Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the deaths of Hanna and Star
discovered in April 2019

Independent Chair: Gary Goose MBE
Report Author: Christine Graham
May 2023

Preface

The Newham Community Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to both Hanna and Star's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Newham Community Safety Partnership on receiving notification of the murders of Hanna and Star in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

After much consideration, this review took the position that in order to properly scrutinise the deaths of both young women, it was necessary to identify any potential links between them and opportunities that may have affected the chronology of events and resulted in a different outcome for one or both of them. In view of that we have produced one overarching report as the cases are interlinked by virtue of the same killer and their bodies being discovered at the same time and in the same location.

To assist the reader, text that relates to Hanna only is in brown and text that relates to Star only is in blue.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Hanna and Star's murders.

Section 3 will look in detail at the **agency involvement**.

Section 4 considers **Hanna and Star and their individual situations.**

Section 5 will analyse **the perpetrator** and what is known about him**.**

Further analysis is provided in **Section 6.**

Section 7 will bring together **the lessons identified,** and **Section 8** will collate the **recommendations that arise.**

Section 9 will bring together **the conclusions** of the Review Panel.

Appendix One provides the **terms of reference** against which the panel operated.

Appendix Two looks at the status of a **Registered Sex Offender**.

Appendix Three sets out the **perpetrator's previous convictions**.

The **ongoing professional development** of the Chair and Report Author is provided in **Appendix Four.**

Where the review has identified where there was an opportunity to intervene, this has been noted in a text box. Examples of good practice are highlighted in italics.

Contents

Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 This report of a domestic homicide review examines agency responses and support given to two women who will be known, for the purposes of this review, as Hanna and Star. Both women were believed to have been residents within the Newham Borough Community Safety Partnership area before their bodies was found at an address within that area in 2019.

1.1.2 Other than they may have crossed paths within the community in which they lived, the review is not aware of any direct connection between Hanna and Star, save for their contact with the perpetrator.

1.1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before their murders, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach this review seeks to identify appropriate solutions to make the future safer.

1.1.4 It was in April 2019 that officers from the Metropolitan Police Service (MPS) gained entry to a flat in the London Borough of Newham. Concerns had been raised by a member of the public for the welfare of the occupier of the flat; a man who subsequently is identified as the perpetrator in this case. Once inside, police found the occupier to be absent but became suspicious of a chest style freezer within the flat and the deceased bodies of Hanna and Star were found inside that freezer. Both women had been murdered.

1.1.5 The perpetrator was subsequently arrested and charged with the murder of both women. In interview he denied involvement saying he was pressured into hiding the bodies by others.

1.1.6 Hanna was 33 years old and first came to the UK from Hungary in 2012. It is not thought that she had contact with her family once she moved here. The post-mortem concluded that Hanna had died approximately two and half years before the bodies were discovered and that the freezer had, intermittently been switched on and off during that time.

1.1.7 Star was 37 years old when she was murdered and had two children with whom she had regular contact. She had last been seen by her mother only a few days before she was reported missing by her family in May 2018. It is believed she was murdered shortly after meeting this perpetrator at around the time she went missing.

1.1.8 Due the condition of both Hanna and Star's bodies when they were found, it was not possible for the pathologist to say exactly what had happened to them. The pathologist said that Hanna had multiple wounds to her head, particularly around her eye sockets, although there was no haemorrhage or facial fractures. There was evidence of significant, direct blunt impact force to her ribs. It was not able to determine the exact cause of death. There was an absence of drugs and drug metabolites.

1.1.9 Star had been strangled, her voice-box crushed and fractured in three places, some of her ribs were also fractured and there was a tear to her liver. Her body had been placed in the freezer on top of the body of Hanna.

1.1.10 In the summer of 2020, the perpetrator stood trial for both murders. He entered a plea of not guilty to the murders but was convicted by Jury. He was subsequently sentenced to life imprisonment, to serve a minimum term of 38 years (minus 490 days on remand) before he can be considered for parole. He refused to leave his cell at court for his sentencing.

1.1.11 During the investigation into the murders, police uncovered evidence that the perpetrator was a serial abuser. He has convictions for violence and sexual offences against previous partners and children, there were also a number of other serious allegations made against him that had not resulted in a prosecution. He had been previously placed upon the sex offenders register for life. He has a diagnosed mental health condition and had spent time in hospital for treatment. There is strong evidence that he targeted vulnerable women and can be properly described as a predatory sex offender.

1.1.12 The review has considered agency contact and involvement with both victims from September 2014 for Hanna, and January 2016 for Star, until the time of the discovery of their bodies. These dates were chosen to show life before both women met the perpetrator.

1.1.13 The review has considered significant all known events in the life of the perpetrator to the point of his arrest.

1.1.14 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.15 This review makes multiple recommendations across a range of agencies and for the safeguarding system within Newham and some to be considered nationally.

1.1.16 The review has considered a number of significant areas of concern and notes the following for specific mention:

- **The identification of the true risk that this perpetrator posed to any women with whom he sought to establish a relationship and the systems in place to manage that risk.**

- **Whether any perceived 'status' of the victims affected the safeguarding services they received across agencies, in particular whether there was evidence of an attitude within services of 'deserving and underserving' members of our community.**

- **The vulnerability of women, such as Hanna within hospital settings, to predatory sex offenders such as this perpetrator.**

1.1.17 Whilst this review rightly focusses upon the murder of two women, we do recognise the abuse that many other women suffered at the hands of this perpetrator. We must use this review to recognise that we must do more protect so many women from the hands of predatory sex offenders and abusers such as this man.

1.1.18 It is within the context set out above that this review is set.

1.2 Reasons for conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the perpetrator has been found guilty of murdering both Hanna and Star. Therefore, the criteria has been met.

1.2.4 The purpose of the Domestic Homicide Review (DHR) is to:

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

1.3 Methodology and Timescales of the Review

1.3.1 Newham Community Safety Partnership was advised of the deaths by the Metropolitan Police Service (MPS) and in response to the notification, a paper was presented to the Newham Community Safety Partnership on 14th January 2021. At this meeting, the partnership was advised that the murder enquiry had established that there was an intimate relationship between Hanna and the perpetrator. It was also established that Star was thought to have been staying in the flat prior to her death. The Community Safety Partnership agreed that the criteria for a DHR had been met.

1.3.2 The Home Office was notified on 8th February 2021.

1.3.3 Gary Goose and Christine Graham were appointed as Independent Chair and Report Author in November 2020. As the criminal process was complete the review was able to proceed immediately.

1.3.4 It had been agreed with MPS that the Family Liaison Officer and the Chair of the DHR would contact Star's family. Unfortunately, before this was achieved the family were notified by a third party of the legislation regarding DHRs, which caused some distress. The Chair and FLO addressed this directly with the family. The Chair apologising for any upset that had been caused.

In response to this situation the Borough's DHR Toolkit has been updated with learning to make it clearer who is responsible for contacting families.

1.3.5 The first panel meeting was held on 25th January 2021 on Microsoft Teams. The following agencies were represented at the first meeting:

- Barts Hospital
- Change, Grow, Live – Substance misuse service
- East London Foundation Trust
- Hestia – Domestic abuse service
- London Borough of Newham – Domestic Abuse and Sexual Violence Commissioner
- London Borough of Newham – Homelessness Prevention and Advice Services
- London Borough of Newham- Adult Social Care
- Metropolitan Police Service – Review Team
- Metropolitan Police Service – Senior Investigating Officer
- National Probation Service
- NHS North East London Integrated Care Board

1.3.6 Apologies were received from London Community Rehabilitation Company (now the National Probation Service)

1.3.7 At the meeting the Domestic Homicide Review was explained to the Panel and the Chair stressed that the purpose of the review is not to blame agencies or individuals but to look at what lessons can be learned to better protect others in the future.

1.3.8 At this meeting, the panel agreed that it was appropriate that, whilst the reviews into both Star and Hanna would run side by side, they each had their own report, albeit the information about the perpetrator would be replicated across both reviews.

1.3.9 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.3.10 The Terms of Reference were agreed subject to Hanna and Star's families being consulted.

1.3.11 The Review Panel met nine times, with a number of meetings with individual agencies also being held and the review was completed in September 2023.

1.3.12 It has not been able to complete this review within the six months due to the complexity of the information and delays caused by COVID-19, both the lockdown and the ongoing pressures on agencies.

1.3.13 When the review progressed to the stage of writing the overview report, it became clear that it was going to be difficult to write two separate reports in a meaningful way as the cases were so intrinsically interlinked. Therefore, with the support of the DHR panel and family a joint report has been produced.

1.4 Confidentiality

1.4.1 The contents and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved by the Home Office Quality Assurance Panel for publication.

1.4.2 To protect the anonymity of the deceased, their family and friends, the victims and those associated with them have been given pseudonyms.

1.4.3 The first victim is known as Hanna and this pseudonym was chosen by the Report Author.

1.4.4 The second victim is known as Star and this pseudonym was chosen by her family.

1.4.5 Star's children are referred to as Child 1, Child 2 and Child 3 (as determined by the family)

1.4.6 The males that feature in Star's life, other than the perpetrator are referred to as Male 1 and Male 2.

1.4.7 The perpetrator will only be known as the perpetrator.

1.4.8 The other females that feature in the perpetrator's life are anonymised for the purposes of safety, security and confidentiality.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- The family of Star
- All CSP members
- The Mayor of London
- Domestic Abuse Commissioner
- Fiona Hackland – LB Newham – Assistant Director of Public Health Commissioning Team
- Sean Mcdermid – LB Newham – Chair of Community Safety Partnership
- Daniel Card – Metropolitan Police Service. - Borough Commander

1.6 Terms of Reference

1.6.1 The review sought to consider if professionals had a good understanding of risk and whether risks were identified and responded to appropriately. This included identification of any escalation of offending by the perpetrator.

1.6.2 The review paid particular attention to the vulnerability of the victims and considered all factors affecting their vulnerability including, but not exclusively any prejudice arising from culture, ethnicity, financial independence, social and family isolation, their health (including mental health), trafficking and No Recourse to Public Funds (NRPF) and how these may have impacted on their ability to engage with services who could have supported them.

1.6.3 The full Terms of Reference can be found in Appendix One.

1.7 Contributors to the Review

1.7.1 Those contributing to the DHR do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of the person or body participating in the review to have regard for the guidance.

1.7.2 All Review Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the Panel or meeting for an interview.

1.7.4 A number of agencies contributed to the review.

- Barts Hospital – Panel member and IMR for both all parties
- Catholic Worker's Farm – Chronology for Hanna
- Change, Grow, Live – Substance misuse service – Panel member and IMR for Star
- East London Foundation Trust – Panel member and IMR for perpetrator
- Hestia – Domestic abuse service – Panel member
- London Borough of Newham – Domestic Abuse and Sexual Violence Commissioner – Panel member
- London Borough of Newham – Homelessness Prevention and Advice Services – Panel member and IMR for Star and the perpetrator
- London Borough of Newham- Adult Social Care – Panel member and IMR for Hanna and the perpetrator
- Metropolitan Police Service – Review Team – Panel member and IMR for all parties
- Metropolitan Police Service – Senior Investigating Officer – Panel member
- National Probation Service – Panel member and IMR for perpetrator
- National Referral Mechanism (NRM) – Chronology provided for Hanna
- NHS North East London Integrated Care Board – Panel member and IMR for the GPs of all parties
- nia – (Specialist Domestic Abuse service) Panel member and IMR for Hanna and Star

- Providence Row – Chronology for Hanna
- Salvation Army – Chronology for Hanna
- Victim Support – Panel member and IMR for Hanna and the perpetrator

1.7.5 The review was assured that all panel members and IMR authors were independent of any direct involvement with any of the subjects of this review.

1.7.6 The following individuals contributed to the review:

- Star's family

1.7.7 Attempts were made through HMPS and the Probation Service to engage the perpetrator with this review. He declined to assist.

1.8 Engagement with family

1.8.1 **Hanna's family**

1.8.1.1 In January 2021 the Family Liaison Officer (MPS) contacted Hanna's family to advise them that the Chair and Report Author would be writing to them. A letter was then sent, along with the Home Office leaflet, to the family. These had both been translated into Hungarian.

1.8.1.2 Hanna's family indicated that they did not wish to engage with review and this position has been respected and no further contact has been made.

1.8.2 **Star's family**

1.8.2.1 Family and friends are integral to Domestic Homicide Reviews and therefore extensive effort has been made to include Star's family in this review. As set out above, the intention had been that the Chair and FLO would contact the family but on 6th January 2021 a third party contacted LB of Newham to enquire about the review. On 7th January Star's cousin, who is the single point of contact for the family, contacted the Chair and dialogue was established, with an email setting out the process for advising the family of the review being sent on 15th January.

1.8.2.2 On 30th January the Chair and Report Author met with Star's cousin and sister to explain the review to them. They accepted a referral to AAFDA[1] and this was made the same day. On 18th February the Report Author met, virtually, with the AAFDA Advocate allocated to provide background to the case. A good rapport was established with the family. They felt able to contact the Chair to provide additional information into the review and to seek clarification when needed.

1.8.2.3 At the end of April, the Chair and Report Author were advised that the family had appointed a solicitor to represent them going forward and, a few days later, the Chair and Report Author met, remotely, with the solicitor.

1.8.2.4 The family indicated that they would like to meet the panel in person. Due to COVID-19 restrictions this took some time to arrange. The meeting was held, in a neutral location, on

[1] Advocacy After Fatal Domestic Abuse

27th September. This meeting was well attended by agencies and Star's cousin was supported by her solicitor and AAFDA advocate.

1.8.2.5 Once the panel agreed that the report was ready to be shared with Star's family, the Chair and Report Author met with Star's cousin and her solicitor to firstly, introduce them to the report and then, when they had been able to read it in their own time, to receive their feedback on the report.

1.8.2.6 Once the Executive Summary, for publication, was agreed this was shared with Star's cousin and her solicitor.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
Clare Hughes	Lead Named Nurse for Safeguarding Children and Interim Head of Safeguarding Adults	Barts Health NHS Trust
Eloise Simpson	Senior Practitioner Quality and Governance Lead	Change Grow Live
Piers Adamson	Services Manager	Change Grow Live
Ian Young[2]	Advance Customer Support Senior Leader	Department of Work and Pensions
Laura Anderson	Advanced Customer Support Senior Leader for East London DWP	Department of Work and Pensions
Edward Lander	Newham Crisis Pathway and Specialist Teams Service Manager	East London NHS Foundation Trust
Emma Crivellari	Named Safeguarding Adults Professional	East London NHS Foundation Trust
Aneta Mularcayk	Domestic Abuse Services Area Manager	Hestia
Saabena Khanum	Senior IDSVA	Hestia
Tamara White	Domestic Abuse Services Area Manager	Hestia
Senay Dur	Director	IMECE Women's Centre
Sharmeen Narayan	Domestic Abuse and Sexual Violence Commissioner	LB Newham Public Health Commissioning
Olcay Aniker-Lumley	Senior Manager, Homelessness Prevention and Advice	LB Newham
Simon Whitlock	Senior Commissioner Adults and Health	LB Newham Public Health Commissioning
Claire Solley	Director of Quality Assurance, Safeguarding and Workforce Development	LB Newham

[2] Replaced during review by Laura Anderson

Marija Kalsnic	Team Leader of Specialist Pathways Service	LB Newham – Homeless Prevention and Advice
Katie Burgess	Senior Safeguarding Governance Officer	LB Newham – Adult Social Care
Meril Eshun-Parker	Director	London Black Women's Project (LBWP)
Kelly Hogben	Acting Detective Inspector Specialist Crime Review Group	Metropolitan Police Service
Emma Tuckmachi	Named GP for Safeguarding Adults in Newham	NHS North East London Integrated Care Board
Daniel Wilson	Designated Professional Safeguarding Adults	NHS North East London Integrated Care Board
Caroline Murphy	Director of Operations	nia
Antony Rose	Head of Service	Probation Service
Rachel Nicholas	Head of Service – London Domestic Abuse Service	Victim Support

1.10 Domestic Homicide Review Chair and Report Author

1.9.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary led the police response to the families of the Soham murder victims. He was awarded an MBE in the Queen's 2006 New Years Honours List for 'Services to Policing'. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.9.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.9.3 Gary and Christine have completed, or are currently engaged upon, a number of domestic homicide reviews across the country in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England and Adult Care Reviews.

1.9.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.9.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Full details of ongoing professional development can be found in Appendix Four.

1.11 Parallel Reviews

1.11.1 **Star**

1.11.2 In May 2019 an incident report was reviewed by the Mental Health Trust's Patient Safety Grading Panel, chaired by the Trust's Chief Medical Officer. A Concise Report was requested and provided. As a result, the Grading Panel made the decision that an Serious Incident Review was not require. Following this, and the commissioning of a Domestic Homicide Review, into which the local clinical commissioning group (CCG, the legally responsible body at the time) had input, it was determined that an additional independent mental health homicide review was not required in this case.

1.11.3 The Independent Office for Police Conduct (IOPC) undertook an investigation into the way in which the Metropolitan Police handled the reports made to them of Star as a Missing Person.

1.11.4 The Home Office have suggested that the recommendations from the police complaints investigation into this case are included within the report. However, investigations carried under the legislation that governs police complaints have their own legal framework and working guidance/practice in relation to the publication of any findings. It is thus not within the authority of this review to require such inclusion.

1.11.5 At the time of writing this report the inquest into the deaths had not been reopened. HM Coroner will be provided with a copy of this report in order to help them in any future decision making in respect of inquests.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[4] According to a statement by Refuge, women are more likely than men to be killed by partners/Ex-Partner 1s, with women making up 73% of all domestic homicides, with four in five of these being killed by a current or former partner[5]. In 2013/14, this was 46% of female homicide victims killed by a partner or Ex-Partner 1, compared with 7% of male victims.[6]

1.12.3 The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men[7]. Furthermore, in 2017/18, 93% of defendants in domestic abuse cases were men[8] and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[9].

1.12.4 Hanna, Star and the perpetrator were of minority ethnic groups. The Chair and Report Author were conscious that they, and the majority of the DHR panel, were predominately white and middle aged. It was important to the Chair and Report Author that Star's family had confidence in them to undertake a review that did justice to Star. After having discussed their concerns with the commissioners, and having agreed that the panel did contain sufficient specialist advice, it was decided that this would be addressed directly with Star's family. Through their solicitor, they indicated that they appreciated being asked but that they had no concerns and were happy for the Chair and Report Author to continue.

1.12.5 The Chair and Report Author have worked particularly hard with the commissioners to ensure that the panel heard, via local agencies and charities, the lived experience of women from minority ethnic groups who experience multiple vulnerabilities including domestic abuse.

1.12.6 In addition, this review has considered a range of other issues affecting Hanna and Star such as the impact of substance misuse, dyslexia and homelessness and the effect these may have had both on her and on organisations providing services for them.

4 (Women's Aid Domestic abuse is a gendered crime, n.d.)

5 ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#the-long-term-trends-in-domestic-abuse November 2018.

6 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

7 Ibid

8 CPS (2018), 'Violence against women and girls report, 2017-18). September 2018 https://www.cps.gov.uk/sites/default/files/documents/publications/cps-vawg-report-2018.pdf

9 Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017'. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759770/women-criminal-justice-system-2017..pdf November 2018.

