Nationality & Immigration Status	Disability
Isabella	Victim	26	Black British (Caribbean)	N/K	N/A	N/K
Luke	Partner/ Perpetrator	27	Black British	N/K	N/A	N/K
Martin	Victim's Ex-Partner	31	Black British	N/K	N/A	N/K
Susan	Mother	N/A	Black Caribbean (Grenada)	N/K	N/A	N/K
Lauren	Sister	22	Black British (Caribbean)	N/K	N/A	N/K

- 1.1.3 Criminal proceedings were completed in May 2022. Luke pleaded not guilty to murder but was found guilty of murder in a unanimous decision. He was sentenced to life imprisonment, to serve a minimum of 15 years.
- 1.1.4 This Domestic Homicide Review was commissioned by the Safer Lambeth Partnership. Having received notification from the Metropolitan Police Service, a decision was made

to conduct a review. Subsequently, the Home Office was notified of the decision in writing on 28 January 2021.¹

- 1.1.5 All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records.

1.2 Contributors to the Review

- 1.2.1 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 23 agencies were contacted to check for involvement with the parties concerned in this DHR. Of these, two had only limited contact and submitted a Summary of Engagement (SoE) or a Short Report. However, 15 agencies had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared. Late in the DHR, enquiries revealed that the CPS may have been able to assist the review regarding a prosecution of Luke in September 2020. A report was requested to cover questions raised by the panel.
- 1.2.2 The following agencies and their contributions to this Review are:

Agency	Contribution
Certitude London	IMR and Chronology
Crown Prosecution Service	Short Report only
General Practitioner – IMR by Lambeth and Lewisham Named Adult Safeguarding GP	IMR and Chronology
Kings College Hospital NHS Foundation Trust	IMR and Chronology
Lambeth and Southwark Housing Association	IMR and Chronology
London Ambulance Service	IMR and Chronology
London Borough of Lambeth – Adult Social Care	IMR and Chronology
London Borough of Lambeth – Housing Services	IMR and Chronology
London Borough of Lambeth – Revenues and Benefits	IMR and Chronology

¹ In May 2024 the term DHR was amended by act of Parliament to “Domestic Abuse Related Death Review”. It was considered that this report should remain a DHR, as the victim’s family have been provided with all written support and advice using the term DHR. It should be noted that this review is clearly focused on a case of homicide.

Metropolitan Police Service	IMR and Chronology
National Probation Service	IMR and Chronology
Refuge – The Gaia Centre	IMR and Chronology
Refuge – National Domestic Abuse Helpline (NDAH)	IMR and Chronology
The Riverside Group – Housing for Luke	IMR and Chronology
South London and Maudsley NHS Foundation Trust	IMR and Chronology
Thames Reach Rapid Response Team (RRT), Croydon Reach, Lambeth Outreach	IMR and Chronology

- 1.2.3 Independence of IMRs: All IMRs, except for that covering Isabella's GP, were written by authors independent of case management or delivery of the service concerned. The ICB IMR on Isabella was not independent because the author had very brief contact with Isabella, but this was only identified after the IMR had been completed. There were no concerns from the panel that this had affected the findings of the IMR. The IMR author for Certitude was present at the premises when Luke was resident. The Certitude IMR was requested very late in the process and the organisation could not offer an independent author, the Chair balanced the panel's requirement for essential information against independence and requested an IMR to inform the review.

1.3 The Review Panel Members

Name	Job Title	Agency
Bola Abolade	Designated Safeguarding Nurse NHS SE London ICB	NHS South East London Integrated Care Board (ICB)
Rachel Abraham	Croydon Outreach Service Manager	Thames Reach
Justin Armstrong	Independent Review Officer	Metropolitan Police Service (MPS) Specialist Crime Review Group (SCRG)
Pippa Beeston	Head of Lambeth and Wandsworth	National Probation Service (NPS)
Alistair Briggs	House Manager	Certitude London
Allison Carew	Performance manager	Residents Services, London Borough of Lambeth
Julie Carpenter	Safeguarding Specialist,	London Ambulance Service NHS Trust (LAS)

Kimberly Cassius	VAWG Programme and Commissioning Manager,	Safer Communities Team, London Borough of Lambeth
Daniel Comach	Principal Social Worker,	Children and Families, Lambeth Children's Social Care (CSC)
Seamus Costello	Lambeth Borough Lead	Lambeth Addictions Consortium
James Eastaway	Programmes Director, GP & Safeguarding Lead	Minet Practice
Susan Eldred	Safeguarding Adults Team	Kings College London NHS Foundation Trust (KCH)
Alison Ely	Trust wide Named Nurse for Safeguarding Children and Domestic Violence and Abuse Lead	South London and Maudsley NHS Foundation Trust (SLaM)
Michael Fullerton	Safeguarding Adults Lead Nurse	Guy's and St Thomas' NHS Foundation Trust (GSTT)
Jade Holvey	Associate Director	Adults Commissioning, Integrated Health and Adult Care, Lambeth Council and Lambeth ICB
Emma Keegan ²	Chief Executive	Lambeth and Southwark Housing Association
Delisha Louis	Domestic Abuse and Safeguarding Interim Lead	Resident Services London Borough of Lambeth
Clement Lourdusamy	Quality and Assurance Auditor	Children's Social Care (CSC), London Borough of Lambeth
Karasu Mala	Safeguarding Lead	Guys and St Thomas' NHS Foundation Trust (GSTT)
Andrew Meeking	Senior Operations Manager	Victim Support
Angela Middleton	Patient Safety Lead Mental Health, London	NHS England (NHSE) and NHS Improvement (NHSI)
Rachel Nicholas	Domestic Abuse Lead	Victim Support London
Jenni Nykanen	Clinical Service Lead	South London and Maudsley NHS Foundation Trust (SLaM)
Isabella Rossi	Senior Operations Manager	Refuge
David Rowley	Designated Nurse	Adult Safeguarding Lead, Lambeth CCG

² Emma joined the panel in April 2023, LSHA were previously represented by Angela Bailey

Naeema Sarkar	Assistant Director of Quality Assurance,	Lambeth CSC
Alastair Smith-Agbaje	Chief Executive	Lambeth and Southwark Mind
Richard Sparkes	Acting Deputy Director, Adult Social Care	London Borough of Lambeth
Jade Speed	South East Safeguarding Specialist	London Ambulance Service (LAS)
Liz Turner	Director of Business Development and Safeguarding Lead	Riverside Group
Joanna White	Head of Unpaid Work	National Probation Service
Beth Winter	Outreach Services Area Manager	Thames Reach
Alice Wu	Named GP and Adult Safeguarding Lead	Lambeth Integrated Care Board (ICB)
Mark Yexley	Independent Chair	Standing Together Against Domestic Abuse

- 1.3.1 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.
- 1.3.2 The Review Panel met a total of five times, with the first meeting of the Review Panel taking place on the 23 June 2021. There were subsequent meetings on 23 September 2021, 6 December 2021, 27 April 2022, and 26 April 2023.
- 1.3.3 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 withstanding Together. Mark has received Domestic Homicide Review Chair training from Standing Together and has completed the new 2024 Home Office DHR Chair Course. He has chaired and authored 28 DHRs, including joint DHR/Safeguarding Adult Reviews. Mark is a former Detective Chief Inspector with 42 years' experience of dealing with domestic abuse. He was the head of service-wide Strategic and Tactical Intelligence Units combating domestic violence offenders, Head of Cold Case Rape Investigation unit and Partnership Lead 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 England in London and the South East. This work involves independent reviews of NHS services, training and selection for foundation doctors, specialty grades.