Section Two – The Facts

This section provides a chronology of the lives of Hanna, Star and the perpetrator. To assist the reader, below is a basic timeline of the key dates:

	Hanna	Star	Perpetrator
May 2007			The perpetrator was placed on the Sex Offenders' Register for life. He was 22 years old at the time.
February 2011		Star lost her council tenancy that she had held since 2003	
2011		Star had long absences from her family, sleeping on and off at friends' houses or sleeping on the streets in the Newham area. She suffered from anorexia, anxiety, and depression. Star was sexually exploited by a range of men in return for money, food, or a place to sleep. She had developed a drug habit to cope.	
2012	Hanna first came to the UK		
2013	Hanna returned to Hungary		
2014	Hanna was trafficked back to the UK		
January 2016	Hanna was admitted to hospital in January 2016 after a serious assault by another man, and it is during this hospital stay that **she met the perpetrator**		
17th March 2016	On 17th March Hanna left the Unseen UK Safehouse in Bristol to go and live with the perpetrator in London		
29th September 2016	The last recorded contact with Hanna		
Beginning of 2018		Star was seen with the perpetrator at the beginning of 2018	

2nd May 2018		Last call was made from Star's phone at 2.38 pm	
10th May 2018		Star was reported missing to the police by her family saying that they had not seen her for two months	
26th April 2019	Both Hanna and Star's bodies were discovered in the freezer in the perpetrator's home		

2.1 Introduction to Hanna

2.1.1 Hanna was born in Hungary. It is known that, when she was in the UK, at some point Hanna reported to the Welcome Centre that she had been sexually abused by her stepfather. She said that when she confided in her mother, she refused to believe her or protect her. It is not known if this was reported to the Hungarian authorities.

2.1.2 In 2004 Hanna married and had two children in Hungary. The couple separated in 2007 and their marriage was annulled in 2008. Hanna's mother-in-law became the children's legal guardian.

2.1.3 Following the breakdown of her marriage, Hanna initially lived with friends in Hungary whilst her divorce progressed, and she sought access to her children. In 2011 she met a man who promised to help her and to get her work. He took her to Germany where she said that 'drugs were taken, and women sold for sex'.

2.1.4 Hanna first came to the UK in 2012. She discovered that she was pregnant so returned to Hungary in 2013. Here she gave birth to the baby and placed the baby for adoption. No other information is known about this part of her life.

2.1.5 When she did an assessment with nia in January 2016, Hanna provided further information about her background saying that she met a man in Hungary. They had become close and started a relationship. Within six months, he was sexually exploiting her and had bought another man into the home to have sex with her and the man paid her, and she gave the money to her partner. Hanna stated that she had then been trafficked to Birmingham, arriving by minibus on 16th September 2014, by her partner and was living in a shared house with four other women. They had all been forced into prostitution and had regular male customers and had to hand over the money to her partner. Hanna said that she managed to escape from her partner when they were out one day. She had managed to run off a train when she saw a police officer and she ran in that direction, and they caught her and asked if she wanted help. Hanna told them she just wanted to get away from the man (partner). Hanna stated she is not sure what happened as she must have passed out, because the next thing she knew she awoke in Lewisham hospital, she was later discharged and went to Catford to the Embassy, she told them she was homeless with no documents/Identity and that she only had £90. She reported that they told her there was nothing they could do to help her, so she left and made her way to Stratford. She had not seen that partner since. Upon arrival to Stratford, Hanna was street homeless and begged for money, doing odd jobs here and there. Hanna stated whilst she was homeless in Stratford, she met her new partner

who told her he was also homeless; however, she later found a flat and they moved in together.

2.1.6 Hanna was known to use drugs. Her ex-husband informed police that she had not used drugs or alcohol during their marriage, although after their divorce he had heard that she was smoking 'grass'. It is not until later and towards the end of her life that there is a suggestion that she was using Class A drugs, namely heroin.

2.1.7 During the police murder investigation, a search of the perpetrator's address was undertaken and several handwritten notes by Hanna were discovered detailing the violent, controlling, and coercive behaviour she was receiving from the perpetrator.

2.1.8 The post-mortem was not able to ascertain the exact cause of death due to the decomposition of Hanna's body. However, there were multiple defects and wounds present to the top of Hanna's head particularly over the vertex and forehead. She had damage to the left side of her head and around her eye sockets but no haemorrhage or facial fractures. Hanna had posterior fractures to all her ribs bar two. Further examination showed that injuries to Hanna's 9th and 10th ribs occurred between one and three weeks prior to her death and was not associated with or caused by the fall from the balcony in February 2016. It was noted that the 10th rib fractures were complete and grossly displaced stating that a significant, direct, blunt impact force would have caused the fractures. Due to the lack of penetrating lung injury associated with the fractures, it was not possible to link the fractures with the cause of death.

2.1.9 The toxicology examination revealed an absence of drugs and drug metabolites.

2.1.10 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 **From September 2014**

2.2.2 Between 2014 and 2016 Hanna reported numerous domestic incidents including false imprisonment and rape by her ex-partner, Male 1. The review has not been able to establish when this relationship began.

2.2.3 On 16th September Hanna was found by British Transport Police sitting on the edge of the Victoria Line platform. She was taken to the station control office where she said that she had been in the tunnels looking for her sister. Hanna was detained under S136 of the Mental Health Act and taken to the Mental Health Unit at St Ann's Hospital[10].

2.2.4 On 1st November MPS were called to a public house as a female was distressed. The female, Hanna, reported to officers that, whilst staying in the basement of a flat she had been raped and her property had been stolen. She was taken to Islington Police Station to speak to Sexual Offence Investigation Trained (SOIT) officer. It was recorded that Hanna was aggressive, shouting and wanting to know who was going to get her property back. Hanna did not disclose what had happened and declined being treated by the London Ambulance

[10] St Ann's Hospital have no record of Hanna attending and Place of Safety Unit at St Ann's was closed at least 10 years ago.

Service. Due to the unsubstantiated allegations no further action was taken by the police. Officers were concerned about her safety as she had nowhere to stay, and Adult Social Care were unable to help[11]. She was provided with a meal and given the opportunity to shower. She was provided with details of the Hungarian Embassy and a homeless shelter in Islington. She told officers that she had been diagnosed with a personality disorder in Hungary which is managed with medication, which she declined to take. She told officers that she slept with people to obtain accommodation and was a regular drug user. The reports were shared with Adult Social Care.

2.2.5 On 25th November Hanna attended the Welcome Centre in Ilford and reported that she had been made homeless. She was described by the centre's manager as an 'attractive, pretty young lady' who appeared a little immature and she believed that Hanna may have a learning difficulty.

2.2.6 On 8th December MPS received a call from a member of the public reporting that they had witnessed an assault. Hanna had been seen walking with her partner, Male 1 and a friend of his. An argument occurred between Hanna and the friend. The friend had grabbed Hanna's arm and pulled her hair. Male 1 had separated the two and the three continued to walk down the road. The friend was arrested, and, in interview, he said that Hanna had been rude to him, and he admitted pulling her hair once. A Police Caution for Common Assault was issued.

2.2.7 A statement was obtained from the informant who disclosed that, earlier in the day, they had seen Hanna being pushed several times by Male 1. A welfare check was created and assigned to the Emergency Response Police Team (ERPT) to attend the home address of Hanna. She was present with Male 1. She was spoken to and made no allegation against Male 1 and refused a referral to any domestic abuse agencies.

2.2.8 Hanna was referred, by MPS, to Victim Support, on 8th December, through the automatic data transfer (ADT[12]). The crime type was recorded as Assault Without Injury with a DV flag attached to the case.

2.2.9 On 10th December the allocated Victim Referral and Assessment Centre (VARC) Officer from Victim Support attempted to contact Hanna by mobile phone without success. The VARC Officer attempted again to contact her on 11th and 12th December.

2.2.10 The case was closed on 12th December and the VARC Officer emailed the referrer to advise them of this and instructed the referrer to provide the client with details of Victim Support's details and to re-refer if needed.

2.2.11 On 18th December MPS officers stopped Hanna with Male 1 and another male (the friend from the previous incident) after they had been seen acting suspiciously. There had been several burglaries in the area in the recent weeks. Checks on the Police National Computer (PNC) were completed and showed that Hanna was known to the police and had a warning signal marker 'suicidal'. A note had also been put on her PNC record stating that officers should contact the Sapphire Team[13] in relation to her recent rape report (2.2.6). This was

[11] There is no record of contact with Newham ASC at this time
[12] This allows the victim to be automatically referred to Victim Support by a tick being placed in a box on CRIS
[13] The Sapphire Team specialises in investigating sexual offences

completed by officers and Hanna's contact information was shared. A CRIMINT (MPS intelligence system)[14] report was recorded.

2.2.12 Hanna was registered and verified by the Welcome Centre on 4th December and was given a Street Link number in order that outreach workers would have a record of her and where she was sleeping rough.

2.2.13 On 28th December MPS were called by a member of the public reporting a male and female arguing in a park. Officers attended and found Hanna and Male 1 in the park. The officers spoke to Hanna and Male 1 separately. Hanna told officers that they had been to the mosque for food and were walking back through the park when Male 1 asked her for a sexual act. When she declined, he became argumentative. He started telling her that he was jealous of her looking at other men. Words of advice were given by the officers.

2.2.14 On 28th December a further referral was made by MPS to Victim Support and Hanna's case was reactivated. Contact was attempted to Hanna on 29th December without success. The case was closed.

2.2.15 **2015**

2.2.16 On 31st January MPS were called by a bus driver who had witnessed a male slap a female around the face. The Computer Aided Dispatch (CAD) was allocated to ERPT who conducted a search of the area and found Hanna and Male 1 engaged in a heated argument. Officers spoke to them separately. Hanna disclosed that she had been slapped by Male 1. She had visible swelling on the left side of her face and a small cut to her neck just below her chin. Male 1 was arrested for Actual Bodily Harm.

2.2.17 Whilst giving her statement, Hanna disclosed that Male 1 had physically assaulted her on 25th January and raped her on 30th January. She was taken to a MPS Safe Haven where the Sapphire Team took over the rape investigation and Hanna provided a video recorded interview.

2.2.18 Officers contacted Newham Housing Officers for accommodation for Hanna. It was explained that as Hanna had No Recourse to Public Funds[15] they were not able to provide her with accommodation. Hanna said that she would spend the night with a friend.

2.2.19 The following day Newham Adult Social Care agreed to provide one night's accommodation and assisted Hanna with contacting the Hungarian Embassy. The police took Hanna to the accommodation.

2.2.20 Male 1 was bailed with conditions.

2.2.21 On 2nd February Newham Action Against Domestic Violence referred Hanna to Adult Social Care (ASC) through the Access to ASC Team, as Hanna was homeless and experiencing sexual and domestic violence. The same day Hanna was accompanied by the police to the ASC

[14] CRIMINT (MPS INTELLIGENCE SYSTEM) is the MPS's intelligence system

[15] Section 115 of the Immigration and Asylum Act 1999 states that a person will have 'no recourse to public funds' if **they are 'subject to immigration control'**. This means they have no entitlement to the majority of welfare benefits, including income support, housing benefit and a range of allowances and tax credits.

offices in Newham Dockside as her abusive partner had been bailed to the address that they shared. Hanna was provided with one night's temporary B&B accommodation by the police.

2.2.22 The next day, 3rd February, an officer from Access to Adult Social Care contacted Hanna to discuss her plans – where she planned to live in the long term and the option of returning to Hungary was discussed with her as she had no recourse to public funds in the UK. She said that she had been returned to Hungary in August 2013 but returned to the UK in 2014. When asked why she returned to the UK, Hanna said that she wanted a normal life, to set up a business – a tattoo parlour or restaurant in Lakeside – and send for her children. Hanna had no money, clothing, or personal documentation.

2.2.23 Hanna disclosed that the person she met when she returned to the UK three months earlier had forced her to go on the 'game' (their words). She had then met a second person outside a church in Stratford and she moved into this person's home. She described him as a jealous man who made her lose all contact with her friends. She said that he beat her and was very controlling.

2.2.24 Hanna had nowhere to stay. She said that she would go to the Welcome Centre or to the church. Both would provide food but not accommodation. She said she had no money but had a friend in Edmonton who owned a barber's shop and would help her with work. She said that she would walk to Edmonton. Later in the day the Access Officer spoke to Newham Action Against Domestic Violence, but the officer was unable to locate Hanna's file. The Access Officer advised that Hanna would not be provided with housing as she had no recourse to public funds. The Access Officer was advised by Newham Action Against Domestic Violence that because Hungary was part of the EU, Hanna would be entitled to support if she had been working in the country for a year. It was agreed that Hanna would be accommodated at the Stratford Hotel for one night only to allow a better assessment of her situation. Hanna was advised that it may be in her best interests to return home to Hungary but, if she chose not to do this, she would have to find her own accommodation. Hanna was taken to the accommodation by the police after having shared her phone number with the Access Officer (the police had provided her with a mobile phone).

2.2.25 Hanna told the Access Officer that she had no papers and although she had told the police it had not been taken seriously. She said she thought her friend would help her out for 2-3 days but if this did not work out, she would contact the Access Officer for help with contacting the Embassy. Hanna was advised that, if she moved to Edmonton, there would be no further involvement from the Access Team in Newham and that she would have to present at the Civic Centre in Edmonton.

2.2.26 On 10th February Hanna called MPS and reported that on 9th February Male 1 had approached her telling her he had letters for her, and she needed to return to live with him. When Hanna told him to leave, he grabbed her. Hanna told police that she had seen Male 1 on the streets on several occasions and believed that he may be following her. Male 1 was arrested. Charging him for breach of bail was considered but, as the rape allegation had not reached the evidential threshold at the time for submission to Crown Prosecution Service for charging advice, he was charged with Common Assault and remanded in police custody to attend court.

2.2.27 Hanna was referred, by the MPS, to Victim Support and an unsuccessful attempt to contact Hanna was made. The case was closed and referred to MPS when further attempts to contact Hanna on 13th and 16th were unsuccessful.

2.2.28 MPS made a referral to Victim Support on 17th February regarding the incident on 31st January and this was recorded as Rape of Female aged 16 or over. An initial call was made to Hanna but there was no reply. Two further, unsuccessful, calls were made by Victim Support on 19th February. An email was sent to MPS advising of the unsuccessful attempts and asking them to provide Hanna with their details.

2.2.29 On 26th February a further contact attempt was made to Hanna titled '14 day follow up'. A male answered the phone, so the VARC officer asked for Hanna, and the call was terminated. The case was closed the same day.

2.2.30 On 3rd March two further calls were made to Hanna under the '14 day call back policy'. The calls were not answered, and the case was closed.

2.2.31 On 3rd March Hanna saw her GP. Her presenting complaint was her mental health. She was accompanied by her partner.

2.2.32 Hanna saw her GP again on 26th March when she disclosed that she had been kicked by her boyfriend and that when 'he gets drunk he acts this way'. She said that the previous night she had slept rough because she had been 'kicked out by her boyfriend' but was hoping for shelter in the Welcome Centre that night. She was given a further prescription of her medication. A further follow up appointment was arranged.

2.2.33 On 5th May Hanna attended 'Move On Move Up' retreat at Lambourne End. She is noted to have enjoyed the retreat and had made positive contributions to the programme.

2.2.34 Hanna's last Facebook post was on 11th May.

2.2.35 On 15th August a charging authorisation from Crown Prosecution Service was received for rape in relation to Male 1. The assault that was reported to have occurred on 25th January was NFA as the six-month time limit for charge had expired.

2.2.36 On 24th August officers attended HMP Pentonville where Male 1 was remanded and charged him with rape.

2.2.37 The last contact that Hanna had with the Welcome Centre was on 20th August when she attended and said that she was staying with a friend in Ilford.

2.2.38 Hanna attended a police station on 12th October and asked to withdraw her allegation of rape, stating that she had made it up and that was now back in a relationship with Male 1. Male 1 was arrested on 20th October and charged with Breach of Court Bail as he had been in contact with Hanna. He was remanded in custody.

2.2.39 On 21st October Hanna spoke to the Sexual Offences Investigation Trained Officer (SOIT) and Detective Sergeant leading the investigation of rape. She admitted that when she had called to withdraw the allegation of rape, Male 1 had been beside her. She stated that 'she had no-where to stay; no recourse to public funds and had missed her appointment with the Hungarian Embassy to get her passport so that she could claim benefits'. Hanna said that she wanted to withdraw her statement as she did not want to attend court.

2.2.40 **2016**

2.2.41 Efforts were made to contact Hanna, but she did not return them, and police were unable to locate her therefore a 'Notice of Discontinuance' was served in relation to the court case for the rape on 12th January. A locate/trace marker was placed on PNCID so that if she did come into contact with the police, it would flag to officers that the police were trying to locate her.

2.2.42 Police were called on 17th January by a member of the public who had heard a female scream for help. The female was identified as Hanna and found on a grassed area. She said that her boyfriend had pushed her from their 6th floor balcony. London Ambulance Service were called. Male 1 ran over and started to try and get Hanna off the ground and he was told by members of the public to stop.

2.2.43 Male 1 told officers that Hanna was suicidal and had jumped. Hanna was taken to the Royal London Hospital by ambulance. She had sustained a fractured left shoulder blade, minor fractures of her spine, broken ribs, and bleeding in her abdomen. She provided a statement in which she said that Male 1 had kept her captive and had assaulted her. He was arrested.

2.2.44 Crown Prosecution Service authorised charges for False Imprisonment and Assault by Beating. Male 1 was charged and remanded in custody. The rape charge was reviewed and reinstated by Crown Prosecution Service.

2.2.45 Hanna was admitted to the trauma wards at the Royal London Hospital for conservative treatment of spinal fractures, liver laceration, rib, and shoulder fracture. She also had a chest drain inserted due to pneumothorax.

2.2.46 On 17th January Newham Adult Social Care received a Notification of Assessment from Newham University Hospital's Social Work Team.

2.2.47 On 18th January Hanna was reviewed by the homeless team and safeguarding team. It was recorded in her medical notes (Barts) that she had been visited on the ward by the police, but no further information was recorded.

2.2.48 On 19th January it was recorded on Hanna's medical notes that she was reviewed by the homeless team and had also been to RAMFEL (Refugee and Migrant Forum of East London). The plan recorded in her medical notes was that calls would be made to the Embassy about obtaining her a new passport and RAMFEL. The homeless team said they would visit Hanna again.

2.2.49 On 19th January Hanna was referred to nia via the One Stop Shop. The referral stated that Hanna was being treated by the Royal London Hospital and a phone number was provided. The number did not connect so the IDVA contacted the Royal London Hospital and spoke to the ward sister. The IDVA's contact details were provided in order that the IDVA could speak to Hanna.

2.2.50 The IDVA spoke to the SOIT officer who had been working with Hanna for some time and was told that Hanna was in a bad way and would need support when she was discharged from hospital.

2.2.51 The IDVA continued to attempt to call Hanna via the ward sister without success. The ward sister was not able to connect the call, so the IDVA left her contact details. Three attempts were made to contact Hanna.

2.2.52 On 19th January a referral was made to Victim Support by MPS in relation to the incident on 17th January. The crime type was recorded as Attempted Murder.

2.2.53 Hanna's medical notes recorded that she was visited by the homeless team on 20th January and that they would refer her to Providence Row as she was a victim of domestic abuse, had No Recourse to Public Funds and was Eastern European. It was noted that they would come to assess her. They had contact with Hanna on 21st January.