- 1.4.2 *Independence:* Mark Yexley has no connection with the London Borough of Lambeth area. Mark was previously employed by the MPS, he was never posted to Lambeth Borough or the Central South BCU. Mark was previously Chair of the Haven Sexual Assault Referral Centre (SARC) Strategic Board whilst serving with the MPS. At that time, the Havens were managed by three individual NHS acute trusts. He has had no connection with the Haven service under the current KCH commissioned arrangement. Mark retired from the police in January 2011.

1.5 Terms of Reference for the Review

- 1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2018 to the date of the murder in December 2020. This timeframe was chosen because it was believed that this would cover the time that Isabella was known to have been in a relationship with Luke. Agencies were asked to summarise any relevant contact they had had with Isabella or Luke outside of these dates. Agencies were asked to pay particular attention to Isabella's previous relationship and known incidents of domestic abuse before she met Luke.
- 1.5.2 Key Lines of Inquiry: The Review Panel considered both the generic issues as set out in the 2016 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 Isabella and Luke [and wider family];
 - The opportunity for agencies to identify and assess domestic abuse risk;
 - Agency responses to any identification of domestic abuse issues;
 - Organisations' access to specialist domestic abuse agencies;
 - The policies, procedures and training available to the agencies involved in domestic abuse issues;
 - Whether Isabella's/Luke's race had an impact on their access to services;
 - Whether Isabella/Luke could have been subject to or experienced any unconscious, and/or conscious bias in their contact with agencies;
 - Whether Luke's mental ill-health had an impact on access to services for either party;
 - Whether the issue of pregnancy could have impacted on access to services;
 - Whether the COVID-19 pandemic had an impact on the service provision; and access to services for Isabella/Luke.

1.5.3 To address specific issues in this case (including in relation to equality and diversity as identified in 1.5), and because of their relevant expertise, the following agencies were invited to take part in the review, even though they had not been previously aware of the individuals involved:

- Black Thrive

1.5.4 Lambeth and Southwark MIND

2. Summary of Chronology

2018

- 2.1.1 In January 2018, Isabella was aged 24 years and had separated from her previous partner Martin. Luke was aged 25 and under the care of South London and Maudsley NHS Foundation Trust (SLaM).
- 2.1.2 Isabella was living with her grandparents in the London Borough of Lambeth. Isabella had been in a relationship with Martin since 2011. She had previously reported domestic abuse by Martin, and he had been convicted of assaulting her in 2015. Following the assault there were a further 15 recorded contacts between Isabella and Martin and the police. These incidents were generally recorded as arguments between Isabella and Martin. In 2017 Martin told the police he had been in an ‘on-off’ relationship with Isabella for around five years. Friends state that Isabella had ended her relationship with Martin in 2018. The last recorded police incident involving Isabella and Martin was in 2019. The Overview Report provides a detailed chronology of those incidents. This report will focus on the relationship between Isabella and Luke and the events leading to her death.
- 2.1.3 Luke was a long-term patient of South London and Maudsley NHS Foundation Trust (SLaM). Luke had first been detained under the Mental Health Act in 2008, when he was 16 years old. He remained in the under the care of SLaM until his arrest for Isabella’s murder. Luke had a diagnosis of ‘unspecified non-organic psychosis’. Luke was receiving regular ‘depot’ injections of an anti-psychotic drug.³ He was living in supported accommodation, in Lambeth. Luke had previously been arrested for violence offences. It should be noted that in 2014 his doctors recorded an impression of “Morbid Jealousy” after he expressed paranoid beliefs that his then girlfriend was cheating on him.
- 2.1.4 **Luke assaulted a male with scissors.** On 17 February 2018 police were called to a residential care home where it was reported that Luke had assaulted a 55-year-old male resident at the hostel and pressed scissors towards a person’s neck. The incident began over a TV sold to Luke by the other resident. Luke was arrested and charged with assault. He pleaded guilty at Magistrates Court and sentenced to a Community Order and financial penalties.
- 2.1.5 **Isabella met Luke in the Summer of 2018** – it is not known exactly when a relationship started.
- 2.1.6 **Luke arrested for damage and threats with hammer at hostel.** On 3 October 2018 at 11:00, Luke attended the Depot Clinic and was seen as “increasingly irritable and argumentative”. He was described as being fixated on the issue of the depot and kept asking what it was as it made him feel drowsy with stomach pains. He refused his depot

³ A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it lasts a lot longer.

injection and was offered an opportunity to review his medication with the consultant. Later, at 12:40, police were called to Luke's hostel. Luke had been seen to smash a mirror with a hammer before banging on the office door and making threats to kill - he was arrested in possession of a hammer. After Luke was taken to a police station, he was examined by the custody nurse. Luke's mental health state was assessed by two doctors and the duty social worker. Luke was placed under s.2 Mental Health Act 1983 (admission for a compulsory assessment). SLAM admitted Luke to Lambeth Hospital. He was subsequently charged with criminal damage and affray. He was given Unpaid Work requirements and financial penalties.

- 2.1.7 **Luke stabbed a patient with a fork.** On 7 October 2018, police were called to Lambeth Hospital, SLAM where Luke had stabbed another patient with a plastic fork. This caused a hole in the victim's clothing and a minor scratch. No arrest was made, and Luke and other patient were moved to separate wards to reduce risk.
- 2.1.8 **Luke not taking medication and making threats.** On 12 December 2018, Luke's supported living accommodation emailed SLAM. It was reported that Luke was not fully complying with his medication and had been walking around with a metal object, threatening to break people's heads if they went to his room. SLAM attempted a home visit the following day. Luke did not engage, and a medical review was arranged.
- 2.1.9 **Luke arrested for criminal damage at hostel.** On 14 December 2018, police were called to Luke's supported living. It was reported that he had kicked and forced open three internal doors of resident's rooms, whilst searching for his girlfriend. Luke was found in his room with his girlfriend. No details were taken of the girlfriend. Luke was arrested and charged with criminal damage.

2019

- 2.1.10 **Isabella's grandmother died in January 2019 and her grandfather died in February 2019.** This resulted in Isabella being made homeless. She lived with family members and friends, she also accessed services for people living on the streets.
- 2.1.11 **Fire at Luke's supported living hostel.** On 14 February 2019, the police were called to a suspected arson in Luke's room. It was reported that Luke had a disagreement with staff. Luke returned to his room and then ran from the premises. A fire was then discovered in Luke's room. Luke was found outside his mother's home. Luke was initially detained under the Mental Health Act and taken to Lambeth Hospital. He was interviewed by police and declined to answer any questions. In the absence of evidence showing the fire was started intentionally the case was closed as NFA.
- 2.1.12 Isabella told a friend that Luke had burned down the hostel because Isabella would not see him on Valentine's Day. Isabella's friends stated that Luke started living with Isabella from this point.
- 2.1.13 In February 2019, Isabella moved in with a female friend in Croydon. Isabella had her own room at the property and Luke stayed over. Isabella stayed with the friend until June 2019.

During this time Isabella was travelling to Lambeth to collect Luke's medication from a pharmacy for him.

- 2.1.14 **Isabella and Luke's engagement.** In March 2019, Isabella and Luke had an engagement party at a hall in Lambeth, which Isabella had hired. Luke invited an ex-girlfriend to the party. Isabella's family said that people disapproved, and only 20 from 100 people invited attended. Isabella's sister recalled *"(Luke) put his whole hand into the cake and ruined it. Isabella was really upset but tried to carry on, as she had worked really hard on everything for the party. Luke saw it as a gathering not an engagement party, did not care about it being an engagement, just saw it as place with food and drink, and a gathering of family friends"*. Family friends noticed there was something "odd" about Luke.
- 2.1.15 **Isabella left friend's home following arguments with Luke.** Isabella was asked to leave her friend's home in Croydon in June 2019. The friend had concerns about the number of arguments at her home between Luke and Isabella. Isabella stayed with her father for a week and was later put up in a hotel.
- 2.1.16 **Luke informed SLaM his girlfriend had been pregnant.** On 18 July 2019 Luke was seen by his consultant psychiatrist. His room was seen as dirty and untidy, and he stated he had run out of money – he said he had given money to his girlfriend. Luke said that his girlfriend had been pregnant but had lost the baby. Luke's dosage of anti-psychotic medication was reduced. Luke later told SLaM staff that his girlfriend had had two miscarriages. It should be noted that the panel found no evidence to support Luke's claim concerning the pregnancy.
- 2.1.17 **Isabella self-referred to SLaM.** In August 2019, Isabella self-referred to SLaM Improving Access to Psychological Therapies (IAPT) for experiencing low mood. She was triaged on the phone and offered appointments of 4 and 18 August 2019. Isabella did not attend, and a letter was sent to her with a copy to her GP informing them of them she did not attend on 28 August 2019.
- 2.1.18 **Isabella self-referred to SLaM.** On 6 October 2019 Isabella self-referred to SLaM IAPT for depression and anger issues. She stated, *"I've been on depression tablets, I was in an abusive relationship I know I take my anger out on my new partner which isn't good at all, I also lost both my grandparents this year and I saw my grandmother pass in front of me which has scarred me for a long while."*
- 2.1.19 **Isabella self-referred to the Gaia Centre, the Lambeth commissioned, domestic abuse service.** On 15 October 2019, Isabella telephoned the Gaia Centre, Refuge to make a self-referral. The case notes state *"The client self-referred to the Gaia Centre to access the group support programme. In her initial contact, the client is recorded to have shared that she had been trying to move on from the perpetrator, but he continued to exercise a "hold over" her. She stated that she used to live with her grandparents, but they have died; her father lives near the perpetrator so she cannot go there. The client explained that she did not feel scared of the perpetrator at this time but was worried that she would return to him. The client explained that she had been referred to SLaM for counselling, was taking anti-depressants and was feeling angry. The client also explained*

that she had sought support from housing and had been advised to look for private rented accommodation. She reported to have been bidding since 2012. She disclosed her needs were around housing and remaining separated from the perpetrator.”

- 2.1.20 The Gaia Centre duty worker tried to contact Isabella by phone without success on 16 and 17 October 2019. Messages were left asking her to call back. On 18 October 2019, the duty worker called and spoke to Isabella. Isabella said she could not speak and said she would call back on 21 October 2019.

- 2.1.21 On 23 October 2019, Isabella contacted the Gaia Centre duty worker stating she was able to complete the initial assessment. It was explained that there was no one available at that time to make the assessment and Isabella was advised to call back. Isabella explained that she was in need of support around her mental health and was expecting a call from IAPT that day. Isabella stated that she was staying at a friend's house but was unable to remain there long term, and Housing Services had advised that she was not priority. The duty worker advised that Isabella look for accommodation on OpenRent and contact the Citizen's Advice Bureau (CAB) for advice on how much housing benefit she would be entitled to. The duty worker explained that a Gaia Centre peer mentor would then be able to assist her to apply for the rent deposit scheme. It was recorded that Isabella would call back for an assessment. This was completed five days later. Isabella was provided with information about the group programme and the number for the Gaia Centre.

- 2.1.22 **Isabella reported previous domestic abuse and previous overdose to Improving Access to Psychological Services (IAPT) (SLaM).** On the same day, Isabella spoke to IAPT for a telephone triage and had a telephone consultation with a trainee psychological well-being counsellor. Isabella reported taking 16 anti-depressants a month prior, not with the intention of suicide but to 'feel numb'. She was living with her cousin, and they were considered as a protective factor. It was noted that Isabella had high levels of risk owing to a past abusive relationship. Isabella stated that she wanted to move on from domestic abuse, referring to her previous partner, stating that her "ex-partner always comes back, I am tied to him". A crisis plan was constructed for Isabella. A letter was sent to Isabella's GP outlining this referral, requesting GP monitor mood in the view of self-harming and to refer to Single Point of Access if mood deteriorated and risk of self-harm increased. IAPT recorded that Isabella agreed to attend anger management and priority counselling sessions.

- 2.1.23 **Luke moved into Riverside supported living.** On 4 November 2019, Riverside recorded Luke's entrance into the service. He signed and agreed terms and conditions.

- 2.1.24 **Luke informed SLaM his girlfriend was three months pregnant.** On 19 November 2019, the SLaM care coordinator attended court with Luke. This was in relation to criminal damage and threats to kill charges from 2018. Luke reported that his girlfriend was three months pregnant.

- 2.1.25 Shortly before Christmas 2019, Isabella's mother, Susan, stated that Isabella asked if Luke could spend Christmas with them. Her mother agreed that he could if he behaved.

Isabella then came to her mother on 24 December 2019 in tears. She said that Luke had argued with her. Isabella told Luke that he needed to bath and change his clothes before he went to her mother's for Christmas, Luke did not want to. Isabella's mother spoke to Luke. Luke was eventually invited to attend on Christmas Day at 13:00. Luke arrived with Isabella at 10:00. Susan said that Luke was desperate for food. The conversation after dinner turned to grandchildren and Susan asked Isabella when she was going to have grandchildren, and Isabella said in a few years, and Susan said, "*not with him*" indicating Luke. Isabella put her head down. Susan recalled by this time Luke was becoming a problem to Isabella, "*there was drama all the time, and arguments*".