2.2.54 On 20th January Hanna complained to a nurse that she could hear staff discussing sensitive information regarding her lifestyle prior to her admission. The complaints process was discussed with her, but a formal complaint was not made, and she disclosed that she had been a victim of human trafficking. The nurse advised Hanna to discuss this with the Homeless Team regarding referrals to the appropriate charity for support.

2.2.55 The IDVA tried to telephone Hanna again on 20th January, but the ward phone was engaged.

2.2.56 A MARAC meeting was held on 21st January and nia were asked to research charities that might be able to provide accommodation for Hanna. Despite contacting several organisations, nia were unsuccessful as Hanna had no recourse to public funds.

2.2.57 Providence Row had contact with Hanna on the hospital ward on 21st January. Whilst they were there, two men came into the room and one claimed to be her ex-partner, the other was a patient on the ward. The member of staff that was present was concerned and asked the men to leave. The incident was raised with the ward staff.

2.2.58 On 22nd January the IDVA left a message for the ward sister to contact her. It was also noted on Hanna's medical records that the ward was waiting for the outcome of the homeless team's discussion with the Hungarian Embassy about repatriating Hanna to Hungary as she was illegally in the UK having, allegedly, been trafficked across Europe for the purposes os sexual exploitation before arriving in the UK.

2.2.59 On 22nd January nia contacted the Hospital Social Work Team to advise that they knew Hanna but that they could not assist her as she had no recourse to public funds. nia asked the Hospital Social Work Team to assess Hanna and take the case forward.

2.2.60 The IDVA spoke to Hanna who said that she was in pain but OK. The IDVA said that she would continue to search for accommodation and contact Hanna again on Monday 25th January.

2.2.61 When the IDVA spoke to Adult Social Care she was informed that they did not have a team to support those with no recourse to public funds and was advised to contact the Hospital Social Work Team via email and request support for Hanna as she had no recourse to public funds, was destitute and efforts to secure accommodation via the charity sector have so far been unsuccessful. The IDVA set out the physical injuries that Hanna had sustained and asked for an assessment to be carried out.

2.2.62 Hanna's medical records on 22nd January noted that Providence Row had now completed a housing assessment and that they were waiting for feedback. It was also recorded on Hanna's notes this day that she had been downstairs with a friend, but the name of the friend was not noted. On 23rd January it was noted that Hanna was off the ward a number of times during the shift. Again, on 24th January it was noted that Hanna was regularly leaving the ward for a cigarette.

2.2.63 On 25th January a Discharge Access Officer recorded that a notification of assessment had been received on 25th January for discharge planning. Her case was assigned to a Hospital Social Worker for screening. It is noted that the referral did not provide a discharge date. On 26th January the ward was advised by Newham Social Care that they should contact the refugee team about accommodation for Hanna upon discharge.

2.2.64 On 26th January the Hospital Social Worker recorded that Hanna was independent and self-caring on the ward and had no social care needs but did have a need for safe accommodation. As a result, there was no Care Act assessment undertaken (as had been requested by nia on 22nd January). Hanna was given advice and guidance and information about the National Domestic Violence helpline to seek refuge accommodation. It is not clear from the records what this advice and guidance consisted of and there is no record to indicate if this information was fed back to nia. There was no further action from the Social Work Team.

2.2.65 On 28th January Hanna was referred to the Modern Slavery Victim Care Service provided by the Salvation Army by Providence Row. The NRM[16] (National Referral Mechanism) assessment was commenced with Hanna via telephone supported by Providence Row. Hanna had difficulty understanding them on the phone so it was agreed that they would visit her on the ward to carry out a face-to-face interview. When she entered the NRM service, Hanna's status was RG Pending[17].

2.2.66 On 29th January it is noted in Hanna's medical notes that the NRM Team contacted the ward as they wanted to interview her. Hanna agreed to the interview.

2.2.67 Hanna was seen on the ward by the homeless team and Providence Row the same day. The plan agreed was that:

- NRM Team would go and assess Hanna on 30th January with a view to her receiving a refuge place and support
- nia have a bed available at (location withheld – Chair) from Tuesday. When a decision was made by the Salvation Army, Hanna would decide which option she wished to take
- As Hanna did not have a SIM card she could not be contacted by her ex-partner. It was agreed that she could use the ward phone to speak to the police. The police were aware and had the ward phone number
- She said she would like a TV when one was available and was given TV cards
- The 'no visitor' policy was still in place

Hanna was in full agreement with these plans. Providence Row replaced the sim for Hanna's mobile phone.

[16] [16]National Referral Mechanism (NRM) – Framework for identifying and referring potential victims of modern slavery.

[17] RG Pending means that she was waiting for Reasonable Grounds decision to be made. This decision is made by the Single Competent Authority (SCA) and the Home Office. Reasonable Grounds means that the person is a victim of modern slavery.

2.2.68 On 29th January, the IDVA spoke to the OIC to inform him that, at present, no accommodation had been found. The IDVA then made a referral to Catholic Worker's Farm[18] (CWF) and was informed that this was the second referral they had received for Hanna. The worker at CWF said that, as there was an indication that Hanna had been trafficked an offer of accommodation was made 'in principle'. The IDVA contacted the hospital to advise that accommodation would be available from Tuesday, and they agreed she could stay on the ward until then.

2.2.69 The IDVA then spoke to Hanna to carry out an assessment. (The information that Hanna gave in that assessment is set out at the beginning of this report.). She said that the two-year relationship had been abusive throughout. The IDVA explained to Hanna about the accommodation at CWF and Hanna was hesitant as she thought it seemed too far away and told the IDVA about her caseworker. She referred to this woman as A but did not know which organisation she worked for.

2.2.70 The IDVA spoke to Open Doors and was advised that she could refer Hanna to both Open Doors[19] and the Medaille Trust who are a trafficking organisation. The IDVA contacted A (it is not clear if she worked for Providence Row or the Salvation Army). A said that she was supporting Hanna to find accommodation and was also struggling as Hanna had no recourse to public funds, but she had completed a referral to the Salvation Army via the trafficked route and they were going to carry out an assessment at the hospital on Saturday 30th January. They would then contact the IDVA and let her know if Hanna was eligible for support. The IDVA told A that Hanna had a place in principle at CWF, but A said that she had spoken to them, and she had been rejected by them after they had asked A to carry out certain checks. The IDVA and A discussed the fact that the support that they were each offering was overlapping and they agreed to work together to support Hanna to find accommodation and then discuss the case further once she was settled.

2.2.71 The NRM carried out their face-to-face assessment with Hanna on 31st January.

2.2.72 Hanna's medical records indicate that on 31st January she was away from the ward from 22.30 to 00.30 hours.

2.2.73 Hanna decided that the Salvation Army was the best option for her, and it was intended that discharge would take place on 3rd February.

2.2.74 During the night shift of 1st/2nd February Hanna spent long periods of time away from the ward and the site management team were made aware**. It is during these periods away from the ward that she was befriended by the perpetrator within the hospital area.**

2.2.75 Hanna's health records note that on 2nd February the homeless team were waiting for a call from the Salvation Army Trafficking team about transport to the refuge. Hanna was noted as not being keen to go due to a friendship she had made with another patient **(**the perpetrator) on a different ward and Hanna was very concerned about the rules that would be in place at the safehouse in Bristol. Hanna then left the ward with the Salvation Army escort at 6.15 pm and she was very tearful on discharge and said that she did not want to leave a new friend that she had made. It is now known that this friend was the perpetrator.

[18] http://thecatholicworkerfarm.org/
[19] Open Doors have no record of Henriett being referred to or accessing their services

2.2.76 After her discharge, the Royal London Hospital wrote to her GP based at a local medical centre. The letter provided all the information about her fall and the injuries and treatment but did not provide details of the safeguarding/domestic abuse concerns or involvement of the homeless team.

2.2.77 On 4th February Hanna visited her GP and was accompanied by her support worker. The documentation notes Hanna's move from London to Bristol. The consultation focused on the injuries that Hanna had sustained in the fall from the balcony, her need for a referral to the fracture clinic and that she had a viral infection.

2.2.78 On 9th February Victim Support attempted to call Hanna for the first time and the call was declined after one ring.

2.2.79 On 10th February MPS received information relating to Hanna from the Salvation Army Modern Slavery Adult Victim Care and Co-ordination Centre in the form of a National Referral Mechanism (NRM). This identified her as a potential adult victim of modern slavery. This referral detailed an interview with Hanna at the Royal London Hospital in which she had provided history and details of her life with her ex-husband in Hungary, sexual exploitation, and drug exploitation and how she came to the UK. She was described, in the referral, as aggressive, agitated, and impatient when she was spoken to.

2.2.80 Details were placed on the CRIS for the attempted murder to bring it to the attention of the Investigating Officer. Information about the attempted murder investigation was shared with the National Referral Mechanism Case Manager at the National Crime Agency (NCA)[20].

2.2.81 In the NRM form Hanna gave consent for the form to be shared with support agencies but did not give consent to police involvement. When the information was shared with MPS, it was highlighted that Hanna would not co-operate with any law enforcement investigation.

2.2.82 Hanna visited her GP on 18th February to address the pain that was not being controlled since she had reduced the level of medication she was taking. She was provided with appropriate advice.

2.2.83 On 22nd February the IDVA contacted the OIC and was informed that Hanna was safe and living in supported accommodation in Bristol provided by the Salvation Army. They were supporting her to obtain benefits and she was well. The IDVA advised that, as Hanna was now in Bristol, she would be closing the case. She asked if Hanna needed support with accessing organisations in Bristol and was told that all her support was being provided by the Salvation Army. The IDVA tried to call A from Salvation Army, but her line was engaged.

2.2.84 Victim Support made a second attempt to call Hanna on 23rd February and after a few rings an automated message advised that 'the other person has hung up'.

2.2.85 Hanna continued living in a safe house in Bristol and, during this time, Hanna was in regular contact with the perpetrator.

2.2.86 On 1st March Victim Support made a third attempt to call Hanna and again received the automated message that 'the other person has hung up'.

[20] Despite repeated attempts to contact NRM the review has not been able to gain more information about their engagement with Henriett

2.2.87 Victim Support made a final attempt to call Hanna on 10th March. The call rang twice and then was declined on the other end of the line. The referrer was advised by email that Victim Support had been unable to contact the client. They were asked to provide details of the service.

2.2.88 On 11th March Male 1 was charged with rape. The court trial for all assaults was listed for 27th June 2016.

2.2.89 On 17th March Hanna left the Unseen UK Safehouse to go and live with the perpetrator in London.

2.2.90 Hanna disengaged from the service provided by the NRM on 24th March.

2.2.91 On 3rd May Hanna received from NRM her Positive Conclusive Grounds decision, this means that there were 'conclusive grounds' to say that she was a victim of modern slavery.

2.2.92 Efforts to contact Hanna were made but the police were unable to locate her. Hanna did not appear in court on 27th June and so no evidence was offered. On 27th June the SOIT recorded on CRIS that Hanna sent a text message saying, 'Hi (name) is Hanna .just to let u know, I try to call u all weakend and all morning, but I couldn't get trouth, I'm not well that's why I cant come court today. I have tonsillitis and a fevear. Doctor give me sicknote I will give that to u when am coming to London. I contact the court to let they know I cant turn up. I still want to go ahead with the case. Thx to ur susport and help. Will email u or call u thanks Hanna'.

2.2.93 A court hearing was held on 24th July that MPS were not aware of, so no evidence was offered at the hearing and the case was discontinued. A letter from the Crown Prosecution Service Reviewing Lawyer was sent to Hanna to advise her of this decision.

2.2.94 On 29th September MPS were called to Upton Park Tube Station to four males and a female acting suspiciously. When officers arrived, three of the men left. The female was identified as Hanna and the male as the perpetrator. The perpetrator admitted to purchasing drugs and showed officers a bag of cannabis. Both were searched for additional drugs, but nothing further was found. The perpetrator was issued with a Fixed Penalty Notice for possession of cannabis. This was the only contact that the police had with Hanna and the perpetrator together.

2.2.95 The last recorded sighting of Hanna was on 29th August 2016 when she and the perpetrator were stopped by the police. The notes subsequently found inside the perpetrator's flat indicated that Hanna was alive and living with the perpetrator through to late September.

2.2.96 This was the last contact that the police had with Hanna.

2.3 Introduction to Star

2.3.1 Star was born in London in 1980 and was the youngest child with three siblings. Her parents came from Cyprus, to where her father returned after her parents divorced.

2.3.2 She was 37 years old when she was murdered and had two children with whom she had regular contact. Star had been seen by her mother a few days before she disappeared. She

was reported missing by her family on 10th May 2018. She was not seen again before she was found deceased in April 2019.

2.3.3 The scope set out for this review is 1st January 2016 to April 2019 (the discovery of Star's body). This enables the review to gather a sufficient breadth of knowledge of what life was like for Star before her murder.

2.3.4 **Star's connection to the perpetrator**

2.3.5 Using information gathered by the police as part of the missing person and murder investigations has allowed us to piece together a picture of how and when Star may have met the perpetrator.

2.3.6 The perpetrator has not denied knowing Star and it is clear that, at the time that she went missing, the beginning of May 2018, Star was spending time with him. Examination of mobile phone data shows that there was contact between Star's mobile phone and a phone used by the perpetrator in March, April, and early May 2018. Star's mobile phone made its last call at 2.38pm on 2nd May.

2.3.7 A photograph recovered from Star's phone was taken shortly before midnight on 1st May and appears to be taken in the perpetrator's kitchen. The detail of the photograph suggest that she was standing close to the oven door upon which her fingerprint was recovered.

2.3.8 Witnesses who gave statements to the police have said that they saw Star with the perpetrator early in 2018 and that they believed that she was with him because he had access to drugs.

2.3.9 The review therefore believes that Star had direct contact with the perpetrator no more than 2-3 months before she went missing.

2.4 Information outside the scope

2.4.1 It is known that from June 2006 Star experienced domestic abuse, reporting incidents to the police involving the fathers of her children. Children's Social Care (CSC) became involved in June 2007 assisting Star to move to her mother's home with the children. She later settled in her own home and had a job in the retail industry.

2.4.2 In 2008 she was arrested and charged with Failure to Notify a Change in Circumstances in relation to her benefits which was discontinued at court. Star lost her job, and her family say that she began to associate with people in the area who used drugs. At the beginning of December in 2009 Star was advised that housing benefit was not being credited to her rent account and that she was now liable for her rent and, on 29th November 2009 the amount she owed was £348.93.

2.4.3 In February 2011 Star was evicted from her council tenancy by bailiff's warrant for rent arrears of £2931.74. She had held this tenancy from 22nd September 2003. Star had moved to her mother's address in January.

2.4.4 In June 2011, Star advised Newham Council that she had been asked to leave her mother's address. She was asked to provide an 'Exclusion Letter' from her mother so that a referral

to Housing Options could be made. In July 2011 Star made a homeless application to LB Newham. She attended an emergency appointment at LB Newham. She said that she had part time employment as a sales assistant in Barking. She explained that she had been evicted in February 2011 due to rent arrears that occurred when she had problems with her housing benefit. She stated that she needed to renew her housing benefit form and tax credit and that when she did not provide the information required to support her application, her benefit was suspended. In October 2011 Star was deemed to be intentionally homeless having been evicted from her council property due to rent arrears. (This decision remained in place moving forwards).

2.4.5 Sadly, by this time Star's drug using had led to long absences from her family, sleeping on and off at friends' houses or sleeping on the streets in the Newham area. She suffered from anorexia, anxiety and depression.

2.4.6 In October 2013 Star's sister expressed concerns to her GP about Star's drug use, saying that she was using crack cocaine and maybe heroin. Following disclosure of this information the surgery attempted to contact Star by telephone. When this was unsuccessful, they wrote to her asking her to come to see the GP but there was no response.

2.4.7 In May 2014 the Housing Prevention and Advice Service at Newham Council (HPAS) were notified by Children's Social Care that Star's children were in the care of her mother. Star approached HPAS seeking accommodation. Her application was treated as a single person. Star attended an interview on 29th May as part of the application. Star was advised the same day that she was not considered to be in priority need as she did not have any children living with her and was not vulnerable due on medical grounds. As part of the assessment the circumstances that led to the intentionally homeless decision on 20th October 2011 were re-assessed and it was decided that there had been no break in the causation of homelessness. (The review has established that there was no mention in the HPAS records to Star being a victim of domestic abuse or having been previously heard at MARAC).

2.4.8 Star began her first treatment episode with local substance misuse services 'Change Grow Live' (CGL) in May 2015, having been referred by a relative.

2.4.9 **2015**

2.4.10 In May 2015 Star was referred to the IDVA (service provided by Aanchal at this time) by the police. Star had been a victim of stalking and was homeless. The perpetrator of these offence was a man we will identify as Male 2. He was an ex-partner who she no longer wished to be in a relationship with. There had been domestic abuse in the relationship. Star said that she had been homeless for two weeks and was hiding from the perpetrator (on the streets and in sheds). She said that he knew her friends and family and kept going to the family home address to try and find her. A risk assessment was undertaken. The score of 18 indicated a risk level of high. Male 2 had made threats to kill during a phone call that was overheard by the police. Star was then taken to the police station where she made a statement. Star said that there was no sexual relationship, but that he would hold a knife and screwdriver to her and question why she does not want to sleep with him. She said he strangled her daily. She was very scared and wanted a refuge space. The police contacted Adult Social Care to seek housing for Star and the male was subsequently arrested. The investigation did not lead to a prosecution due to insufficient evidence.

2.4.11 The Aanchal IDVA referred the case to Newham Housing. In a telephone call the housing officer asked more questions and then advised that, based on the information provided, he did not think that Star qualified for housing. He did agree to provide accommodation for one night only as his opinion was that Star is not experiencing domestic violence.

2.4.12 Star was accommodated in a hostel in Ilford and encouraged to attend the 'One Stop Shop' in the morning and the One Stop Shop advocates would seek refuge space. A phone number was requested from Star who said that she would call back later to provide it as she was calling from the police station. The One Stop Shop was a previous model of commissioned DA services where several specialist agencies were commissioned to provide services. For example, advocacy, MARAC, culturally specific services, drop in services. This model ended in May 2018 and since that time a single specialist provider has been used for community-based services within the borough.

2.4.13 On 1st June 2015 the case transferred to the nia[21] IDVA. The Aanchal IDVA called Star at the hotel to advise that a nia IDVA would be in touch. In the handover from the IDVA at Aanchal to the IDVA at nia, the Aanchal IDVA said that as Star is not in a relationship with the suspected perpetrator of that abuse, this was not domestic abuse.

2.4.14 The case was accepted by nia's IDVA service and a refuge search revealed that there were no spaces. The nia IDVA liaised with housing link for the service who advised Star to present at Housing/Out of Hours Housing. As it was too late for Star to present at housing a request was made to access contingency funds (discussion between nia IDVA & Aanchal Advocate) and it is not clear from the notes who held that fund, or the process for applying to it/refusal. Star was advised to present at Forest Gate Police Station and contact out of hours housing. She was assured that the refuge search would continue the next day.