2020

- 2.1.26 On 10 January 2020, Luke's consultant psychiatrist emailed clinical colleagues expressing possibility of "Morbid Jealousy" as his girlfriend reported that Luke's jealousy was getting worse. There was no risk assessment found in relation to this comment.
- 2.1.27 **Luke argued with Isabella at Riverside, Isabella commented on his 'demanding behaviour'.** On 3 March 2020, Riverside recorded that Isabella visited Luke. Luke was upset that she had not arrived earlier, and an argument ensued. It was noted that staff diffused the situation. Isabella was very tearful and said that she was fed up with his demanding behaviour. During their heated exchange, Isabella said that she was homeless. She was advised to attend the Civic Centre to get help. She became calmer, and Luke accepted that his behaviour was out of place. Staff monitored the visit for its duration. This incident was not recognised as domestic abuse by Riverside staff at the time.
- 2.1.28 **On 23 March 2020, the Prime Minister announced the first lockdown for the COVID-19 Pandemic, ordering people to stay at home. Lockdown measures came into force on 26 March 2020.⁴**
- 2.1.29 **Isabella reported sleeping rough.** On 8 April 2020, Lambeth Housing conducted a telephone consultation with Isabella. She stated that she had an argument with a friend and was no longer able to stay with her. A full assessment was booked for 9 April 2020. Isabella attended the assessment and reported sleeping rough.
- 2.1.30 **On 16 April 2020, the National Lockdown was extended for a further three weeks.**
- 2.1.31 **Luke caused damage at Riverside.** On 25 April 2020, Luke returned to Riverside and damaged the light fittings. He had also been observed on CCTV pacing up and down the corridor in an agitated state. He was also seen trying to force the fire door open. Luke was asked about his behaviour, and he did not want to talk about it.
- 2.1.32 **Luke reported 'falling out' with his partner to SLAM.** On 6 May 2020, Riverside conducted a face-to-face support review with Luke. Luke was reported as being compliant with medication, but he had noticed side effects. It was noted that he managed medication with his GP. Luke was advised on the state of his room. Luke stated that he had recently

⁴ <https://www.instituteforgovernment.org.uk/charts/uk-government-coronavirus-lockdowns>

got engaged to his long-time partner and was hoping to get married within two years. He had recently had a 'falling out' with his partner and this had negatively affected his mental health.

- 2.1.33 **On 10 May 2020, the Prime Minister announced the conditional plan lifting lockdown. People who could not work from home should return to work.**
- 2.1.34 **Isabella called the National Domestic Abuse Helpline reporting her abusive boyfriend.** On 30 May 2020, Isabella contacted the National Domestic Abuse Helpline. She reported *"her boyfriend is abusive towards her and her unborn baby, that she is scared and vulnerable. She said that she wanted to leave her boyfriend for their safety"*. Isabella requested a call back at an agreed time that was safe for her on 1 June 2020. (The phone number provided by Isabella matched the number that Luke's GP had recorded for his 'girlfriend').
- 2.1.35 **Isabella and Luke moved out of Isabella's friend's home.** Isabella's friend stated that Isabella and Luke had been living with her at her home in Croydon, since February 2020. The friend asked Isabella to leave, with Luke, in June 2020. Luke was described as having 'bad episodes. Isabella's friend was concerned about her own children, she put it to Isabella that she was concerned about her landlord. Isabella had not mentioned pregnancy to Courtney.
- 2.1.36 **On 23 June 2020, the Prime Minister announced 'National Hibernation' coming to an end, relaxing restrictions.**
- 2.1.37 **Isabella moved into new flat.** On 5 August 2020, Isabella moved into a new Lambeth and Southwark Housing Association (LSHA) flat in Lambeth the block is designated as "Women Only". LSHA were provided with information on Isabella by Lambeth Housing. Isabella completed the LSHA application form stating she did not have any support needs or social worker. Her reason for homelessness was that her father had sold the family home. There was no specific question relating to domestic abuse and no further information provided.
- 2.1.38 **SLaM established that Luke had been absent from Riverside for two months and had not had medication supervised.** On 18 August 2020, SLaM care coordinator contacted Riverside as they were unable to contact Luke. The Riverside key worker stated that Luke had been staying with his girlfriend for the past two months. They had been unable to supervise his medication intake. Staff had maintained weekly contact with Luke. Luke had given assurances about his medication and staff had no concerns about his mental state.
- 2.1.39 **Luke in rent arrears and reported girlfriend's miscarriage.** On 4 September 2020, Riverside service manager and support worker met with Luke. His arrears were discussed, and he said he had not been able to meet his support worker or pay his service charge, as his girlfriend had a miscarriage.
- 2.1.40 **Luke accused Isabella of infidelity and threatened neighbour with a knife.** On 8 September 2020 at 00:18, police were called via 999 to Isabella's flat. It was reported that Luke had been at the address and an argument started after Luke accused Isabella of having another man in the address - Luke stated he could hear the man. Isabella suggested that she believed that the voices heard by Luke were in his head and a sign of

deteriorating mental health. It was reported that after the argument, Luke left the flat. Police report states that Luke searched through Isabella's room. He flipped the bed over whilst searching. He threw some sheets and part of the bed out of the window. Isabella then saw Luke standing outside the entrance to her flat holding a knife. This was witnessed by a neighbour, who was heard to say, 'He's got a knife'. Luke followed Isabella's neighbour up a communal staircase in possession of the knife. Fearing Luke would use it on him, the neighbour told Luke that he had a glass bottle and would use it if Luke were to come any closer, fearing he was going to be stabbed. It appears that Luke backed away telling the neighbour he was 'very lucky'. Luke then left the building. The call was recorded by police as a 'Non-Crime Domestic' and a Public Order Offence. Police completed DASH questions, and these were recorded on Body Worn Video (BWV). There was no referral to MARAC. Luke was later arrested for affray and possession of an offensive weapon. Luke was later charged, and the police kept in custody to attend court.

- 2.1.41 SLam was called by Brixton Police concerning Luke, then in custody. A Mental Health Act assessment was arranged, and Luke agreed to an informal admission. SLam records show that Luke was assessed by two psychiatrists and an Approved Mental Health Professional (AMHP). *"Luke requested admission so informal admission was considered – the least restrictive alternative. Request for inpatient bed made – no recommendation made for admission under the MHA"*.
- 2.1.42 **Luke bailed with conditions to comply with SLam directions.** Luke was bailed from magistrates' court with conditions to comply with any directions given by mental health practitioners, whose care he was under. SLam was made aware of the bail conditions, through liaison with the court, and these conditions were uploaded onto his clinical record. There was no application for a Domestic Violence Protection Order (DVPO). It is not clear that SLam was provided with any instructions on what to do if Luke did not comply with their directions.
- 2.1.43 **Riverside enquired about SLam bed for Luke, staff advised against lone working with Luke.** On 11 September 2020, Riverside contacted care coordinator to enquire on the bed for Luke at Maudsley Hospital. Riverside requested that the care coordinator read previous emails from Riverside and respond to them. There were shared concerns that if time lapsed, Luke may change his mind about a voluntary admission. Riverside advised that staff would not be lone working with Luke.
- 2.1.44 **Isabella's landlords warn her about partner's behaviour.** On 17 September 2020, LSHA emailed Isabella; she was told how to view her rent account online, and they confirmed a conversation about Isabella's 'ex-partner'. Isabella was advised that if they received further complaints about him, they would serve notice seeking possession and end Isabella's tenancy. The email also confirmed Isabella's rent arrears. Isabella was later sent a Notice Seeking Possession of her flat on 14 October 2020.
- 2.1.45 **Luke not accepted for SLam hospital bed.** On 19 September 2020, Luke had a SLam Assessment. Luke was not accepted in hospital as he had adequate support systems in 24-hour supported living.
- 2.1.46 **Isabella warned of anti-social behaviour at her flat.** On 23 October 2020, LSHA had a phone call from a tenant complaining about shouting coming from Isabella's flat on the

night of 22 October 2020, also sounds of furniture moving. LSHA called Isabella and she stated the noise was not her boyfriend, she was arguing with a cousin. Isabella advised that she was suffering from depression and had been unable to leave home to pay the rent. LSHA advised her that she had just moved in and was causing anti-social behaviour. She was advised that the case would be referred to court.