2.4.15 During the nia IDVA's conversation with Star she confirmed that she had been friends with the perpetrator, Male 2 for a year. She said that their friendship broke down when the Male 2 wanted their friendship to develop into an intimate one. Star said that Male 2 had become aggressive towards her. On two occasions he had threatened her with a pair of scissors to her stomach, a screwdriver to her neck and her continued to stalk her. As a result, Star felt threatened by his behaviour. She said that he told her to *'keep looking over her shoulder, even if he ends up in prison, he'll send his friends after her'*. Star said that she had lost a lot of weight due to all the stress the prolonged situation has caused her and that her GP had recommended a special diet to help her gain some weight. The nia IDVA asked Star several times if she had ever been in a relationship with Male 2 and she stated that they were only friends. There is no record of the IDVA sharing this information with the investigating officer. From this point the IDVA referred to is employed by nia who are now providing the service.

2.4.16 The refuge search was unsuccessful as Star needed to remain in London to maintain contact with her children. The IDVA advised Star to attend the local service centre or go to Forest Gate Police Station for supportive temporary accommodation. The IDVA said she would contact Star the next day (2nd June).

2.4.17 On 2nd June a MARAC referral was completed by the IDVA, but this was not accepted by MARAC as it was not considered to be domestic abuse.

[21] nia runs services for women and girls who have been subjected to sexual and domestic violence and abuse, including prostitution. They offer community-based services in Hackney, Haringey, Barking and Dagenham, Waltham Forest, Redbridge, Tower Hamlets, Havering, Newham and Brent.

We have not been able to locate the referral or any correspondence in relation to the rejection of the referral. It does appear that a 'literal' definition of domestic abuse may have been used relying upon the phraseology of 'intimate or family member' at the time. We are simply unable to say whether, after clarification that Star was in a relationship with the perpetrator, the MARAC referral was accepted and heard or not.

2.4.18 The IDVA called Star on 2nd, 3rd, and 4th June but there was no answer. The IDVA spoke to an officer in the Community Safety Unit at Forest Gate Police Station. She was advised that the case was still open, and that Male 2 had been spoken to and warned not to contact Star. The IDVA was advised that Male 2 had been released on police bail and was due to return to the police station on 28th July.

2.4.19 The IDVA called Star again on 5th June (x2), 12th June and 15th June (multiple times) without success. On 15th June the case was closed as the IDVA was unable to engage with Star.

2.4.20 On Monday 15th June the police were called by Star. She reported that she had been staying temporarily with a friend, Male 2 and he had taken her bank card and £100 from her account. Star said that she wanted officers to get her money back. When officers attended Star further disclosed that previously Male 2 had gone into her bedroom and raped her. When it was explained to Star that officers would need to take a full account from her and evidential swabs, Star became hesitant and did not elaborate on any details but said that she would attend the police station in the morning. The Sapphire Team[22] was advised.

2.4.21 The following morning a supervisor noted that they had only been informed of the report and had been unable to get in contact with Star. They tasked officers to attend Star's last known address and if unsuccessful to place a locate trace for her on PNC. Officers attended the address which was Star's mother's address. They spoke to both Star's mother and sister who had not seen her over the recent days. A locate trace was put on PNC for Star.

2.4.22 On 20th July, Star and Male 1 were arrested for Burglary. The investigating officer for the rape report and a Sexual Offences Investigation Trained (SOIT) Officer spoke to the Custody Sergeant and took Star to a consultation room to speak with her. Star said that she did not want to pursue the allegation and that Male 2 had paid her money back. The officers spoke to Star about her safety, re-iterating the help and support that was available. Star declined any help. The report was closed with Outcome Code 16 – *Named suspect verified. Victim unwilling to assist police.* No further action was taken in relation to the burglary.

2.5 Detailed chronology for Star – 1st January 2016 – April 2019

2.5.1 **2016**

2.5.2 On 3rd August 2016, Star called police reporting that she had stayed at her friend Male 1's address, the previous week. When she woke, her trousers and knickers were on the floor, and he, was asleep next to her. She said that she did not remember how this happened and said that she did not feel anything. Star told police that she had made a report against this man the previous year as he had stalked her. She stated that her mother did not know about this incident and explained that she was using her friend's phone providing landline to be

[22] MPS specialist unit that investigates sexual offences

contacted on. Officers attend Star's address the following morning and her mother told them that she was with friends.

2.5.3 The police record that several attempts were made to contact Star, including through her family and friends. As police were unable to establish contact with Star, on 24th August 2016 a review by the Detective Inspector was completed and the report was closed with Outcome Code 16 – *Named suspect verified. Victim unwilling to assist police.*

2.5.4 On 28th September Star saw her GP with a range of symptoms - anxiety, depression, insomnia, not eating well or putting on weight, a cough and headache. There is no documented enquiry into factors in her life that may be causing her mental health and physical symptoms. She was examined and prescribed with amitriptyline and nutritional supplements.

2.5.5 Star ended her first episode of treatment with Change Grow Live on 29th September. She left treatment in an unplanned way and attempts to re-engage her were unsuccessful.

2.5.6 On 25th October police were called by a member of public stating that rough sleepers were in the stairwell of a block of flats and were refusing to leave. He provided information that they were an *'Asian male'* approximately 25 years and an *'Asian female'* approximately 20 years and said that he believed that they had taken drugs.

2.5.7 Officers attended and found one female present; identified as Star. She stated that she was waiting for a friend. She was recorded to have concealed her bag inside her jacket. Officers conducted a search under Section 1 PACE 1984 (a power that allows officers to search for stolen or prohibited items, or illegal drugs). Nothing was found and no further action was taken by police.

2.5.8 The search was recorded onto a CRIMINT report. There was no further information regarding the identity of the male.

2.5.9 On 15th November a child of Star's called police reporting that a man outside his flat had attacked him. He stated that he knew the man as Male 1.

2.5.10 Police attended and spoke to a male known as Male 2 who was known to have just been released from Prison. Officers described this male as being 'drunk'. The police were told that Male 2 and Male 1 had an altercation outside in the street, after Male 1 had gone into the block of flats shouting abuse towards Star, which Male 2 had tried to stop. Star told both males to leave, her child was present and Male 1 had punched him in the face.

2.5.11 Officers attended Male 1's address which appeared to be empty. Whilst there, they received a call informing them that Male 1 had returned to Star's flat. Officers returned and saw Male 1 walk down the communal stairs of the block having something in his hand which he discarded onto a window ledge.

2.5.12 Star and her child told officers that Male 1 had been writing on the walls. Officers noted abusive, threatening words towards Star had been written on the wall in nail varnish. Male 1 was arrested for Criminal Damage and Common Assault. Star was spoken to and told officers that she believed that Male 1 was stalking her. Male 1 was charged with Criminal Damage and Common Assault.

2.5.13 **2017**

2.5.14 Star began her second treatment episode with Change Grow Live on 16th January having self-referred to the service.

2.5.15 In January Star's GP received a request for blood results and current medication from Change Grow Live.

2.5.16 At the end of March Change Grow Live advised Star's GP that she had disengaged from the service.

2.5.17 On 19th April Star ended her treatment episode with Change Grow Live in an unplanned way and attempts to re-engage her were unsuccessful.

2.5.18 Star visited her GP in October. The consultation notes record a history of sleep problems and drug addiction. The GP noted that Star was thin and emaciated and said she had no current symptoms.

2.5.19 On 28th December Star engaged in her third, and final, treatment episode with Change Grow Live, having self-referred into the service. She was provided with a safe storage box to secure her medication.

2.5.20 Change Grow Live referred Star to MARAC on 29th December. This referral was made because Star alleged that Male 1 was stalking her and had, in the last two months, raped her. She told them that she had reported this to the police.

2.5.21 **2018**

2.5.22 On 11th January Star was referred by Change Grow Live and nia[23]to MARAC based on professional judgement and the assessment that she was high risk. The referral stated that there were three alleged perpetrators of abuse although Star's relationship to them was not clear. None of the perpetrators were the perpetrator responsible for Star's death.

2.5.23 On 30th January the IDVA attempted to contact Star but was unsuccessful. On 31st January, the IDVA spoke to Star and a risk assessment was completed. Star outlined her situation to the IDVA. She said she was currently living in a house and had been locked in for a couple of hours. She said she felt safe as the person told her they were locking the door and they would be back soon. She had stayed there the previous night but did not have anywhere to go that night.

2.5.24 Star said she had been homeless for about a year. Her oldest two children were with her mother and the youngest had been adopted. She said she was able to visit the oldest but only during the day and she could not stay overnight at mother's house. She said that she had not seen the baby since she was removed. Star said that when she no longer had the children with her, her benefits had changed, and she had lost her housing.

2.5.25 Star said that she had not received benefits for a year. She said that she was addicted to heroin but that she did not drink alcohol.

[23] nia provide the Independent Domestic Violence Advocates (IDVA) service

2.5.26 Star explained that she had been paying for accommodation with sex, which has resulted in her being severely and repeatedly abused. She said, *'I have come to expect it now, I'm just numb to it.'*

2.5.27 She said she was depressed but she had not tried to take her own life as she was living for her children. She explained that she used to be a dance teacher and has had a string of abusive relationships before becoming homeless. She said that she had anorexia, and the GP had given her high nutrition shakes to help boost her body weight. She had been provided with foodbank vouchers by Change Grow Live.

2.5.28 Star said she wanted to get out, to get clean and be safe. The IDVA explained about refuges and Star is very keen to go into one. The IDVA said she would investigate them and call back in a few hours. When the IDVA asked Star about housing, she said that the council had declared that she was intentionally homeless and so they would not provide her with emergency accommodation. Star also said she had reported to the police a few times, but it only made things worse, so she had stopped reporting the abuse.

2.5.29 The IDVA conducted a refuge search and found one space available (Solace Women's Aid). A search of night shelters found that one night shelter had no spaces. A second said that the IDVA should email a referral form, but that Star needed to be able to abstinent from drugs during opening hours.

2.5.30 The IDVA attempted to call Star four times without success, so sent a text and left a message with Star's mother and her number for Star to call back when she could.

2.5.31 The IDVA made a referral to London Exiting Advocacy (LEA) which is a nia service that supports women to exit sexual exploitation through prostitution. A MARAC research form was completed in preparation for the MARAC meeting. This included an overview of the current situation from the point of the initial referral.

2.5.32 Star's case was heard at MARAC on 1st February. Change Grow Live reported that they were concerned that Star had been living with someone who was giving her money for 'sexual favours'. They said that they believed there were other perpetrators, but they did not have the details. The IDVA reported that Star had been rehoused 'yesterday'[24] . It was reported that Star had said that she was paying for her accommodation in the past by 'sex work' and had been abused, beaten, raped, held against her will and given alcohol by force. The IDVA also reported that she had been expecting a telephone call from Star, but this did not happen, and the offer of accommodation was withdrawn. Star's whereabouts was not known. The risk was agreed as life threatening. The action agreed was for the IDVA to contact Star and identify the other perpetrators.

2.5.33 On 5th February Solace emailed to the IDVA to say that they had tried to contact Star, but she was not picking up the calls. The reason for them trying to contact her was to advise that the place in the refuge was no longer available.

2.5.34 The IDVA picked up a text from Star on 5th February that had been sent on 3rd (the weekend) in which she says, '*Hiya [name] I'm sorry I haven't ot back to you as I lost my phone straight after I had spoken to you. I found my phone this morning I tell you all about i please please*

[24] This is assumed to be 31st January 2018

please can ou call me I hope and pray that you haven't given up on me if you can't get throw to me on my phone then can ou call me on this number it's me [name] hope you still remember me. waiting for your call please god'. The IDVA tried to ring Star but as there was no reply, she sent a text that said, '*Hi - I'm sorry but only received your texts today as don' work on weekends. I have tried to call both of your numbers but there's no reply - is there a good time for me to cal you tomorrow? I really hope you're ok and please don't worry - we are here to offer you support. [name].'*

2.5.35 On 7th February the IDVA contacted Change Grow Live to advise that initially engaging well she was now unable to contact Star. She told her about the text she had received over the weekend. The worker from Change Grow Live replied to say that she was having the same difficulty in seeing Star. She said she was in touch with Star's mother who said that she was OK and that she had seemed very excited at the prospect of a hostel when they had spoken the week before. She said she would try again the next day to contact Star and let the IDVA know the outcome.

2.5.36 On 8th February the IDVA advised MARAC that the action had been completed. Change Grow Live advised the IDVA that Solace had been in touch as they wished to offer Star a place in refuge. The IDVA spoke to Star who confirmed that she had received a voicemail from Solace a couple of days ago and so she had left them a message that morning. She told the IDVA that Solace had called her back and, after doing a referral over the phone, they needed to speak to a key worker. Solace confirmed to the IDVA that the space had not been offered and they needed to speak to Change Grow Live before accepting her. The IDVA notes that on 9th February that Solace had advised Change Grow Live that they were considering offering Star a place, but it was dependent upon her attending a GP appointment with them that day and being scripted.

2.5.37 On 12th February the IDVA was advised by Solace that Star was in a Refuge.

2.5.38 On 23rd February staff at the Solace Women's Refuge contacted police and reported Star as missing. She was last seen on 20th February. The staff told police that Star was taking Methadone and had left the refuge stating that she was collecting her prescription. She had also failed to attend her meeting at Camden City Hall. Concerns were raised that Star may be '*prostituting to get money for drugs'*.

2.5.39 Police were notified later in the day by staff at the Refuge that Star had made contact stating that she was in Barking.

2.5.40 On 23rd February Star underwent Urine Drug Screening at Change Grow Live and tested positive for heroin and crack-cocaine. Star was, currently, living in emergency refuge accommodation in another area of London (details known to this Review). Despite her care having been transferred to Change Grow Live Camden, this was her last report of use to services.

2.5.41 Star received her last prescription for methadone on 24th February which would last her until 2nd March. This was the last time that Star was clinically assessed at Change Grow Live.

2.5.42 On 24th February Star returned safe and well. Staff at the Refuge advised the police but stated that she was sleeping so could not be spoken to by police on the phone. They told police that Star had told them that she had been staying with friends.

2.5.43 On 9th March Star moved out of the Solace refuge with no reference to her plans. Staff at the refuge had tried to contact Star and her mother since she had left but had been unsuccessful.

2.5.44 On 23rd March Star collected her last GP prescription.

2.5.45 Star attended Change Grow Live in an unplanned way on 26th April to request a food voucher due to a lack of income. She was provided with a food bank voucher. This was the last time that she seen face to face at Change Grow Live.

2.5.46 The first mobile number linked to Star was used for the last time on 27th April.

2.5.47 On 30th April Star ended her third and final episode of treatment with Change Grow Leave in an unplanned way (i.e. she no longer attended). Attempts to re-engage her were unsuccessful.

2.5.48 A note was made on Star's phone that she had an appointment with her GP on 4th May.

2.5.49 Star was seen at her mother's address with a friend on 2nd May. Star's mother gave her £20 and told her it was the last time she would give her money for drugs. The second mobile number for Star ceased use on this day and Star was allegedly being taken to Brighton by a female.

2.5.50 There is no record of Star attending the GP appointment on 4th May that was noted in her phone.

2.5.51 It is reported that Star was last seen by Male 1 on 6th May when he later told police that he refused her access to his home.

2.5.52 On 10th May, Star was reported missing by her sister to the police. She stated that she had not seen Star for two months and was now getting concerned as people had been calling her raising concerns. A missing person report was recorded as medium risk.

2.5.53 Star was said to have been staying with her friend Male 1 for the last three months but had left his address after an argument over drug use. She returned to the address on 6th May, but he would not let her in, so she left. The previous rape and assaults by Male 1 were cited.

2.5.54 In the report, Star is described as a '*drug user*' who took heroin and was involved '*possibly in prostitution to fund her drug habit*'. It was recorded that she sometimes slept rough and would also beg. Star was recorded to have been diagnosed with anorexia and depression which she had been prescribed medication but did not take. Star had previously told family that she had intended to commit suicide. She had previously swallowed pills and threatened to jump off a bridge.

2.5.55 Enquiries were made with previous partners and Male 1. The police liaised with the Women's Aid Refuge that Star had stayed at, Newham Drug and Alcohol services she had used, and her phone data investigated. Intelligence and hospital checks were conducted regularly throughout the investigation and authority was sought from Star's family for Star to be circulated as a missing person via Twitter and Missing People Charity.

2.5.56 The Missing Person enquiry established that personal items belonging to Star including her driving licence, clothing and birth certificate had been left at the refuge where she had been staying until March.

2.5.57 During the Missing Person investigation there was a continual receipt of possible sightings of Star reported throughout England and Wales that police say were investigated.

2.5.58 Through mobile phone data it was identified that the perpetrator's mobile phone number appeared on Star's call data as one of the last numbers to call her before her phone usage ceased. On 26th June the MISPER IO (the police's missing persons investigating officer) and Jigsaw[25] Officer visited the perpetrator's address. There was no reply, and a letter was left. Enquiries were made with neighbours with one recalling seeing a *'slim girl'* with the perpetrator a few days previously. When shown Star's photo believed it may have been her.

2.5.59 On 30th May Star was referred into Newham MARAC by Change Grow Live based on professional judgement.

2.5.60 On 30th May Change Grow Live contacted the IDVA and asked her to make contact as they had received reports from her family that Star was missing, and they were unsure that this was the case, or they just did not know her current whereabouts in refuge. The IDVA called Star and 'a lady called Jo' picked up and said that she was Star's friend, and that Star was missing. She said that Star had been asked to leave the refuge as she did not stick to the house rules, but she had nowhere else to go. When the IDVA spoke to Change Grow Live about the conversation with Jo, she came to believe that she had in fact spoken to a man who was named on the original referral. He was a man who allowed vulnerable women to stay with him. The IDVA updated the police on the phone call.

2.5.61 On 21st June 2018 Star's case was heard at Newham MARAC. Change Grow Live shared that Star had said that she has no fixed abode, was sleeping rough or staying with men in crack houses. Star had reported that she had been sexually assaulted on multiple occasions and had been locked in a bin chute by a perpetrator. Star said she was not being romantically involved with any of the alleged perpetrators. It was noted that Star had stayed in a refuge in Camden, but "did not engage" and subsequently left. Change Grow Live reported that Star usually has telephone contact with friends and family, but this has stopped, and that Star's sister has said that she believes that one of the alleged perpetrators had killed her.

2.5.62 The IDVA (nia) shared that Star had engaged in December 2017 and was placed in Camden refuge but believed that she had been evicted. The IDVA had called a number linked to Star and reached a male (not known perpetrator) who had advised he had not heard from Star recently. The police advised that Star had been reported missing.

2.5.63 The IDVA tried to call Star on 21st June, but it cut to an engaged tone. The IDVA tried to call Change Grow Live but there was no reply.

2.5.64 On 2nd July the Jigsaw Officer visited the perpetrator's address. He told the officer that he did have a female (F7) staying at his address who had assaulted him. When asked about Star, he stated that he knew her through another female but had not seen her.

[25] Jigsaw manage Multi-Agency Public Protection Arrangements (MAPPA) offenders living in the community as well as those serving sentences for their relevant offences. MAPPA is the process through which the Police, Probation and Prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community to protect the public. The Central Jigsaw team coordinate the Pan- London response (with our legislative partners) providing the police response to the strategic overview for MAPPA.

2.5.65 On 4th July the female that the perpetrator stated he knew Star through, was spoken to. She confirmed that she had last seen Star when Star stayed with her for two days up to 2nd May. She told officers that they had a minor argument and Star left to get some money. She stated that Star had threatened to take an overdose. She was further spoken to on 27th November and told officers that she believed that Star was dead because she would not leave the area and not contact anyone.

2.5.66 On 19th July the IDVA emailed Change Grow Live to enquire if anything more was known about Star, as is concerned for her safety. Change Grow Live had no updates either about her whereabouts and safety and stated that they believe that she was still considered a missing person and the Police were still looking for her and would keep the IDVA updated. The IDVA sent an email to the MARAC Chair (MPS) with their concerns about the information that they had received from different sources and asked for an update on the investigation. The MARAC Chair responded by asking the IDVA for clarification about the information she had shared. The IDVA assisted by asking the source of information to speak to the police, and she agreed.

2.5.67 Concerns were reported that Star might have been killed with Male 1 as a key person named. An action was also set to visit the perpetrator again. On 21st August the IO contacted the perpetrator who stated that he had not seen or heard from Star in a few months and could not remember the exact dates.

2.5.68 Investigation and lines of enquiry actions continued by the Missing Person Unit (MPU). Dental records for Star were obtained and comparisons were made with unidentified bodies. Consultation with the National Crime Agency (NCA) UK Missing Person Bureau was sought, and actions were created including review of her notebook that had been seized and organising an underwater search of nearby docks.

2.5.69 The IDVA contacted the police for a further update on 20th August. The officer advised that he was no longer in the Missing Persons Unit and provided the details of the OIC. The IDVA was advised that the loft at the home of Male 1 had been searched but nothing was found. The officer took the IDVA's number and agreed to update with any developments.

2.5.70 **2019**

2.5.71 A meeting with Star's family was held on 28th January. A review on the CRIS (the Metropolitan Police's crime and incident recording system) documented that although the National Crime Agency (NCA) had not conducted a full and thorough review, their overview *'reinforces the strongest current hypothesis that Star is no longer alive'*.

2.5.72 On 10th February a police supervisor review considered the working hypothesis highlighting facts gathered for and against Star being alive.

2.5.73 On 20th February the IDVA closed the case as all notifications had been made to the police and they had promised to advise of any updates.

2.5.74 Star's body was found in April of 2019.

2.6 Introduction to the perpetrator

2.6.1 The perpetrator was born in Whitechapel and, after his parents divorced, he lived with his father and stepmother in the Forest Gate area of London.

2.6.2 On his Police National Computer (PNC) record the perpetrator had warning markers of RSO/ViSOR subject[26], mental health, suicidal, self-harm, Ailment (due to Crohn's Disease), and Violent (for Grievous Bodily Harm, Domestic Abuse convicted assault and spitting at a police officer).

2.6.3 **The perpetrator is a serial perpetrator of abuse towards females.** From 2001, when he was 16 years of age through to 2018, he had been reported for violence and domestic abuse against a number of young girls and vulnerable women. The reports did not necessarily result in prosecutions or subsequent convictions.

2.6.4 The perpetrator's previous convictions are listed in Appendix 2. **However, convictions alone clearly did not represent this perpetrator's level of risk.**

2.7 Chronology for the perpetrator

2.7.1 **Outside the scope of the review**

2.7.2 **2001**

2.7.3 In March 2001, at the age of 16 the perpetrator's mother reported that he was engaging in sexual activity with a 15-year-old relative. This was confirmed by the girl, but the child was not willing pursue the case. The Child Abuse Investigation Team of MPS and Children Social Care investigated, He was arrested and interviewed. Due to insufficient evidence no further action was taken. In June 2001 the perpetrator reported having been assaulted by his father, brother, and stepmother. He was taken into Police Protection. Consideration was given to placing him with his mother, but it was recorded that, 'this was not possible due to a High Court Order granted in 1991 stating that she could not have contact with her son'. Due to his age, the police directed him to the Homeless Person Unit.

2.7.4 In 2001, the perpetrator came to notice for violent and controlling behaviour towards a female. This was against his 16-year-old girlfriend Female 1 who became pregnant and gave birth to their son in 2002.

2.7.5 **2002**

2.7.6 In 2002 he was named in a crime report raised by Essex Police as being responsible for punching his girlfriend whilst on a school trip.

2.7.7 Also, in 2002 the perpetrator was living with his father in Beckton, but he was asked to leave and made a homeless application. The case was closed when he did not attend his appointment and he made no further contact with the council.

2.7.8 He made a further homeless application in December 2002 but, once again, the application was closed when he did not attend his appointment.

2.7.9 **2003**

[26] Registered Sex Offender/ Violent and Sex Offender Register

2.7.10 On 7th January the perpetrator applied to join the Council's housing register claiming that his father had kicked him out and he was homeless.

2.7.11 During the homicide investigation his wife's brother provided a statement recalling the violence his sister encountered from the perpetrator including having a cigarette held on her arm which led to a permanent scar.

2.7.12 In August 2003 the perpetrator made a further homelessness application when he submitted a GP letter to demonstrate that he had mental health problems and was vulnerable. His application was assessed on 17th September, and he was accepted as unintentionally homeless and in priority need, meaning that the council had a duty to provide him with temporary accommodation until he was permanently housed. He was placed in temporary accommodation.

2.7.13 In September 2003 the perpetrator was found guilty of theft having stolen a mobile phone from a hostel where he was staying. He was fined £200 with costs.

2.7.14 In November 2003 the perpetrator was arrested for Taking and Driving Away a vehicle. No further action was authorised by CPS.

2.7.15 **2004**

2.7.16 (Exact date not documented) The perpetrator was admitted to the Newham Centre for Mental Health inpatient unit. He was diagnosed with a mental and behavioural disorder due to use of multiple substances. He reported that he was prescribed drugs before going to prison and that this was stopped when he went to prison.

2.7.17 In January 2004 the perpetrator and his friend were assaulted and robbed of their personal items by two suspects. Insufficient evidence led to not further action being taken by the police (for relevance see entry at 2.5.20).

2.7.18 The perpetrator was arrested on warrant in February 2004 in relation to a Department of Health and Social Security (DHSS) benefit fraud. On 1st March he was convicted of fraud and failing to appear at Bodmin Magistrates Court. He was fine £100.

2.7.19 In March 2004 the perpetrator reported that three males forced entry to his flat, assaulted him and took his mobile phone. During the investigation his mental health keyworker was spoken to who said that he had been suffering with his mental health for approximately 2 years after he was attacked in a park. The police were informed that he also suffered from anti-social behaviour disorder.

2.7.20 In June 2004 the perpetrator was arrested for being on warrant by City of London Magistrates for failing to surrender. On 7th July 2004 he reported being assaulted by three males who took his personal belongings.

2.7.21 At some point in 2004, Female 2 became involved in a relationship with the perpetrator, it is reported that she was 14 years old at the time and that he was 19 (see later entries at section 5.1 of the report)

2.7.22 In August 2004, Female 2 reported that she had been assaulted by the perpetrator. She said that the perpetrator, who was 19 years old at the time, was her boyfriend. She disclosed that he grabbed her round her throat, banged her head against the wall and refused to let her go. He was charged with Actual Bodily Harm (ABH) and False Imprisonment. He was found not guilty at court.

2.7.23 **2005**

2.7.24 The perpetrator was stopped and searched by the police in January 2005. He was found in possession of cannabis and a Cannabis Warning was issued.

2.7.25 In February 2005 the perpetrator' father reported that the perpetrator had taken his car. He was arrested for Taking and Driving Away a vehicle, no insurance, and no driving licence. He was found not guilty in court in June.

2.7.26 Police were called to the perpetrator's address on 31st March 2005 by a member of public after seeing a girl hanging over the balcony being pulled back inside by a man. The girl (female 2), who was 14 years old, told officers that she had been staying at the address with her boyfriend (the perpetrator). They had an argument and she wanted to go home. She told police that the perpetrator had just come out of prison and that he had been arrested for False Imprisonment on her previously. The female told police that she and the perpetrator were not engaged in a sexual relationship. Officers took the female to the police station and her mother was called. When her mother attended, she reported that he had attended their home the week before and had taken jewellery. The assault and theft reports resulted in no further action by police.

2.7.27 In April 2005 police received a report from Female 2's mother that her 14-year-old daughter was 7 weeks pregnant, and that the perpetrator was the father. Initially Female 2 was reluctant to speak to police due to her experience at court the previous year and so she had 'lost faith' in the criminal justice system. Female 2 was still seeing him.

2.7.28 Later, in April 2005 police were called to report an assault of a 14-year-old girl who had recently had a fight and fallen out with Female 2. She informed officers that she had been walking in the street when she saw the perpetrator and Female 2. He had shouted out to her and told Female 2 to hit her. He then swung out and hit her in the face causing her to sustain a bruised eye. He then threatened her by stating that if she touched his girlfriend again, he would 'shove a knife up your arse' and spat at her. The victim and her parents asked that he was spoken to and warned about his behaviour. A harassment letter was sent to him, and the investigation was closed.

2.7.29 On 30th April Female 2 was stopped by security in a supermarket store for taking a sandwich. She reported that this perpetrator had been holding her against her will. He ran off. Female 2 disclosed she had gone to the perpetrator's address on 25th April, and he had then held her against her will locking the door with a pole against it. The Investigating Officer liaised with Children's Social Care, and, with joint working, Female 2 provided a Video Recorded Interview (VRI) detailing the sexual relationship, pregnancy, physical assaults, and false imprisonment by the perpetrator.

2.7.30 On 29th May 2005 the perpetrator reported to police that he was grabbed by a male, placed in a headlock, and forced inside a property. He managed to escape through a window and had sustained cuts to his hand and pain to his body. Officers took the perpetrator to hospital.

When spoken to, he admitted experiencing mental health difficulties and said that he had not been receiving treatment for his 'schizophrenia since January'. At hospital he was referred to their mental health team. After being discharged, the perpetrator was taken to Tottenham Police Station. Intelligence checks were conducted showing that he had been arrested two days previously for a GBH by BTP.

2.7.31 The perpetrator admitted to officers he had not been telling the truth because he was scared. He then provided two further differing accounts. Enquires were made with BTP and it was established that the male had admitted to assaulting the perpetrator in response to racial abuse. CCTV also showed the perpetrator under the influence of alcohol and sustaining injuries after falling to the ground following being punched. It was ascertained that the perpetrator had attended a party with the male. At the party he was found to have stolen items. A fight ensued between him and the male. This account was supported by other witnesses. The Investigating Officer made numerous attempts to contact the perpetrator to progress the investigation including sending out a letter asking the perpetrator to contact him in the next 14 days. Due to non-engagement from the perpetrator, the report was closed.

2.7.32 On 3rd June 2005 the perpetrator reported to police that he had been assaulted on a bus and his mobile phone had been taken. Advice was sought from CPS, and they advised no further action as the perpetrator was not willing to pursue the allegation and give evidence.

2.7.33 On 13th June Female 2 was reported missing from her mother's address.

2.7.34 On 20th June the perpetrator was convicted of driving with no insurance and no driving licence. He was fined £300 plus costs and disqualified for 6 months.

2.7.35 On 30th June Female 2's father reported that he had found her and was at King Georges Hospital (KGH). Female 2 told officers that on 13th June she had received a telephone call from the perpetrator asking to see the scan pictures of their baby. She agreed to meet him which led to her being held against her will and assaulted by him. She stated that he said if she left, he would 'Do her and fuck the baby up' and he would commit suicide. She disclosed that she had engaged in sex with the perpetrator and although she did not want to, she did not say no as he had hit her once previously when she had refused his advances.

2.7.36 During the investigation, it was disclosed that over a three-week period the perpetrator had repeatedly beaten and raped Female 2 (vaginal, oral, and anal) in various hotel/hostels. He also assaulted her, held her against her will, assaulted her with a hammer and a shower pole.

2.7.37 On 7th September 2005 it was reported to police that a 14-year-old girl, Female 3, had been sexually and physically assaulted by the perpetrator, who she knew as (name provided but not revealed in this report). She said that on 19th August she had attended Whipps Cross Hospital with the perpetrator after he had self-harmed. After the hospital had asked the perpetrator to leave, he threatened that he would kill himself if Female 3 did not run away with him.

2.7.38 It was also reported that, on 20th August, the perpetrator had booked a hotel room under a false name and whilst there he had assaulted her, on the first night, with a curtain pole. The following night he had beaten her and then tied her hands and feet to each corner of the bed and then raped her (vaginally and anally) and had forced a bottle and television remote control into her. The girl suffered internal injuries and lacerations to her wrists. She said

that the perpetrator had repeatedly raped her at various hotels and hostels. He had taken her to see prostitutes telling them that she wanted to start sex work. Female 3's parents had not reported her missing as he had allowed her to contact them every evening.

2.7.39 Female 3 had managed to get away from the perpetrator and call her sister. the perpetrator attempted to contact Female 3 and told her mother that if she 'informed the police then she would get shot'. Special Schemes[27] were placed on the family home address for all calls to the address to be treated as urgent by police.

2.7.40 During the investigation, Female 3 was reported missing after meeting up with the perpetrator on 21st September after telling her parents she was with a friend. She returned and left again on 27th September.

2.7.41 On 28th September a third-party reported that Female 3 had been assaulted by the perpetrator. She was reported missing and was said to have reconciled with the perpetrator. The informant said that the perpetrator had thrown a mobile phone at Female 3's head.

2.7.42 The perpetrator was arrested on 3rd October and was charged with ABH, False Imprisonment and Sexual Activity with a child[28].

2.7.43 On 18th October the police were informed that the perpetrator had threatened the manager of a hotel where he was staying. He had threatened him and held a knife to the manager's neck whilst taking his mobile phones and money. On 1st November the perpetrator was produced from HMP Pentonville for arrest and interview. An identification procedure was held on 22nd November, and he was identified.

2.7.44 On 23rd November 2005 the perpetrator was found not guilty at Stratford Magistrates Court of racially abusing and assaulting a victim at Stratford Station on 28th May 2005. The victim received a dislocated shoulder and internal eye bleed.

2.7.45 The CPS were consulted about the offences in September and the perpetrator was charged with 29 offences, consisting of Rape, Sexual Activity with a Child, False Imprisonment, Assault by Penetration, ABH, Wounding, Common Assault, Possession of an Offensive Weapon and Robbery on 25th January 2006. At court the case was dropped after Female 3's evidence was deemed to be unreliable.

2.7.46 **2007**

2.7.47 On 22nd February the perpetrator was convicted of Sexual Activity with a child under 16, contrary to Section 9 of the Sexual Offences Act 2003, after he had engaged in sexual activity, as a 19-year-old, with a 14-year-old girl (Female 2) on 10th June 2004.

[27] Special Schemes - is to alert officers to information that could mitigate risk, whether that be to Officers and Staff, members of the public, or Partner Agencies by putting mid screen comments on specific addresses. Special Schemes will remain on the system for a maximum of 6 months before an email is sent to the IO asking whether the scheme is to be extended or deleted. In April 2020, As a result of an Independent Office for Police Conduct (IOPC) investigation involving a domestic assault, a recommendation has been made that the MPS take steps to make Safeguarding teams and departments aware that special schemes can apply to the addresses of perpetrators of domestic abuse and should be used where appropriate to do so.

[28] Outcome recorded in May 2007

2.7.48 On 29th March he was sentenced to 30 months' imprisonment and placed onto the Sexual Offenders Register subject to notification requirements for life, thereby falling under MAPPA[29] management. This is explained in more detail in Appendix Two.

2.7.49 On 25th April the perpetrator was released on licence conditions to (1) reside at an Approved Premises (2) comply with random drug testing at the Approved Premises and (3) attend Community Sex Offender Groupwork Programme (CSOGP)[30]. On 30th April he was registered by MAPPA as a Category 1 Level 1 offender.

2.7.50 On 1st July 2007 the perpetrator was reported missing after he had not returned to the address where he had been staying since 25th April 2007. He was in breach of his prison licence conditions to stay at his address between 11pm and 6am. He had also failed to register his new address with police, as is a requirement of his RSO notification. As his previous mental health difficulties and suicide attempt were highlighted, the risk was graded as high. This was later re-assessed as medium. The missing report was closed after information was received that he had been in contact with a friend. the perpetrator was circulated as wanted for arrest on breach.

2.7.51 The perpetrator was arrested on 25th August 2007 for beating and sexually assaulting a 17-year-old, Female 4. It was reported that he had beaten her with a hammer, punched her several times to the face and used various implements to insert inside her vagina. The female reported that she had been beaten on several occasions since July 2007. She had extensive bruising across her body, several small stab wounds to her thigh and finger. Her left arm was broken. He was charged with GBH, ABH and wounding. A referral was made to MARAC. The Eaves Women's Aid and Advocacy Service were contacted and advised that they would contact Female 4 to offer additional support.

2.7.52 On 27th August the perpetrator was returned to prison.

2.7.53 The perpetrator appeared at Havering Magistrates Court on 17th September charged with offences of Rape, Sexual Assault by Penetration, Grievous Bodily Harm and Actual Bodily Harm on 1st May. The victim was a 17-year-old female. He was remanded in custody annd appeared at Snaresbrook Crown Court on 23rd July and sentenced to 4 years 9 months for GBH x3 and ABH against a 17-year-old female.

2.7.54 **2008**

2.7.55 On 23rd July 2008 the perpetrator was convicted of GBH, ABH and wounding and sentenced to 57 months in prison.

2.7.56 **2010**

2.7.57 After a screening meeting on 30th November the perpetrator was registered as Category 1 Level 1 offender and assessed as being of high risk of harm. He was to be managed, on his release from prison, with licence conditions – (1) to reside at an Approved Premises , (2)

[29] Multi-Agency Public Protection Arrangements - https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

[30] https://ecsa.lucyfaithfull.org/community-sex-offender-groupwork-programme

Non-contact condition with victim, (3) to notify his supervising officer of any developing relationships with females and (4) to address his offending problems[31].

2.7.58 On 7th December 2010 the perpetrator was released from prison and the police were notified. The next day, 8th December, the police received a report setting out the perpetrator' licence conditions. He was under licence with probation until 22nd April 2013 with conditions not to enter RM8 and to inform his probation officer of any intimate relationships with women. Two CRIMINT reports were created and one stated that the perpetrator 'is clearly a significant danger to young females and there are serious concerns he will commit again'.

2.7.59 On 31st December 2010 the perpetrator was stopped with a female in relation to a theft of low value items from Iceland. Searches were conducted but nothing was found, and officers recorded a CRIMINT information report. No-one was arrested at the time. After returning to the police station further check were completed, an arrest enquiry was created for the female as she was shown as wanted. There was no information recorded about the association between the perpetrator and the female or if they were in a relationship.

2.7.60 **2011**

2.7.61 On 11th April the perpetrator was allocated a council tenancy. He continued to hold this tenancy and it is at this address that the bodies of Star and Hanna were subsequently found.

2.7.62 The perpetrator was visited by Resident Services from the council on 10th May to help him to apply for housing benefits and sustain his tenancy. He was identified as a vulnerable tenant with mental health problems.

2.7.63 **2012**

2.7.64 The perpetrator was arrested on 2nd March in relation to a residential burglary but, as there was insufficient evidence, no further action was taken.

2.7.65 On 17th March the perpetrator walked past police officers smelling of cannabis so he was stopped and searched. Nothing was found and no further action was taken.