- 2.1.47 **Luke made suicidal statements to Isabella.** In the early hours of 27 October 2020, Luke visited Riverside after midnight to take his medication. Later, Isabella called to find out if he had attended to take his medication. She expressed concerns about him drinking alcohol and making suicidal statements. She said that she would call the next day to speak to Luke's key worker. (The panel noted that alcohol could make Luke's drugs, haloperidol, less effective).
- 2.1.48 **Luke's partner reported him falsely believing she was pregnant and being unfaithful.** At 10:44, the care coordinator called Luke's partner by phone and expressed concerns for Luke and that he thought she was pregnant, which was not true. Luke had accused her of being unfaithful with someone in her family circle, this was also not true. Luke said that he felt unwell and may need to be in hospital. He was drinking alcohol and that was out of character.
- 2.1.49 **Luke reminded by SLaM where he should reside, in breach of bail conditions.** Luke's care coordinator phoned Riverside concerning an incident. Luke's 'family' had reported that Luke was observed as being intoxicated and behaving in a bizarre manner at her house. The care coordinator had discussed this with Luke and reminded him he was not allowed in her accommodation. Luke refused to engage and slammed the phone down. It was reported that Luke had been seen at Riverside, agitated, pacing up and down and incoherent in his speech. It would have been normal practice for a Safeguarding Referral to have been made, but there is no record of this.
- 2.1.50 **Isabella told friend Luke had assaulted her.** Isabella's friend informed the review that Luke had hit Isabella at some point in October 2020. Luke bought Isabella an iPhone after the assault. The friend advised Isabella to report the assault to the police.
- 2.1.51 **Luke assaulted Isabella by headbutting her.** On 1 December 2020, Isabella informed her friend that Luke had assaulted her by headbutting. Isabella sent the friend photos via WhatsApp showing her swollen face and eye. The friend tried to encourage Isabella to call the police. Isabella's mother also stated that on this date Luke had headbutted Isabella. This resulted in Isabella sustaining a black eye. Isabella's mother advised her to go to hospital and report the assault to the police. Isabella said that she did not want to because she was frightened. Her mother advised that the police could get Isabella a restraining order.
- 2.1.52 **Luke informed Riverside he had broken up with girlfriend as she was unfaithful.** On 5 December 2020, Luke informed Riverside staff, face-to-face, that he had broken up with his girlfriend. He implied that she had been unfaithful to him. On the following day Luke informed staff that he was back with his girlfriend.
- 2.1.53 **Luke alleged sexual assault at Riverside.** On 11 December 2020, Isabella phoned Riverside to inform them that she was coming to collect Luke's belongings. This was due to a serious incident at Riverside, and he would not be coming back to live there. She

recounted Luke's report that he believed he was sexually assaulted at the premises and believed another resident was in his room. This was reported to the police. Luke was referred to a Sexual Assault Referral Centre. Police checked internal CCTV for the time period that Luke gave for the attack, and he was the only person seen to enter his room. External CCTV showed no entry through the window. Police could find no evidence to support Luke's allegation and the case was closed. Subsequent enquiries made by Riverside show that Luke did not stay there on the night of the alleged sexual assault. He stayed there two days prior.

- 2.1.54 **Riverside informed SLaM Luke not taking medication.** On 16 December 2020 Riverside emailed SLaM care coordinator to state that Luke had not returned to get his medication. It was noted that Luke's phone appeared to be switched off.
- 2.1.55 **On 19 December 2020, the Prime Minister announced tougher restrictions for London and South East England with a 'Stay at Home' alert level. Christmas mixing rules were tightened. Restrictions to came into force on 21 December 2020.**
- 2.1.56 **Luke was warned on breaching his tenancy at Riverside, not staying at venue.** Luke attended Riverside reception to collect his mail. He said he would be away from the service from 20 December 2020 until 2 January 2021. Luke was informed that his licence was in jeopardy. Luke told Riverside he was staying away due to COVID-19 and sharing bathrooms at Riverside.
- 2.1.57 **Riverside informed care coordinator of Luke's two-week absence and not taking medication.** Two days before Isabella's death, Riverside recorded that Luke had not been at the service for almost two weeks. He was not engaging with support. Several attempts had been made to contact him without success. It appeared that Luke had changed his phone number. He had not been attending to get his medication.
- 2.1.58 On the day before her death, Isabella's friend remembered that Isabella was not using her WhatsApp on her phone. Friends recalled that Isabella was usually on social media every day.
- 2.1.59 **The murder of Isabella.** On the evening of Isabella's death, police were called to Isabella's flat by a concerned neighbour. Officers forced entry to the flat and found Isabella with multiple stab wounds and Luke in the premises. Attempts to save Isabella's life failed. Luke was arrested and a homicide investigation commenced.
- 2.1.60 Enquiries established that Isabella and Luke were captured on CCTV visiting a local supermarket shortly before her murder. They were seen to purchase two pregnancy tests. One used, 'negative' pregnancy test was found at the scene of Isabella's death, another was found unopened. Luke's defence statement to court stated that Luke had asked Isabella to take a pregnancy test to prove that she was not having an affair.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

- 3.1.1 Isabella's murder resulted in the loss of a kind and loving daughter, sister and friend, and is devastating. Luke is the person responsible for this act. This is a clear case of interpersonal violence and there are many lessons to be learned for all agencies involved.
- 3.1.2 The Review Panel extends its sympathy to the family and friends of Isabella. Their involvement in the review process has provided a valuable insight on Isabella as a person, and some of her experience of agencies. This review aims to use their contribution and the work of the panel to bring improvements for other people and to help prevent future tragedy. Isabella's family have fully supported this review in the hope that it will somehow reflect her as a person. It is recognised that the family received support throughout this process from VSHS. The Chair would also like to extend thanks to VSHS for their support and professional communication.
- 3.1.3 In this case, Isabella's family brought to the panel's attention a serious assault in the month of her death. They also provided information on how Luke treated Isabella on a day-to-day basis. They revealed a level of isolation, and that Luke had effectively taken over Isabella's home in the time immediately before her death.
- 3.1.4 Agencies had a clear opportunity to provide a coordinated response in the months immediately before Isabella's death to provide protective measures.
- 3.1.5 Luke was seen by police and health services to have been involved in a domestic incident where he was experiencing a psychotic episode, this involved accusations of infidelity, jealousy, use of weapons. Luke had a previous history of self-harm in front of previous girlfriend. He had been suspected of arson on Valentine's Day when he was with Isabella. There was no appreciation of the threat presented to Isabella and no referral to MARAC. Police did ensure that Luke was kept in custody, and he was released into the care and control of NHS mental health services. The NHS were unable to provide the care recommended for Luke and they exerted no supervisory control over him, despite there being legal enforcement options available through bail conditions.