2.7.66 The perpetrator was stopped and searched on 23rd June as he was in a known drugs crime hotspot. Nothing was found and no further action was taken. He was then stopped again later when he was at the rear of shops with four males. His speech was slurred, and he had red eyes as well has holding a crack pipe. He was advised by officers.

2.7.67 On 15th July the perpetrator was arrested for stealing a laptop and cash. He was charged with theft and found not guilty at court.

2.7.68 On 10th August Essex Police were contacted as the perpetrator attended the address of his previous partner (and the mother of his child), Female 2, to see his child. He was allowed into the flat and into the child's bedroom and the living area. He asked to stay the night, but the victim refused. He returned in the morning as planned. When they were all leaving the

[31] The policy at the time was that the MAPPA management level was decided by MAPPA Level 2 Chairs (DI & SPO) by way of a screening meeting. The guidance was and still is that people should be managed at the lowest level providing there is a robust Risk Management Plan in place.

flat to go their separate ways, he made the excuse that he had stomach pain and needed the toilet. As she was in a rush, she allowed him to stay for that reason.

2.7.69 When she returned to her flat a few hours later she realised that he had been in her bedroom and stolen items to the value of £2000. He had no permission to enter her bedroom. Due to previous domestic abuse incidents and the fact that the suspect was still outstanding, this was treated as high-risk incident. An Essex Police Domestic DV1 was completed even though the victim had not raised any major concerns other than the past previous violent incidents. the perpetrator was placed on the system as wanted for burglary and the address was flagged on Storm. An alarm was offered but declined by the victim.

2.7.70 When the DV1 risk assessment was completed with the victim (Female 2) she replied 'no' to all questions except:

17. HAS (.....) EVER THREATENED TO KILL YOU OR SOMEONE ELSE AND YOU BELIEVED THEM?
YES. When together 6 years ago suspect threatened to throw her off a balcony. At the time they were near balcony in a block of flats, therefore victim believed he would do it. Suspect arrested previously.

18. HAS (.....) EVER ATTEMPTED TO STRANGLE / CHOKE / SUFFOCATE / DROWN YOU?
YES. Victim was aged 13yrs. Suspect 19 yrs. Suspect strangled victim. Her family had to fight him off.

19. DOES (.....) DO OR SAY THINGS OF A SEXUAL NATURE THAT MAKES YOU FEEL BAD OR THAT PHYSICALLY HURT YOU OR SOMEONE ELSE?
YES. *note from officer* Victim was in sexual relationship with him from age 13. Her parents reported this, and victim believes he was charged, served prison sentence and was on sex offender register.

23. ARE THERE ANY FINANCIAL ISSUES?
YES. He was unable to pay rent and does not have a job. he has been in and out of prison for the last 7-8 years

24. HAS (.....) HAD PROBLEMS IN THE PAST YEAR WITH DRUGS (PRESCRIPTION OR OTHER), ALCOHOL OR MENTAL HEALTH LEADING TO PROBLEMS LEADING A NORMAL LIFE?
YES. Drugs - cannabis. Mental health - he is on medication, but victim is unsure what his condition is.

25. HAS (.....) EVER THREATENED OR ATTEMPTED SUICIDE
YES. Suspect - attempted to slit wrists holding knife across wrists. Tried to take overdose of painkiller. Tried to suffocate himself with blankets.

26. HAS (.....) EVER BREACHED BAIL/AN INJUNCTION AND/OR ANY AGREEMENT FOR WHEN THEY CAN SEE YOU AND/OR THE CHILDREN?
YES. Bail conditions - unsure of full details.

27. DO YOU KNOW IF (.....) HAS EVER BEEN IN TROUBLE WITH THE POLICE OR HAS A CRIMINAL HISTORY?
YES. Domestic violence - victim was previous victim for GBH. Other - sexual incident - sex with under 16. Theft of motor vehicle.

29. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD TO THIS?

YES. Many previous violent incidents. Over 6yrs ago when xxxx was pregnant, he punched her in stomach causing injury to unborn child. Baby had blood in bowel (put on Child Protection Register).

2.7.71 On 15th August the perpetrator was arrested at his home address and charged with theft/burglary.

2.7.72 The perpetrator was recalled to prison on 21st August.

2.7.73 In September the council served a Notice of Seeking Possession on the perpetrator due to his rent arrears.

2.7.74 On 28th September he was convicted of the theft/burglary and received 14 weeks imprisonment to run concurrently with his current prison term (see July 2008). At this point he was not subject to supervision by probation.

2.7.75 On 26th October the perpetrator wrote to the council to explain that the reason for his rent arrears was that he was in prison.

2.7.76 The council then wrote to the perpetrator on 6th November, in Chelmsford Prison, advising him that his case would be referred to court for possession whilst arrears continued to increase. He was notified that he was not entitled to housing benefit whilst serving a prison sentence and the arrears were, at that point, £614.23. In November the court action was started for repossession of the property.

2.7.77 **2013**

2.7.78 From 1st January London implemented a change to the MAPPA screening process which moved the decision making from MAPPA Chairs to Offender Managers and Managers in the lead agency.

2.7.79 On 15th January the court granted the council possession of the property. A Money Judgement was also granted for recovery of the debt of £1422.79 and the court costs of £169.50. On 17th January the court notified the perpetrator that they would repossess the property on 27th January.

2.7.80 It appears that between January and October the court order was suspended on the condition that the perpetrator paid the rent at £4 per week to clear the arrears. He could therefore stay at the property and the eviction was put on hold.

2.7.81 On 1st May the police received information that the perpetrator had tried to hang himself in his cell on 23rd January 2013 and had tried to cut his wrists on 13th March, leaving a suicide note for his girlfriend.

2.7.82 The perpetrator was released from prison on 10th May. He was not subject to probation supervision due to the length of sentence. From this point, until 29th August 2018 when he became subject to probation management again, the police were the lead agency for the purpose of MAPPA, and he was managed at Level 1 throughout.

2.7.83 On 14th May the perpetrator was assessed by a consultant psychiatrist from the Psychiatric Liaison Mental Health Team at Newham University Hospital where he was receiving

treatment for Crohn's disease. the perpetrator reported that he was sexually abused by a man in Pakistan when he was a child. He reported chronic passive suicidal thoughts and cannabis use. The consultant psychiatrist was of the opinion that the perpetrator was not acutely mentally unwell.

2.7.84 On 17th May the Hospital Social Work Team (LBN) received notification of an assessment (known as S.2) from Newham University Hospital. the perpetrator had been admitted and an assessment may be required prior to discharge. It was recorded that he had a diagnosis of Crohn's Disease and had been admitted with a mental health presentation.

2.7.85 A member of the Hospital Social Work Team visited the perpetrator on the ward on 20th May and discussed his wellbeing. He said that he had been released from prison on 10th May and that he had a council property that it had been burgled whilst he was in prison.

2.7.86 When the Social Worker visited the ward the next day, 21st May, they were informed that the perpetrator had been sectioned under the Mental Health Act and had been transferred to the appropriate ward. No further action was taken by the Hospital Social Work Team at this time.

2.7.87 On 21st May the perpetrator was admitted informally to the Newham Centre for Mental Health (inpatient unit) following being declared medically fit for discharge from Newham University Hospital but expressing suicidal ideas and plans and reporting hallucinations.

2.7.88 On 22nd May the perpetrator was detained under S5.2 of the Mental Health Act, 1983 (holding power for up to 72 hours) after withdrawing his consent to be on the Ward informally. He was assessed under the Mental Health Act, 1983 by the London Borough of Newham's Approved Mental Health Professional (AMHP) Service and detained under S2 following two medical recommendations and an application being made (assessment order for up to 28 days).

2.7.89 On 31st May the perpetrator was suspected of stealing medication from the ward's medication room. the perpetrator was sent to A and E for medical review and clearance.

2.7.90 The perpetrator made threats to harm nursing staff by cutting their throats on 7th June. the perpetrator self-harmed by making superficial cuts.

2.7.91 A Risk Management Plan (RMP) undertaken on 9th June placed the perpetrator at Level 1 medium risk. This assessment is based on RM2000 which was the risk assessment tool at the time and measured the risk of reconviction as opposed to offending or harm). The RMP had a number of requirements with which the perpetrator had to comply.

2.7.92 On 15th June the perpetrator was reported missing by staff at the Newham Centre for Mental Health after he failed to return after 3 hours unescorted leave. At the time he was a patient on Opal Ward under Section 2 of the Mental Health Act 1983. He returned of his own accord the next morning and said that he had been in the West End drinking with friends.

2.7.93 On 25th June the perpetrator was discharged home from the inpatient ward.

2.7.94 The perpetrator contacted the police on 6th August to report that he had been walking to the bus stop from his parent's address when he was approached by a male who asked him

a question about his tattoo. The male then punched him in the back and took his money and iPod. The report was closed when the police were unable to contact the perpetrator.

2.7.95 On 16th August the perpetrator was assessed the London Borough of Newham's Approved Mental Health Professional (AMHP) Service and detained under S2 of the Mental Health Act 1983 following attending Newham University Hospital after a flare up of his Crohn's disease. the perpetrator reported active suicidal plans, auditory hallucinations, and the belief that a microchip had been inserted into his brain.

2.7.96 A multi-disciplinary team review took place on 9th September on the inpatient ward. Following inpatient assessment, the team were of the view that the perpetrator was suffering from a personality disorder and substance misuse. the perpetrator' S2 detention was rescinded, and a plan made to discharge him from the ward the next week.

2.7.97 A second multi-disciplinary team review was held on 13th September. the perpetrator was assessed to be in a stable mental state and medically fit for discharge. the perpetrator was unhappy with the plan, and he stated he did not have sufficient funds, that his cooker was not working, and he had no keys. He was verbally abusive to the team and made threats to stab members of the public. the perpetrator' discharge was deferred due to his lack of keys for his flat.

2.7.98 On 17th September the perpetrator reported that he had taken an overdose of prescribed medication on the ward. the perpetrator was transferred to A and E for assessment and medically clearance. Upon assessment at A and E there were no clinical signs of overdose. the perpetrator was returned to the inpatient ward.

2.7.99 On 18th September the perpetrator reported to the ward staff that he had taken an overdose of prescribed medication, he was transferred to A and E for medical assessment and clearance; however, he absconded from the department. He returned to the inpatient Ward on 20th September. A ward round review was conducted and the perpetrator was discharged and issued with 7 days' medication. The plan was for the Community Mental Health Team to undertake a 7-day discharge suicide prevention follow up.

2.7.100 On 24th September the perpetrator was detained under S136 (police power) of the Mental Health Act after threatening to jump under a train at Plaistow underground station. He was in possession of a screwdriver and knife. A Mental Health Act assessment was undertaken by the London Borough of Newham's AMHP service. the perpetrator was complaining of derogatory hallucinations and making threats to stab the doctor in the neck and kill himself. the perpetrator was detained under S3 (treatment order for up to 6 months) and admitted to Newham Centre for Mental Health. Upon admission a knife was discovered in his bag, and he said he intended to stab the ward doctor.

2.7.101 On 26th September multidisciplinary team review was held. A plan made for the perpetrator to have a forensic psychiatric assessment and clinical psychology assessment to determine if he met the criteria for a personality disorder. the perpetrator was then transferred to the Tower Hamlets Centre for Mental health due to threats to harm staff.

2.7.102 In October the Rent Officer wrote to the perpetrator' social worker as the rent officer was concerned that they had been trying to find the perpetrator for the past six months and they were not sure if he was occupying his flat as his main principal home. The council then wrote to the perpetrator at various times up until 2019 reminding him that he must pay his rent.

Housing Benefit was paying his rent and he was required to pay £6.47 per week to contribute towards the service charge and £3.70 to clear his rent arrears.

2.7.103 On 7th October the perpetrator was reported missing by staff at Newham Centre for Mental Health where he was a patient under Section 3 of the Mental Health Act 1983. He had arrived there at 4.10 pm from a secure unit at Hackney Mill Harbour and had left the ward at approximately 4.30 pm without telling staff where he was going. He was located by police at approximately 6.32 pm. He said that he had been to the Greengate area and then to meet family and friends before returning to the unit. He refused to say where he had been or who with.

2.7.104 By 10th October the perpetrator' mental state was more stable and he is transferred back to the Newham Centre for Mental Health and a plan was made to issue escorted S17 leave from the ward.

2.7.105 On 23rd October the perpetrator' RMP was reviewed as he had been sectioned. He was again considered as RMP Level 1 medium risk. The required actions remained as earlier with the addition of:

(8) Liaise with Newham Centre for Mental Health
(9) Home visit to be carried when he was released from hospital

2.7.106 The perpetrator was discharged to the community from the Newham Centre for Mental Health on 18th November with a plan for assessment for Dialectical Behavioural Therapy (DBT). The next day, 19th November, the perpetrator did not attend his CMHT outpatient review and was offered a further appointment.

2.7.107 On 24th December the perpetrator was present at a domestic incident between two of his friends.

2.7.108 **2014**

2.7.109 Police were called by the London Ambulance Service on 16th January. They were treating the perpetrator after he had taken an overdose of 50+ opiate tablets when he ran off and could not be traced. He was later located safe and well at his girlfriend, Female 5's house.

2.7.110 On 22nd January the police conducted a home visit in line with the perpetrator' licence and found Female 5 in his room. He had not informed the police of the relationship.

2.7.111 On 29th January police were called by staff at an assisted living accommodation regarding trouble they were having with Female 5 who was a former resident. Officers were told by staff that Female 5 was with this perpetrator. The perpetrator had told Female 5 that a friend had touched his penis whilst he had been sleeping. Female 5 had not believed the perpetrator so attended the venue to confront the friend who admitted to having touched the perpetrator' penis on one occasion. Staff told officers that this male had severe learning difficulties and it was not in his best interest to be arrested. Officers attended The Perpetrator's home address and spoke with him, and he confirmed the sexual assault, reporting it had taken place on 20th January. He had delayed reporting it as Female 5 shared a bank account with the friend. Due to the suspect for the reported assault having severe learning difficulties, it was deemed not in the public interest to proceed with any prosecution.

2.7.112 On 31st January 2014 Victim Support received a referral for the perpetrator from the police as he had been the victim of a sexual assault. Two calls were made to the perpetrator on 31st January, at different times, but he did not answer. The police were advised that Victim Support had been unable to establish contact and had, therefore, closed the case.

2.7.113 On 22nd February the perpetrator reported to the police that he had been harassed and racially abused by Female 5's sister. He said that she had smashed his window previously, but he had not reported it. Female 5's sister was arrested. During the investigation, the perpetrator and Female 5 changed their mind regarding supporting a prosecution and refused to provide an evidential statement. A decision of NFA was taken by police due to insufficient evidence. A risk assessment was conducted grading level as STANDARD and the report was closed.

2.7.114 On 27th February Victim Support received a referral as the perpetrator had been the victim of racially or religiously motivated harassment. Victim Support were unable to establish contact and so the case was closed.

2.7.115 Female 5 called police on 10th March reporting that her sister was constantly ringing her mobile phone being verbally and racially abusive to her and her boyfriend, the perpetrator. Female 5's sister was interviewed under caution. She told officers that she was not happy with Female 5's choice of partner a 'known sex offender and they are concerned for her welfare'. The relationship was also preventing Female 5 from having contact with her child. The case was reviewed, and the decision was made to take no further action due to insufficient evidence.

2.7.116 On 16th March police were called by a member of the public stating that her neighbour had knocked on her door saying that she was scared of her boyfriend. She told them that her boyfriend believed that she was knocking on the door to ask for money for cigarettes. She asked for the police to be called. Female 5 and the perpetrator were walking to his address when the officers arrived. Officers stated that they needed to speak to Female 5 in their vehicle about a complaint. The perpetrator was asked to wait inside his address. Female 5 explained to officers that she was scared of the perpetrator and that she could no longer stay with him. She told officers that he shouted at her every day, was confrontational in his body language, calling her names, threatening to hurt her and family. She believed that he was getting more volatile as the relationship progressed. Female 5 informed they had been together for seven months, and he would not let her go anywhere on her own. He smashed her mobile phone, so she did not have contact with friends and family, having to give his number as a contact.

2.7.117 Officers took Female 5 to her parent's address which was an address unknown to the perpetrator. Target Hardening advice[32] was given. The following day police were called by Female 5's sister as Female 5 had returned to the perpetrator' address**.**

2.7.118 The perpetrator was arrested on 21st March. Female 5 was unwilling to provide a statement, stating she and the perpetrator had resolved their issues. The case was reviewed by police and no further action was taken due to there being insufficient evidence.

[32] Target Hardening advice – crime prevention and safety advice.

2.7.119 The next day, Police were called to the perpetrator' address by the sister of Female 5. The sister explained that she had fostered Female 5's child and had earlier attended an appointment with Children's Social Care where she was told that the perpetrator was a RSO. She was told that whilst Female 5 was in a relationship with the perpetrator, Female 5 would not be able to have contact with her child.

2.7.120 The attending officers spoke to Female 5 who informed them in the DASH questions that she was one month pregnant with the perpetrator' child. She told officers that she was aware that the perpetrator was an RSO. Female 5 was asked if she wanted to leave with her family or the officers, but she refused remaining at the address with the perpetrator. She stated that she would consider her options if her relationship with the perpetrator would lead to her not seeing her child. the perpetrator was spoken to and informed that Female 5's family did not approve of their relationship.

2.7.121 On 21st March the perpetrator was arrested for the criminal damage that had occurred at his home on 16th March. The investigation was not proceeded with by police.

2.7.122 On 23rd April police responded to three calls relating to the perpetrator walking out of Newham General Hospital before being seen and in relation to concerns from Female 5's sister as she had not been seen. Officers attended the perpetrator' address and forced entry under Section 17 PACE 1984 to find Female 5 and the perpetrator asleep in bed together. The perpetrator was arrested. Female 5 withdrew her statement stating that the perpetrator had promised never to hit her again and that she believed him.

2.7.123 On 24th April a female service user (ELFT) disclosed that the perpetrator had been physically abusing her (punching her in the chest), forcing her to take crack cocaine for fear of being hit and pressuring her to undertake sex work. She reported him to the police and informed the care team that there was a warrant out for his arrest for ABH. She expressed concern that the perpetrator would present in a factitious manner to be on the ward with her. She was moved to a Women's Refuge outside of London for her own safety.

2.7.124 On 25th April officers undertaking a home visit to the perpetrator found his girlfriend, Female 5 in his room and he had not informed the police, in line with his requirements. Female 5 knew of his offences by the time the disclosures were made and she was identified as being vulnerable with mental health issues.

2.7.125 On 26th April police were called by Female 5's sister reporting that Female 5 had been beaten by her boyfriend. Police received a further call from the perpetrator reporting that Female 5's sister had made a racist remark to him.

2.7.126 Officers attended the perpetrator' home address to find Female 5 and her sister outside. Officers were informed that Female 5 had been walking with the perpetrator when she saw her sister in the street and disclosed an assault to her. Female 5 stated that she was assaulted on 20th April after an argument with the perpetrator over him forcing her to become an 'escort'. the perpetrator had thrown a plate at her, repeatedly slapped, punched, and kicked her. He threw a mobile phone at her, hitting her nose. When Female 5 attempted to leave he pulled her by her hair. She had visible injuries. the perpetrator was not at the address. He was circulated as wanted and an arrest enquiry was created on CAD.

2.7.127 The perpetrator' solicitor contacted police querying if he could be spoken to under caution. The Investigating Officer informed the solicitor that the perpetrator needed to hand himself in and an interview under caution[33] was not appropriate at this time.

2.7.128 During the investigation Female 5's sister informed police that Female 5 had taken an overdose. Officers spoke with Female 5 with an Independent Domestic Violence Advisor from AANCHAL Women's Aid[34]. Another statement was obtained supporting a prosecution. CPS were consulted and a charge for ABH was authorised.

2.7.129 The perpetrator was remanded by police then bailed by the Court pending trial on 19th August. During this time, he was circulated as wanted for breach of his bail and for a harassment against Female 5. The case was discontinued at Court.

2.7.130 On 30th April the perpetrator was arrested for assaulting his girlfriend at his home address on 20th April after they had an argument. It was alleged that the perpetrator had thrown a plate at her that had missed. He had then repeatedly slapped, punched, and kicked her. He had then thrown a mobile phone that had hit her nose. He was charged on 1st May.

2.7.131 During the investigation, the perpetrator' girlfriend withdrew her statement and took an overdose. She was taken to hospital where the police visited her with an IDVA from Anchaal. Another statement was taken from her supporting prosecution. CPS were consulted and he was charged with ABH. He was bailed by the court pending trial on 19th August. During this time, he was circulated as wanted for breach of bail and harassment.

2.7.132 The perpetrator reported a burglary that he said had occurred between him being arrested on 30th April and being released from court on 1st May. He said that unknown suspects had smashed a window and gained access , then took property from the address. The reports given by the perpetrator initially and then when spoken to by the investigating officer were contradictory. A referral was made to Victim Support on 2nd May. Neighbour enquiries were completed and due to insufficient evidence, no further action was taken, and the report was closed on 21st May.

2.7.133 On 2nd May the perpetrator was taken to A and E at Newham University Hospital by family members after reporting taking a co-codamol overdose. He was admitted informally to the Newham Centre for Mental Health. On 8th May he was reviewed by a consultant psychiatrist and discharged with CMHT follow up.

2.7.134 On 6th May Victim Support received a referral for the perpetrator who had reported being the victim of a burglary on 1st May. They were unable to make contact and so, having sent a text message with their contact details, they closed the case.

2.7.135 On 10th May Victim Support received a referral for the perpetrator (made on 2nd May). They were unable to contact him and having sent a text message with their contact details, they closed the case[35].

2.7.136 On 11th May the perpetrator was detained under S136 by police after making threats to kill himself. The perpetrator informed officers that he suffered from a personality disorder and Paranoid Schizophrenia having been treated as a patient under Section 3 Mental Health Act

[33] Interview under caution – voluntary police interview.
[34] AANCHAL – an organisation that supports women and children.
[35] MPS have not record of a second referral

(MHA) 1983 the previous year at NCMH. He stated that he had not been taking his medication and his family had taken him to Accident and Emergency (A&E). Whilst waiting he heard voices and left as he was concerned that he would hurt someone.

2.7.137 He was admitted informally to the Newham Centre for Mental Health. On 12th May the perpetrator was reviewed by a consultant psychiatrist whilst he was an inpatient on an acute ward at Newham University Hospital and there was no evidence of acute mental illness.

2.7.138 On 28th May the perpetrator reported to police that a wine bottle had been thrown through the window of his flat.

2.7.139 Victim Support received a referral on 30th May for the perpetrator. He was spoken to on the phone. The perpetrator was upset at the time of call, he said he was stressed by the constant damage to his flat by unknown suspects. He disclosed that he suffered with mental health and had short term memory loss. The perpetrator said that the council are fed up with repairing his windows, so he paid privately. He said he had no family or friends and was too scared to leave his flat and to live there. The perpetrator indicated that he would like some emotional support and advocacy support to the council to help him to move out of the area, although he was aware that Victim Support could get him rehoused. Confidentiality was explained and consent was given.

2.7.140 Victim Support spoke to the perpetrator on 1st June and an appointment was made for 4th June. This was confirmed to him on text.

2.7.141 On 4th June Victim Support rang the perpetrator to confirm his appointment for that day. He said that he was no longer able to make the appointment as he had a doctor's appointment. Another appointment was made for 11th June.

2.7.142 On 11th June Victim Support called the perpetrator to confirm his appointment. He said that he could not make it and would contact them when he was ready. Victim Support's details were given to him.

2.7.143 The perpetrator' RMP was reviewed on 20th July, and he remained as a medium risk.

2.7.144 The perpetrator contacted police on 20th July and reported that he had an argument with a suspect who was then racially abusive towards him. Witnesses were spoken to, and they stated that no racial abuse or language was used. No CCTV was available, and no further action was taken.

2.7.145 By 27th July Victim Support had not heard from the perpetrator so the case was closed.

2.7.146 On 5th September Female 5 reported that she had been repeatedly raped by the perpetrator between 27th March 2014 and April 2014. She said that she had met him when they were both hospital patients and that they had a relationship for 7 months. During the relationship, the perpetrator had assaulted her, prevented her from going out, raped her, and threatened to kill her. She was not able to provide a statement as she said she was not ready to talk about what had happened and need counselling first. The perpetrator was not arrested or spoken to in relation to this allegation as an account was not obtained from his girlfriend. The report was closed until such time as Female 5 felt able to provide a report. A referral to MARAC was made.

The panel considered if Body Worn Video (BWV) was available to MPS officers at this time. Whilst MPS began a trial in 2014, Newham was not part of this trial and the roll out of BWV in July 2017.

2.7.147 On 8th September the perpetrator attended the A and E department following a flare up of his Crohn's disease and was admitted to the acute ward. The perpetrator was referred to the consultant psychiatrist from the Liaison Mental Health Team. On 12th September the perpetrator was reviewed by a consultant psychiatrist and there was no evidence of acute mental illness.

From 3rd November 2014 the Domestic Violence Prevention Notice and Domestic Violence Prevention Order became available to MPS officers where it was felt necessary to protect individuals from further violence or threat of violence.

2.7.148 On 20th September the perpetrator attended the ED at the Royal London Hospital due to an increase in Crohn's symptoms. The notes made during this visit noted ongoing issues with depression, history of self-harm and some recent suicidal ideation. He said that he was unemployed due to his health but had previously worked as an architect. He was admitted to a ward.

2.7.149 On 26th September the perpetrator was referred to RAID[36] for a psychiatric review as he reported low mood, anxiety, and suicidal ideation. When RAID came to assess the perpetrator, he refused to see them as stated he felt better after discussion with the team (although it is unclear which team he was referring to) and his father. He was discharged from RAID, but the ward was advised that he could be referred again if required.

2.7.150 On 28th September the perpetrator was re-referred to RAID. No further information is available within his medical records.

2.7.151 On 15th October the perpetrator was discharged from the ward. It is recorded in his records that in October 2014 the perpetrator was 'escorted from the Royal London Hospital by police for questioning regarding a harassment allegation but no further information is recorded.

2.7.152 On 24th November the perpetrator was declined for Dialectical Behavioural Therapy (DBT) due to his risk history, including being on sex offenders register and having been noted to form sexual alliances with vulnerable patients diagnosed with Emotionally Unstable Personality Disorder when an inpatient. The perpetrator was assessed to be a risk to female clients in the group as he may sexually exploit them if taken on for DBT.

2.7.153 On 14th December the perpetrator' RMP was reviewed once again and he was Level 1 medium risk.

2.7.154 On 23rd December the perpetrator attended the ED at the Royal London Hospital with Crohn's symptoms. He appeared unkempt, thin, and frail and a referral was made to RAID for input due to his reported depression No safeguarding alert/referral was completed.

2.7.155 He was admitted to the ward and was reviewed by RAID who recorded that he had been known to mental health services previously. A care plan was in place to support the perpetrator and staff in how to communicate with him to avoid any outbursts. The RAID plan was for daily reviews.

[36] Reinforce Appropriate, Implode Disruptive – This is a three-day course that is a positive approach to working with challenging behaviour. This is a mental health team managed by East London Foundation Trust – ELFT)

2.7.156 Throughout this admission there were increasing recordings of the perpetrator' behaviour towards staff being very difficult to manage. It was reported that he was abusive towards a female staff member, and he refused to discuss this. He said that he did not like being in an open bay as he has voices telling him to hurt others. The perpetrator reported that he found people in the hospital to talk to as this helped to distract him along with listening to music. He reported to RAID that he would take his life if he had a stoma and initially refused surgery but later agreed.

2.7.157 **2015**

2.7.158 When he was reviewed by RAID on 2nd January it was noted that he had been known to mental health services previously and over the last few years his diagnosis has been various types of personality disorder. He had stopped taking his psychotropic medication for about a year, but since being in hospital this has restarted. On assessment he reported that he hears voices which tell him to cut himself which he had acted upon many times. He said that there were three voices which he has heard for many years, and they say derogatory things about him. He reported that the voices have never told him to harm others. He admitted to using cannabis daily which he has been doing for most part of 15 years. It was decided that he would be monitored by the RAID team daily and that he would be sectioned under Section 5(2) if he tried to leave the ward.

2.7.159 The perpetrator was reviewed by the RAID team on 5th January. It was noted that he did not have schizophrenia but some maladaptive personality traits, secondary to difficult childhood circumstances. It was noted that he was finding it difficult in hospital. He interpreted mistakes as him being deliberately targeted and was vigilant to pick up any error or misunderstanding and became anxious about these. A care plan was written to help staff to understand how to approach him and try to reduce misunderstandings and improve communication. It was noted that the key was to tell him in advance and ask his permission. The daily review was to continue.

2.7.160 The perpetrator was reviewed on 6th January, and it was noted that his relationship with the world was complicated. He was reassured that he is not a 'troublemaker' and is not being targeted to be 'experimented on or killed by racists and anti-Islamic factions'.

2.7.161 When he was reviewed on 7th January , the perpetrator had superficially self-harmed with a pair of scissors found in the room. He reported an increase in the voices and paranoid ideation.

2.7.162 On 9th January when he was reviewed, it was recorded that the perpetrator was very angry and had complex relationships with professionals involved in his care.

2.7.163 On 15th January the perpetrator was reviewed three times during the day as his behaviour was difficult for the ward to manage and he was not responding well to staff members.

2.7.164 The difficulties in managing the perpetrator' behaviour was discussed at an MDT meeting on 16th January. It was agreed that the Psychiatry Consultant would review him the next week and he was to be reviewed daily. When staff attended the ward later in the day to carry out his assessment, he had left the ward. It was noted that he had collapsed earlier in the day outside the hospital and investigations were ongoing to clarify why. His care was discussed with the Psychiatry Consultant as there was still conflict with RMNs. It was also noted that

his notes had gone missing. Staff had searched his room and it was not clear if the perpetrator had taken the notes although he did assist in trying to find them.

2.7.165 On 22nd January the perpetrator called police reporting that Female 2's ex-partner was sending threatening messages to him. He stated that he was currently in hospital waiting for an operation for his Crohn's disease. The perpetrator explained that Female 2 was the mother of his child and that they 'maintain a good relationship and often speak on the phone'.

2.7.166 After the initial report, the perpetrator informed the Investigating Officer that Female 2's ex-partner was still sending him messages and had sent a photo of himself outside the perpetrator' flat. Female 2's ex-partner called the Investigating Officer and admitted to sending messages to the perpetrator. He stated that he did it to protect Female 2 but knew that he should have contacted police and Children's Social Care.

2.7.167 Officers issued the ex-partner with a First Instance Harassment Warning over the telephone and sent a copy in the post to his address. The perpetrator was told not to contact Female 2 and advised to contact Children's Social Care if he wished to contact his child.

2.7.168 When the perpetrator was reviewed on 23rd January it was noted that the perpetrator was getting on better with the ward staff and they were happier with managing his care. His medication was changed to manage his symptoms and CBT was used but with limited success. It was noted that he would have surgery in the next 1-2 weeks.

2.7.169 On 23rd January the Hospital Social Work Team (LBN) received notification of assessment (known as S.2) from the Royal London Hospital (RLH). He had been admitted and may need an assessment prior to his discharge.

2.7.170 On 24th January Victim Support received a referral for the perpetrator. A text message was sent with their contact details.

2.7.171 On 27th January the perpetrator reported to police that his tablet and wallet had been stolen whilst he was in hospital.

2.7.172 On 28th January the nursing staff asked RAID to review the perpetrator as he was still troubled by voices and is using listening to music as a distraction as well as finding people in the hospital to talk to.

2.7.173 At his RAID review on 2nd February, it was noted that the perpetrator had been more disruptive at the end of the previous week but had been better over the past two days. His main anxiety was centred on his forthcoming surgery.

2.7.174 It was noted in his RAID review on 4th February that the perpetrator' behaviour towards a female of staff was reported as 'abusive'. He refused to discuss the matter and became agitated and felt that a decision against him had already been made. The next day the RAID team held a review with the medical team as the perpetrator had been informed that his surgery may result in. stoma being fitted. He had said that, if he woke up with a stoma, he would take his life and as a result he had refused surgery. It was agreed that the consultant would speak to him about the surgery. On 5th February he reported that the medication was now taking effect and that the voices were reducing, and he was sleeping better. He was now keener for the surgery and felt that he could cope with the stoma.

2.7.175 On 9th February the perpetrator had made two superficial cuts to his arm with a razor in response to hearing voices. He was reported to be anxious about the surgery.

2.7.176 On 16th February a Social Worker contacted the ward and was informed that the perpetrator was still medically unwell. He was waiting for surgery that was expected on 20th February. It was agreed that his social care needs would be determined once he was medically optimised.

2.7.177 On 17th February the Social Worker visited Royal London Hospital and a nurse reported that he had gone for a cigarette. The ward nurse said that he would be going to St Bartholomew's Hospital on 19th February for his surgical procedure and then would be transferred back to Royal London Hospital and would be admitted to a medical ward.

2.7.178 On 19th February the review with RAID was cut short as the perpetrator had been smoking cannabis and was very stoned.

2.7.179 On 20th February the perpetrator had a laparotomy and stoma fitted. When he was reviewed by the RAID team on 23rd he was coping well post-surgery but finding the stoma slightly difficult. He did not like being in a bay and said that the voices were telling him to harm others. He felt that if this was not resolved if he would discharge himself.

2.7.180 The RAID team tried to review him on 26th, 27th February and 2nd March but, on each occasion, he was off the ward. He had been given home leave on 2nd March until 6pm.

2.7.181 On 4th March the perpetrator discharged himself from the ward against medical advice.

2.7.182 On 6th March the perpetrator was arrested for criminal damage at the Royal London Hospital. He had discharged himself two days earlier against medical advice and had later returned demanding medication. When this was refused, he had damaged a defibrillator machine. Due to his condition, he was admitted to hospital and was summonsed for the offence.

2.7.183 On 10th March telephone contact was made by the hospital social work team with the Royal London Hospital and were advised that the perpetrator had discharged himself from the ward in anger, but they could not provide the date. The social worker telephoned the perpetrator, and the call was answered by a female who claimed that she did not know the perpetrator but said various professionals had been calling her number. A letter was sent to the perpetrator, and no further action was required by social services. The case was closed to the hospital social work team on 16th March as he was no longer an acute patient.

2.7.184 The perpetrator was seen in the CMHT's outpatient clinic on 10th March and a plan was made for the CMHT to administer his anti-psychotic depot injection.

2.7.185 On 18th March the MPS Jigsaw Team set Risk Management Plan (RMP).

2.7.186 The perpetrator did not attend his CMHT review on 20th March and a further appointment was offered.

2.7.187 On 30th March the perpetrator was reviewed by a consultant psychiatrist. The perpetrator had ceased his depot injection due to adverse side effects and information was given on

alternative anti-psychotic medication. The perpetrator reported that he had been smoking cannabis daily. He was allocated a CPN as his Care Programme Approach care coordinator.

2.7.188 The perpetrator called the police on 3rd April saying that he had taken an overdose as he was hearing voices and wanted them to stop. LAS attended and he agreed to attend Newham General Hospital. The hospital called the police some hours later as the perpetrator had left the hospital without being seen. Police attended his address and found the perpetrator who appeared to be safe and well. He said he had left the hospital after two hours because he was frustrated that he had not been seen. He was advised to attend a hospital first thing in the morning to speak to someone regarding his mental health.

2.7.189 The perpetrator's RMP was reviewed on 12th May and he remained at Level 1 medium risk.

2.7.190 On 13th May the perpetrator attended Forest Gate Police Station to register as part of the conditions of his RSO.

2.7.191 On 4th June the perpetrator was seen at an outpatient appointment at Royal London Hospital as he was not coping with his stoma and was relying on a female friend (no name given) to help him. He said that his informal carer was going away next week, and he was anxious about how he would cope in her absence. He said that he had no other support, and it was noted that it was likely that he would need to be admitted.

2.7.192 On 22nd June Police were called by Security Staff at the Excel Centre stating that they had a female who was reporting that she had been held captive. When officers attended, they spoke to a female who identified herself as Female 6. She stated that she had been in an on/off relationship with the perpetrator and approximately one month ago she went to his address. Whilst at the address, he had beaten her, had thrown food on the floor before making her eat it and poked her with a broom handle. Female 6 had a visible bruise to the left side of her head, arm, inner thigh and back. She told officers that the perpetrator' brother had witnessed her being assaulted on one occasion. Female 6 had escaped the perpetrator when they and his brother had come to the Excel Centre. LAS attended and took Female 6 to Newham General Hospital.

2.7.193 An arrest enquiry at the perpetrator' address was conducted but he was not present. He was circulated as wanted for the offences and arrested. Numerous contact efforts were made by officers to speak to Female 6 and obtain a statement from her, this included efforts being made with the assistance of the Newham General Hospital mental health team. Female 6 did not attend the appointments or return contact. Due to insufficient evidence and Female 6 not engaging, no further action was taken by police.

2.7.194 A DASH was undertaken highlighting Female 6's mental health and psychosis. The risk assessment was medium. Special schemes were requested to be placed on Female 6's address.

2.7.195 In interview, the perpetrator said that he had met Female 6 when they were both patients on the Opal Ward at Newham Centre For Mental Health. The case was referred to MARAC and discussed on 26th July 2015.

This was the 8th female since 2001 that the perpetrator had been reported to have been violent and controlling towards. The females were either young and vulnerable though age or vulnerable

through mental health and drug use. The risk that he posed to females had been recognised and managed through the MAPPA process and MARAC referrals. He remained graded at medium risk.

2.7.196 On 26th June a consultant psychiatrist rang the perpetrator. the perpetrator agreed to attend the CMHT the next week for a review and to commence oral anti-psychotic medication. A safeguarding adult concern was raised for Female 6, by ELFT, a female mental health service user who the perpetrator was in a relationship with. He had allegedly held her hostage for a 3-week period and assaulted her. The allegation was reported to the Police and S42 safeguarding adult enquiry undertaken.

2.7.197 On 29th June the perpetrator was reviewed by a consultant psychiatrist and CPN. the perpetrator was calm and appropriate during the review. He reported he had ceased cannabis for two weeks and agreed to commence oral anti-psychotic medication.

2.7.198 On 15th July police were called to a domestic argument between the perpetrator and his brother. No offences were alleged, and a non-crime domestic incident report was recorded.

2.7.199 On 6th August the perpetrator was reviewed by a consultant psychiatrist. the perpetrator denied assaulting Female 6 or holding her hostage. He reported auditory hallucinations and said he had been using cannabis. the perpetrator had ceased his oral anti-psychotic medication when his prescription ran out and he agreed to recommence a depot injection. A plan was made to request a forensic psychiatric opinion.