3.2 Key Themes and Learning Identified

- 3.2.1 This case shows that there needs to be a strong multi-agency partnership focus on tackling and preventing domestic abuse. It should also be recognised that the DHR process and homicide investigation have resulted in some immediate changes in the protocols and procedures. This demonstrates a willingness to implement change and improvements across the areas. There are some key areas that concern national services that require action elsewhere.

Criminal Justice and Mental Health

- 3.2.2 This case has demonstrated the need for a coordinated response across Criminal Justice and Healthcare agencies when managing perpetrators with mental ill-health. Luke's appearance in court in September 2020, for an incident with a knife at the Isabella's home,

took place three months before he stabbed her to death at the same premises. Police presented clear objections to bail, including requesting that Luke did not visit the address or contact Isabella. Luke was released from court without the requested conditions. The Criminal Justice agencies were solely reliant on healthcare professionals manage Luke. The first warning that this condition was not going to be effective was when Luke immediately left court, and his carers did not know where he had gone. Luke's carers, SLaM, had no idea where his girlfriend Isabella lived. Luke went on to kill Isabella in her home.

- 3.2.3 On 9 September 2020, Luke, was released on bail having appeared in custody. The police were responsible for updating Isabella with this new information. This is in accordance with the Witness Charter.⁵ It is noted on the CPS file that the police Witness Care Unit called Isabella on 22 September 2020 to provide her with an update on the case, but she did not answer. The police Witness Care Unit did not want to put Isabella at risk, as she was identified as the girlfriend of Luke, therefore a voice note was not left for her. It is of particular note that the court record for Luke's initial appearance in custody after the attack on Isabella and her neighbour does not show any detail on how the application for bail was considered within the court. It does not show the objections to bail, or the points raised on behalf of Luke, or whether SLaM were involved in the hearing.
- 3.2.4 The management of Luke within the community required a coordinated response between the police and health. Luke represented a significant risk to Isabella and her neighbours. This risk could have been managed through a referral to MARAC by the MPS and/or SLaM. It is recognised that the bail conditions imposed by the court were weak. The court did not impose the restrictions suggested by police. There appears to have been no consideration by SLaM on how to manage that legal responsibility and report any breaches of bail. When Luke was released from court and immediately disappeared, this should have triggered a multi-agency response, led by SLaM.
- 3.2.5 Agencies should be working together to protect the public and patients in partnership. There was a clear role for the SLaM and police. Luke was not staying at his home, not taking regular medication, he was living with a person who was a witness in criminal proceedings against him and next door to the victim. There should have been early consultation between Riverside, SLaM and the MPS to consider the risks presented by Luke with the aim of keeping all parties safe.
- 3.2.6 This learning translates into recommendations N, O, T, W, Z, AB, 1, 2, 3, 4, 5, and 6.

Risk Assessment

- 3.2.7 There was no formal assessment of the risk that Luke presented to Isabella by mental health or adult social care services. The review has indicated that staff knew of 'morbid

⁵ <https://www.gov.uk/government/publications/the-witness-charter-standards-of-care-for-witnesses-in-the-criminal-justice-system>

jealousy', suspicions of infidelity, suspected arson, his use of weapons, anger, non-compliance with anti-psychotic medication. It was clear that Luke was not considered to safe to be alone with Mental Health and housing professionals, and yet no consideration was given to Isabella being alone with Luke. SLaM reviewers consider that the clear concerns around domestic abuse, were "lost in the narrative" rather than recorded in a risk assessment.

- 3.2.8 SLaM did consider the risk that Luke presented to their own staff and instructed that there should be no 'lone working' with Luke. They did not consider the risk of what would happen if Luke was alone with Isabella. As a public authority, SLaM have a duty of care to protect the right to life of the public, not just patients and staff. There was clear information within SLaM files to indicate that Luke presented a risk to those being close to him and they knew he was staying with Isabella. This should have prompted a DASH risk assessment and referral to MARAC.
- 3.2.9 The panel discussed that the current risk assessment processes focus on referrals around potential victims. There should be a robust risk assessment in place that is triggered by information revealed on the perpetrator. In this case, the key risk indicators for abuse were raised in medical records, where Isabella did not directly report.
- 3.2.10 The SLaM risk assessment tool introduced in 2021, after Isabella's death, was seen by the panel, and it considers both victim and perpetrators. It identifies 'pregnancy' as factor to consider and includes an estimated delivery date and also prompts referrals for MARAC and specialist domestic abuse services for victims and Domestic Abuse Perpetrator Programme (DAPP) for perpetrators. The form links to the safeguarding lead and also asks what legal restrictions there are in place for a victim. There are very clear processes in place, but this requires SLaM staff and supervisors to recognise domestic abuse. SLaM have previously made recommendations on raising awareness and processes in cases that preceded Isabella's death. The panel felt that new recommendations needed to be made to ensure policy was put into practice.
- 3.2.11 When the MPS were called to Isabella's home in September 2020, after Luke had searched her home and threatened her neighbour with a knife they recognised the need for a DASH Risk Assessment, but they did not complete it. If the assessment had been correctly completed, with officer's reviewing previous contact with Luke, this could have resulted in a MARAC referral. Consideration could also have been given to updating the DASH after Luke had been released by court on bail.
- 3.2.12 This lesson translates into recommendations C, D, E, F, G, J, K, O, R, T, W, Z, AA, AE, 3, 4, 6, and 7.

Housing

- 3.2.13 Isabella's housing and homelessness were key factors in this review. Isabella was made homeless following the death of her paternal grandparents. She spent time staying with friends and in contact with services for rough sleepers. Isabella was known to have been in fear of her previously abusive partner and the security of her own home was essential to her. There was no coordination between the Local Authority Housing Department and

the Housing Association concerning Isabella's previous history of domestic abuse. A local authority should take a detailed history of any abuse and pass on any concerns to a housing provider. Isabella was eventually rehoused in the first home of her own, it was in a housing association women-only block.

3.2.14 It appears that Luke spent a great deal of time at Isabella's home. Whilst staying at the property Luke's behaviour put Isabella's tenancy at risk and he threatened her neighbours. It is the opinion of Isabella's family Luke had effectively taken over the property and they found very few of Isabella's belongings at the flat. The sabotaging of housing can also be considered as economic abuse. It is not clear that her social housing landlords explored the possibility that Isabella was a victim of domestic abuse with her after the September 2020 incident.

3.2.15 This lesson translates into recommendations L, P, Q, 4, 5, and 9.

Pregnancy

3.2.16 It is known that pregnancy can bring an increased risk of domestic abuse towards women and their unborn child and control over pregnancy is a form of abuse.⁶ It is not known that whether Isabella was pregnant at any point during the period under review. She was not pregnant when murdered. The report made to NDAH from Isabella's phone details reported fears for an unborn child. Luke made numerous statements to his mental health services and adult social care regarding Isabella's pregnancy. He reported that Isabella had had miscarriages on a number of occasions.

3.2.17 Luke was known to be violent, and jealous with links to unexplained fires. As far as healthcare professionals caring for Luke were aware, Isabella had been pregnant. Luke's supported living provider did report concerns to SLAM around Luke's behaviour around his reports of the pregnancy. There appears to have been no consideration to the safety of Luke's girlfriend's unborn child by SLAM or ASC. There were no recorded discussions on the potential for any Child Protection concerns.

3.2.18 The panel have made enquiries with a wide range of healthcare practitioners, including agencies that manage reproductive choices and there was no evidence that Isabella was known to be pregnant. This does not mitigate the fact that agencies who were informed of Isabella's pregnancy did not consider the risks to Isabella.

3.2.19 This lesson translates into recommendations A, B, C, D, G, I, J, K, and 7.

COVID-19

⁶ Women's Aid, *Supporting women and babies after domestic abuse - A toolkit for domestic abuse specialists* <https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf> (Accessed 28 January 2024)

- 3.2.20 The escalation of events that led to Isabella's homicide took place in the first nine to ten months of the COVID-19 pandemic with regulations and restrictions starting in March 2020. This had an immediate impact on all agencies. Many face-to-face processes were changed to online and telephone consultations. Most of the agencies involved in the review took steps to implement the ever-changing regulations. It is not clear that those managing Luke's care gave consideration to how he was complying with national guidance and how that would impact on his health and that of Isabella.
- 3.2.21 There was an immediate impact on Luke's healthcare. SLAM staff quickly moved to remote working. This had an impact on collective reflection and decision making within the trust. Luke's supported living provider reported that Luke repeatedly broke lockdown regulations, he repeatedly used fear of COVID-19 as an excuse not to return to Riverside. This was a clear breach of lockdown law and was compounded that Luke was staying at Isabella's home in women's only block where he had recently been arrested.
- 3.2.22 The effect of COVID-19 on services used by Isabella was evidenced. When Isabella was interviewed by housing services, she was spoken to on the phone by two out of three staff. Isabella would have normally been seen in a 'settling in' visit when she moved to her new flat, but these were not conducted due to COVID-19. Isabella's housing association stated that the incident of September 2020, when Isabella and her neighbour were threatened, would have normally been followed up with an in-person visit to the residents.
- 3.2.23 Pandemics are a natural phenomenon and are considered on the National Risk Register of Civil Emergencies.⁷ The reality of the COVID-19 pandemic had a clear impact on agencies that can identify and respond to domestic abuse. All agencies should consider the learning from the recent pandemic in the UK to inform contingency plans going forward.
- 3.2.24 This lesson translates into recommendations X and 8.

⁷ UK Pandemic Preparedness <https://www.gov.uk/government/publications/uk-pandemic-preparedness/uk-pandemic-preparedness>

4. Recommendations

4.1 Oversight of Lambeth Domestic Homicide Reviews

- 4.1.1 The Community Safety Partnership in Lambeth is the Safer Lambeth Partnership Executive (SLPE). The oversight of Lambeth DHRs is as follows: key themes, learning and any operational or strategic concerns are presented to the VAWG Strategy Delivery Group who report into the Serious Violence Board which is overseen by the SLPE. The SLPE hold ultimate local responsibility for the recommendation to publish to the Home Office, who will have final decision on publishing the DHR. The SLPE also hold responsibility for signing off the action plan and closing the DHR.

4.2 Single Agency Recommendations (Identified by Individual Agencies)

- 4.2.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.
- 4.2.2 These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Safer Lambeth Partnership.

GP

- 4.2.3 **Recommendation A:** In GP Practice B, a health practice has introduced a policy to ensure that vulnerable patients are allocated a named GP. The named GP receives information about every contact with the patient including consultations and letters from third parties. As far as practicable appointments for vulnerable patients will be booked with the named GP, the aim being to provide continuity of care. This has already been implemented.
- 4.2.4 **Recommendation B:** Since January 2021, GP Practice B clinicians are required to identify adults who are accompanying adult and child patients to the surgery and to request their full name as well as their relationship to the patient. Clinicians are required to enter the name of the accompanying person(s) and their relationship to the patient in free text in the consultation record.
- 4.2.5 **Recommendation C:** GP Practice B is a training practice. Registrars continue to receive training on domestic abuse and the training includes asking direct questions to patients about domestic abuse. Registrars are also trained to code 'History of domestic abuse' on EMIS web.
- 4.2.6 **Recommendation D:** GP Practice B staff will continue to be encouraged to exercise a high degree of professional curiosity in their consultations with patients. This is something which is regularly discussed at the daily meetings - patterns of presentations/hypothetical scenarios which would change the staff's perspective of events in relation to the possibility of domestic violence /sexual abuse is often discussed when staff see odd presentations/patterns of presentation.

- 4.2.7 **Recommendation E:** GP Practice A recognises the importance of exercising professional curiosity in consultations with patients and will endeavour to offer referral to support agencies on a timely basis where appropriate.
- 4.2.8 **Recommendation F:** With respect to patients who are known to have a history of violent and aggressive behaviour, GP Practice B practice will enter an alert message in EMIS web to warn practice staff that the patient whose records they are accessing has a prior history of aggressive and violent behaviour.
- 4.2.9 **Recommendation G:** It has been agreed that IRIS will be implemented in Lambeth hopefully this year. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices. **The panel have been informed that IRIS is now running in Lambeth.**
- 4.2.10 **Recommendation H:** Lambeth Health and VAWG committee are developing a domestic abuse policy template which includes sections on 'Interacting with perpetrators of domestic violence and abuse' and a practice pathway for victims of domestic abuse. When this policy template has been completed and approved, it will be distributed to practices in Lambeth. The Domestic Abuse Policy template has now been completed and approved by the South East London Integrated Care Board (SELICB) Quality and Performance Subgroup.

Kings College Hospital NHS Foundation Trust

- 4.2.11 **Recommendation I:** Continued work within the Trust to raise awareness with regards to domestic abuse. The IDVA service is gradually returning to an onsite service following the disruption caused by COVID-19. The IDVAs are now visiting the Emergency Department on a regular basis to raise awareness of the service and to ensure staff members are aware of how to contact them.
- 4.2.12 **Recommendation J:** The Adult Safeguarding service has met with the Emergency Department senior management team to discuss how we can include routine questioning around domestic abuse when a patient is triaged, particularly in emergency departments. This is an ongoing issue as the ED staff are looking to reduce the amount of time patients spend in triage due to the nature of the busy acute setting.
- 4.2.13 **Recommendation K:** The Adult Safeguarding service will work as part of the ED restructuring working group to support with the review of the triage and assessment process. The recommendations will be for clinical assessment to include questions relating to how things are at home are, how safe a patient feels and whether they are in fear of intimate partners or family members.

Lambeth Housing

- 4.2.14 **Recommendation L:** Lambeth Housing should devise a form for the nominating organisation to complete which provides detailed history about the applicant's background. This form can be passed to the organisation rehousing the applicant.

London Borough of Lambeth Adult Social Care

- 4.2.15 **Recommendation M:** Personal details of partners / significant others to be sought as part of review process to seek consent to be included in review process and contacted if the client being reviewed consents.
- 4.2.16 **Recommendation N:** For training for staff to consider domestic violence risks for partners / family members where there is a history of violence towards others.
- 4.2.17 **Recommendation O:** Check and refresh procedure for linking victim survivors and perpetrators on MOSAIC when one, other or both known to Adult Social Care.⁸

London Borough of Lambeth Housing

- 4.2.18 **Recommendation P:** Names and addresses should be recorded on case notes to help establish where someone is staying or who someone is fleeing from – if applications do not wish to divulge that should also be recorded.
- 4.2.19 **Recommendation Q:** Follow up with agencies providing specialised Domestic Abuse support should always be attempted to establish if the applicant has contacted. If no contact, follow up with applicant to understand why no contact has been made.

Metropolitan Police Service

- 4.2.20 **Recommendation R:** It is recommended the Central South (AS) BCU SLT dip sample Domestic Abuse reports to ensure compliance with current MARAC referral criteria and confirm that rationale is being recorded within report regarding MARAC considerations whether or not the case is referred.
- 4.2.21 **Recommendation S:** It is recommended the Central South (AS) BCU SLT debrief the OIC and Supervisors concerned in CRIS 1224134/20. They should be reminded of their responsibilities under the Vulnerable Adult assessment Framework (VAF) and the criteria for Adult Come to Notice (ACN) Merlin reports.
- 4.2.22 **Recommendation T:** It is recommended the Central South (AS) BCU SLT remind officers of their responsibility to ensure that they are aware of the status of cases which they are assigned to in respect of court hearings (if they are not in attendance) to determine court results and / or bail conditions which may have been imposed.

National Probation Service

- 4.2.23 **Recommendation U:** (1) Report author to demonstrate improvements in the completion of pre-sentence report and proposals that reflect the risk and needs of the person on probation. (2) Report author to provide a sample of 5 pre-sentence reports to the line

⁸ MOSAIC is the electronic social care management system used by Lambeth Council to manage adult, children, and finance cases in one platform. It holds workload data, service data and financial information on the provision of social care to short-term and long-term social care uses.

manager to audit the reports to ensure they are of a sufficient quality and appropriate based on the presenting risks and needs of the case.

Riverside

- 4.2.24 **Recommendation V:** Implement any actions recommended as a result of the medication review at Acre Lane which will be finalised by the end of September 2021.

South London and Maudsley NHS Foundation Trust

- 4.2.25 **Recommendation W:** Community Patients in the red zone in the LWC South East Focused Support CMHT to have a clearly documented risk plan, with risk management strategies that are responsive to and proportionate to the risks, including the identification of when a senior review will take place. Risk assessments should be reviewed 6 monthly and/or when a significant change of event occurs that warrants a review of the risk management plan. This should include consideration of potential DVA.
- 4.2.26 **Recommendation X:** The Trust to review the impact of the changed working conditions (required to manage the COVID-19 pandemic) on team reflection and decision making. This is especially relevant to risk assessment in this case. There is a need for teams to assure themselves that such collaboration is still possible within a changed working environment.
- 4.2.27 **Recommendation Y:** The LWC South East Focused Support CMHT to complete the psychological safety questionnaire regarding roles within the team. This covers the area of reflective practice.
- 4.2.28 **Recommendation Z:** The Trust to develop further training for all CMHTs who work with client groups who have a propensity towards and history of violence.
- 4.2.29 **Recommendation AA:** Lambeth Directorate to provide a domestic violence training session to all community and in-patient services. ***Lambeth VAWG had agreed to facilitate a half day training session in September 2021 to all Lambeth SLAM staff, this will include MARAC, intergenerational transmission of violence and working with perpetrators.***
- 4.2.30 **Recommendation AB:** The Trust to explore the interface between Forensic services and Lambeth adult CMHTs.

Thames Reach

- 4.2.31 **Recommendation AC:** All staff complete safeguarding training and yearly refresher training courses. Homeless law, practice and HRA training is offered to staff, the course content includes domestic abuse.
- 4.2.32 **Recommendation AD:** Review updated Thames Reach domestic abuse policy in team meetings.
- 4.2.33 **Recommendation AE:** Staff to inform their manager of all cases involving domestic abuse to ensure policy is followed. This will be logged as a support need on recording systems and discussed in supervision meetings.

4.3 Multi Agency Recommendations (Developed by the Review Panel)

- 4.3.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.
- 4.3.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 3**. The Safer Lambeth Partnership is responsible for overseeing then development and monitoring of an action plan.

National

- 4.3.3 **Recommendation 1:** That Ministry of Justice and Department of Health and Social Care develop processes to manage and monitor bail conditions across NHS mental health services, Criminal Justice Agencies and IDVA/IGVAs. This should include training for court staff to accurately record bail objections raised, submissions by defence and rationale for bail decisions.

Regional

- 4.3.4 **Recommendation 2:** That His Majesty's Courts and Tribunals Service conduct an audit of court records on applications for bail at Croydon Magistrates Court to assess the accuracy court records. Following the review, they should develop systems and implement training for courts staff as required.

Local

- 4.3.5 **Recommendation 3:** The London Borough of Lambeth Safeguarding Adults Board work with Safer Lambeth Partnership to ask partners to audit assessment processes to ensure that domestic abuse is routinely considered in assessment work and recorded. This should include a review of systems to ensure that all statutory agencies have established information sharing protocols to inform risk assessment. Learning from this process can be shared with non-statutory partners to improve information sharing with all agencies.
- 4.3.6 **Recommendation 4:** That HM Court and Tribunals Service and South London and Maudsley NHS Foundation Trust examine systems around the management of bail conditions that involve SLaM patients. Learning from this DHR should be used to ensure that there are robust systems in place to manage public safety. This should include regular audit.
- 4.3.7 **Recommendation 5:** That South London and Maudsley NHS Foundation Trust develop training and awareness programmes for housing providers, including housing associations and supported living premises used by Mental Health Services. This should include a review of policies and training with reference to the Domestic Abuse Act 2021. There should be a focus on Lambeth Housing partnerships with the large social housing provision. This will be developed through the partnership meetings housing associations can be made aware of the training and awareness programme being offered by Safer Lambeth Partnership and South London and Maudsley NHS Foundation.

- 4.3.8 **Recommendation 6:** That South London and Maudsley NHS Foundation Trust implement a system of audit to check the identification of domestic abuse and how risks are managed within the trust and domestic abuse agencies. There should focus on risk assessment of the potential perpetrator, rather than purely victim centred. This should take account of the learning from all DHRs that the trust is involved in and not focus purely on the Lambeth locality. This process should be transparent and include scrutiny from NHS England and local domestic abuse agencies.
- 4.3.9 **Recommendation 7:** That London Borough of Lambeth Adult Social Care and South London and Maudsley NHS Foundation Trust jointly review training and awareness on domestic abuse. Particular consideration should be given to the issue of pregnancy, and coercive and controlling behaviour. This should include identification and management of risk posed by potential perpetrators of domestic abuse.
- 4.3.10 **Recommendation 8:** That the Safer Lambeth Partnership and all Panel Agencies provide assurance that contingency planning is in place to address the impact of a future pandemic.
- 4.3.11 **Recommendation 9:** That Lambeth and Southwark Housing Association closely monitor the conditions of tenancy and ensure that they offer a supportive approach to managing clients in female only spaces and consider vulnerabilities around controlling and coercive behaviour. Breaches of tenancy should consider the risk to the client and specialist domestic abuse agency support should be considered.