2.7.200 On 13th August the perpetrator was seen at the Royal London Hospital for a pre-operative assessment.

2.7.201 The perpetrator was stopped and searched on 24th August when he was found to be in possession of cannabis, and he issued with a Cannabis Warning.

2.7.202 On 26th August the perpetrator was convicted of criminal damage at Royal London Hospital in March. He was ordered to pay £1500 compensation and issued with a 42-day curfew tag.

2.7.203 On 4th September the perpetrator was admitted to Royal London Hospital for reversal of the stoma.

2.7.204 On 5th September the perpetrator was referred to the Liaison Mental Health Team whilst an inpatient on the acute Ward. He was reviewed by a consultant psychiatrist following a disturbance he had caused on the ward when he was aggressive towards the staff. When reviewed by RAID, he said that he felt that staff were treating him like a second-class citizen and that he was annoyed about this. He initially said that he wanted to go back on the ward and stab everyone but then said that he had no intention of doing this and had said it in anger. The consultant psychiatrist was of the view that this was a behavioural aggressive outburst in keeping with diagnosis of personality disorder and that there was no evidence of delirium. He also reported auditory hallucinations and paranoid ideation about nursing staff and being followed on ward, but these did not appear chronic in nature and did not present as main difficulty at present. On 8th September the perpetrator was then reviewed by a consultant psychiatrist from the Liaison Mental Health Team due to him being angry and resentful toward nursing staff. The perpetrator was agreeable to restarting anti-psychotic depot injection.

2.7.205 On 11th September the Hospital Social Work Team (LBN) received notification of assessment (known as S.2) from the Royal London Hospital (RLH). He had been admitted on 4th September and may need an assessment prior to his discharge.

2.7.206 On 13th September the perpetrator was reviewed by the RAID team following an episode of self-harm on the ward.

2.7.207 A complex discharge meeting was held, on 22nd September, with the complex discharge team manager, the mental health occupational therapist and RAID. The OT noted that the perpetrator would need help in the community with self-care. Newham Social Care had indicated that, due to the risk to others, they were not comfortable in providing 1:1 care and that they could not offer 1:2 care. It was noted that this was preventing discharge.

2.7.208 The Hospital Social Work Team received discharge notification from the Royal London Hospital on 22nd September for discharge for the next day. The case was allocated to a social worker.

2.7.209 On 24th September the perpetrator was visited on the ward by the allocated social worker and assessed. He was deemed to require a lower-level Enablement Care Package to help him to regain his independence. It was felt that he needed minimal assistance, prompting and/or supervision to complete tasks such as personal care, washing, dressing/undressing, and preparing food.

2.7.210 The Enablement Service declined the referral based on his history of several arrests and inappropriate behaviour, furthermore male carers could not be organised to support him daily during his six-week enablement programme. It was felt that the Mental Health South West Team would be best placed to support him. The social worker contacted the perpetrator' allocated mental health worker for follow up, but they were not available.

2.7.211 On 25th September the social worker ordered a bath lift from Occupational Therapy. The social worker was advised that toileting equipment was not needed as his back could be washed using a long-handled brush. An enablement service was not required as the perpetrator self-discharged.

2.7.212 The perpetrator was reviewed by RAID and it was noted that the perpetrator felt that his medication was working and he was feeling less paranoid. He was angry about the situation with his care by social services. It was noted that he did not need to remain in hospital form a psychiatric perspective and that his CMHT were aware of the situation and would follow up on discharge.

2.7.213 On 2nd October the perpetrator was discharged from the ward, but it is not clear what care package was in place.

2.7.214 The perpetrator' RMP was reviewed on 20th October, and he remained as Level 1 medium risk.

2.7.215 **2016**

2.7.216 **On 17th January Hanna was pushed from the balcony by her partner of the time. It was whilst in hospital that she met the perpetrator.**

2.7.217 On 22nd January the perpetrator was admitted to the Royal London Hospital from the ED as he had been increasing unwell over the previous two weeks. He said that he had severe abdominal pain and was opening his bowels up to 30 times a day. He said, 'I will kill myself if the pain does not go away'. The next day he was noted to be going in and out of the ward in a wheelchair and it was noted that he was out of the ward for quite a bit of the day.

2.7.218 On 28th January when reviewed by RAID it was agreed that he would continue with his medication and the staff would follow a care plan to reduce conflict. It was noted that he had self-harmed the previous day, 27th.

2.7.219 The perpetrator's brother and a female friend (name not known) visited him on the ward in the evening of 30th January.

2.7.220 The perpetrator was due to have an endoscopy on 2nd February, but this could not go ahead as he would not comply with the consent process. He raised his voice and was verbally aggressive towards staff.

2.7.221 On 9th February the perpetrator was assessed by RAID, and he was doing well from a mental health perspective. When he was seen on the ward on 11th February to discuss a feeding tube, he swore a number of times as staff and said he wanted to leave. He did then agree to speak about the feeding tube. He was later reviewed by the consultant when he was verbally aggressive and said that he wanted to go home the next day. It was agreed that this would be reviewed with a view to discharging him. When he was seen on the ward the next day, he apologised for his behaviour the previous day. He said that he had discussed the options with his family, and he agreed he would take advice and have the feeding tube fitted.

2.7.222 Police were called to the Royal London Hospital on 17th February where the perpetrator was being treated. He reported that he had returned to the ward from a cigarette break to find a male going through his jacket pockets. No property was taken. The perpetrator said that the hospital security had detained the suspect but, on finding nothing, they took his details and let him go. the perpetrator did not wish to speak to the police or substantiate the allegation.

2.7.223 On 22nd February the perpetrator was discharged home. It was noted in his records that, during his time in hospital, he left the ward a number of times a day for a cigarette. He had also been verbally aggressive and intimidating towards staff during his admission.

2.7.224 On 8th March the perpetrator became angry with the Police Offender Manager's questions during a home visit because she knew so much, and he refused to engage. He remained at Level 1 medium risk.

2.7.225 On 24th March the perpetrator was due to attend the Royal London Hospital for his Humira injections, but he did not attend, despite there having been several calls to remind him.

2.7.226 On 15th April the perpetrator was contacted by the hospital to remind him to attend for his injection. He stated that he would not come in as his partner (name not recorded) would do it for him.

2.7.227 On 10th May the perpetrator was seen at the police station for his office visit with the MPS Jigsaw Team. He was seen again at the office on 2nd June.

2.7.228 On 9th June the perpetrator did not attend his CPA review. The consultant psychiatrist was of the view that as his attendance for his depot had been poor, he was unlikely to be gaining any therapeutic benefit from the depot, that there had not been clear evidence of deterioration in his mental state and he continued to describe feeling paranoid, but this does not appear to have increased in intensity or to have led to any risk behaviour to himself or others. He was of the view that diagnostically the perpetrator' presentation appeared more consistent with his previous diagnosis of antisocial personality disorder and associated psychotic symptoms may be more related to cannabis use.

2.7.229 On 12th August the perpetrator went to the police station to register without prompting and apologised for his behaviour during his last home visit.

2.7.230 The MPS Jigsaw Team had an appointment booked to complete an Active Risk Management System Assessment (ARMS) on 12th August, but the perpetrator did not attend.

2.7.231 On 22nd August the perpetrator did not attend his outpatient review with the consultant psychiatrist.

2.7.232 On 28th September the perpetrator attended Forest Gate Police Station to report the theft of his wallet whilst travelling on the underground the previous week. The matter was transferred to British Transport Police for investigation.

2.7.233 On 29th September police were called to Upton Park London Underground Station by a member of public who stated that there was a female with her face covered with a head scarf with four males, all acting suspiciously. Officers attended stopping a female and a male outside West Ham Football Stadium who matched the description provided. The three other males had run away in an unknown direction. The male was identified as the perpetrator. He admitted to officers that he had purchased drugs and showed a bag of Cannabis. Officers searched both the female and the perpetrator under Section 23 Misuse Drugs Act 1986. Nothing further was found on either of them. the perpetrator was issued with a Fixed Penalty Notice (FPN) for possession of cannabis. STOPS reports were recorded for Hanna and the perpetrator on CRIMINT. A CRIS was also recorded for the Cannabis possession by the perpetrator. The CRIS did not record Hanna's details indicating only that the perpetrator was with a female when stopped. The CRIMINT references are not recorded on the CRIS report to link all three reports, being two stop slips, one of which had Hanna's details and the possession of cannabis crime report.

2.7.234 On 5th October the perpetrator had a telephone consultation with the gastro consultant. It was noted that the perpetrator felt that the team had not given him enough attention and follow up.

2.7.235 On 17th October the perpetrator was seen at the police station for his office visit with the MPS Jigsaw Team, having attended on 8th October but not being seen.

2.7.236 On 22nd October the perpetrator was referred by the police to Victim Support following an incident of theft from the person. Contact was made with the perpetrator, and confidentiality was explained to him. the perpetrator told Victim Support that someone had opened his bag and stolen his wallet. He said that, a week after that incident, he had dropped his wallet on the DLR, and it was picked up by the conductor. Initially the conductor had not believed it was his wallet, but he later did. He disclosed that he suffered with anxiety, depression, and Crohn's disease. He confirmed that he did not know who had stolen

his wallet and would like emotional support but was unable to carry out a needs assessment. He consented to the Victim Support number being texted to him so he could call back when it was convenient. The case was closed as the perpetrator had indicated that he would be in touch when it was convenient for him.

2.7.237 On 24th October the perpetrator did not attend his outpatient review with the consultant psychiatrist. the perpetrator was then reviewed in the gastro outpatient clinic on 27th October. He was having problems with pain and frequent stools. He stressed that he did not want to be admitted to hospital and wanted to be managed as an outpatient.

2.7.238 On 10th November the perpetrator was visited at home by the MSP Jigsaw Team.

2.7.239 On 11th November the perpetrator purchased the chest freezer. He did not give his current address but an old address of his father. The freezer was collected from the store.

2.7.240 On 26th November the consultant psychiatrist rang the perpetrator' GP. The GP advised that the perpetrator was attending their surgery in relation to his Crohn's disease and there were no recorded concerns over his mental state or behaviour but his compliance with Crohn's disease treatment had been erratic. The consultant psychiatrist advised that the perpetrator had not attended appointments at the CMHT and would therefore be discharged. He recommended that the perpetrator should be reviewed for paranoid thinking, perceptual disturbance (auditory hallucinations), aggressive and suicidal ideation and recommended a re-referral if concerns arose.

2.7.241 On 16th December the perpetrator was discussed at a local risk management meeting, and it was reported that the police had tried to complete the ARMS assessment with him on four occasions, but he had cancelled all the appointments. His RMP was completed.

2.7.242 **2017**

2.7.243 On 5th January the perpetrator did not attend his appointment at the gastro outpatient clinic and a letter was sent to his GP.

2.7.244 On 20th January the perpetrator rang the CMHT requesting an appointment and apologising for not attending prior appointments. He stated he wished to engage with support from his brother. The consultant psychiatrist agreed to offer a further appointment.

2.7.245 On 21st January a home visit was undertaken to the perpetrator' address by the MPS Jigsaw Team.

2.7.246 The perpetrator contacted the helpline at the Royal London Hospital on 13th February as he was not feeling well again. He said that he felt he was not being treated fairly and he was reminded that he had not attend recent appointments. He said that his phone number on the records was incorrect as his phone had been stolen. He gave a new number.

2.7.247 The perpetrator called the police on 13th February as he said a female associate, who he believed suffered with mental ill health, was banging on his door. She left the area whilst the perpetrator was on the phone to the police. He was advised to call the police if she returned.

2.7.248 On 16th February the perpetrator called the police regarding the female associate who he said had returned and was knocking on his door. Police attended but she had left. the perpetrator said he believed that she was under a Community Treatment Order. the perpetrator was given the number of the Community Safety Unit and was advised to call the police if she returned.

2.7.249 The perpetrator called police again the same day reporting that a female who was known to him was knocking on his door. He told the police operator that she did this all the time and was harassing him causing him stress. the perpetrator stated that it had been an ongoing matter for some time. The CAD was then updated by an officer providing information that the perpetrator had been spoken to. He was advised to call the police if she returned.

2.7.250 On 23rd February the perpetrator attended the gastro outpatient clinic. Prior to this, he had not been attending his outpatient appointments as he said he was being treated unfairly. Due to his ongoing symptoms and weight loss noted at this appointment it was agreed that he would be admitted to hospital when a bed became available.

2.7.251 On 10th March the perpetrator attended the ED at the Royal London Hospital due to increases symptoms of Crohns which he said had increased since he stopped smoking cannabis. He was admitted as he had increasing pain and weight loss. He stated, during admission, that he lived alone, and he said that he did not want further surgery even if this meant that he would die.

2.7.252 The perpetrator called the police on 11th March to report that, the previous day, when he had been admitted to the Royal London Hospital one of his bags containing credit cards and personal belongings had gone missing whilst he was being moved from reception to a cubicle. No suspect was identified.

2.7.253 On 12th March the perpetrator was verbally aggressive to nursing staff. On 13th March the perpetrator said that his symptoms had got worse since he ceased smoking cannabis and that he was losing weight. He stated that he did not want further surgery even if it meant he would die.

2.7.254 The perpetrator was reviewed by a dietician on 14th March. During the assessment he became very upset and emotional and disclosed that he felt he had no hope of any improvement. He said he had no family support as they do not understand his condition. He expressed a difficult relationship with his stepmother and alleged that he had no contact with his biological mother as she had sexually abused and tortured him as a child. He said that he shuts out his friends because he does not want to burden them. He said he has repeatedly thought of ending his life and today he has a plan to go to Sainsbury and buy a knife and stab his abdomen to kill himself. He said he was upset at feeling weak and that people think he is a drug addict because he is so thin. He said that he felt abandoned by the IBD team and had repeatedly thought about ending his life. As a result of this disclosure a further referral was made to RAID but he refused to see them. 1:1 nursing care was offered which the perpetrator refused and said he had no suicidal thoughts.

2.7.255 On 15th March the perpetrator was reviewed by a consultant psychiatrist who noted he was irritable and uncooperative, and reported some fleeting suicidal ideation. He was reviewed by the same consultant the next day, 16th, when the perpetrator complained of hearing voices and said that he had been smoking cannabis. The dose of anti-psychotic medication was increased, and the case was discussed with a colleague and his presentation was viewed

to be suggestive of a drug induced psychosis. On 17th March the perpetrator was verbally aggressive towards a nurse on the ward.

2.7.256 On 18th March nursing staff asked for the perpetrator to be reviewed by the consultant with a view to issuing a 'yellow card' due to his aggression towards them. During the shift he absconded from the ward on more than one occasion and was brought back each time. He was reviewed by RAID and presented with unpredictable behaviour towards himself and risk of aggression towards others. It was decided that he needed to remain in hospital for a mental health assessment, so he was detained under S5.2 (holding power Mental Health Act, 1983). The next day, 19th March a Mental Health Act assessment was conducted by Tower Hamlets Approved Mental Health Professional Service whilst the perpetrator was an inpatient on an acute ward at Royal London Hospital. The perpetrator had complained that relations with the acute treating team had broken down. There was no suicidal ideation and euthymic in mood. It was found that there were no grounds for detention under the Mental Health Act and the S5.2 holding power rescinded. The perpetrator was discharged from the Liaison Mental Health Team's caseload. Staff on the ward were advised to report to the police if there were any further threats/aggression or criminal damage.

2.7.257 On 19th March the perpetrator continued to be aggressive, swearing at staff and threatening them. On 20th March the staff at Royal London Hospital called police as the perpetrator, who had been admitted with gastro/stomach problems, was having a mental health episode in a cubicle. He was sectioned by the hospital's mental health team as he had been acting aggressively, swearing, and throwing property around. The section was removed later the same day as it was decided that he did not have a mental health problem and his behaviour was due to anger issues. CRIMINT recorded and Merlin was shared with Newham Adult Social Care.

2.7.258 On 23rd March the Hospital Social Care Team received a Merlin report from the police after the perpetrator had presented at A and E. He was rated as amber due to previous issues including domestic abuse, being arrested for false imprisonment of his partner, mental health, drug, and alcohol issues. This was recorded for information only.

2.7.259 On 18th April the perpetrator was referred to the Liaison Mental Health Team whilst an inpatient at the Royal London Hospital where he was being treated for Crohn's disease. A doctor attempted to interview the perpetrator, but he declined.

2.7.260 On 24th April the MPS Jigsaw Team reviewed the perpetrator' Risk Management Plan and he was allocated a new officer. He remained at Level 1 medium risk.

2.7.261 On 27th April a consultant psychiatrist from the Liaison Mental Health Team discussed the perpetrator' care with a medical consultant as the perpetrator was requesting a feeding tube due to vomiting. The perpetrator was assessed as having mental capacity. It was noted that the perpetrator was hard to manage on the Ward, pushing boundaries with staff.

2.7.262 On 18th May the Access to Adult Social Care Team were contacted by the Royal London Hospital with a request for a toilet frame and bed lever. A prescription for the equipment was issued.

2.7.263 On 17th June the perpetrator was visited at home by the MSP Jigsaw Team.

2.7.264 On 29th August the MPS Jigsaw Team reviewed the perpetrator' Risk Management Plan and he remained at Level 1 medium risk. As part of the review the perpetrator said that he was not in a relationship, and he did not have any friends.

2.7.265 On 8th October an Active Risk Management System Assessment (ARMS) was completed by MPS Jigsaw Team.

2.7.266 On 4th December Female 2 called the Essex Police. She said she was two months' pregnant, she said that the perpetrator was present, overstaying his welcome. He was only meant to stay the night but stayed a month; and he would not get off her. The police attended and confirmed it was a verbal argument only, but she wanted him to leave. They left together to go shopping. Female 2 was quite happy to do so, and no concerns were raised. She believed he would go back to London when they had done their shopping.

2.7.267 DV1 was completed and graded as standard risk as no violence used and both parties were amicable. The attending officer submitted a PP57 referral as there was a child living at the address-though at school at time of incident. The perpetrator was on the Sexual Offences Register. An email was sent to MPS who were managing him as there appeared to be no notification requirement on PNC; and he appeared to have been living at Female 2's address for last month. The officer in the case also contacted the assessment team who were going to make an application for disclosure under Clare's Law (although there is no further information available).

2.7.268 Female 2 called Essex Police again on 9th December as the perpetrator was, once more, at her address and refusing to leave. He claimed that she had invited him over to wrap his child's birthday present. The perpetrator left and called the police advising he was invited, and they had gone to the hairdressers together, returned, began arguing and he left as he didn't want the child to see the arguments. He said he was now on his way back to London. Essex Police attended the address, but Female 2 declined to answer safeguarding questions. The incident was graded as standard risk.

2.7.269 Following a discussion between the MPS Jigsaw Team and Essex CSC on 13th December, it was agreed that Essex CSC would conduct a home visit on 13th December and that, on 14th December 2017 the MPS Jigsaw Team would visit the perpetrator. He was visited at home on 14th.

2.7.270 On 19th December the Risk Management Plan was reviewed by MPS Jigsaw Team. The incident on 4th December was known and highlighted in the intel checks undertaken. the perpetrator said he was back in a relationship with his ex-partner, Female 2 and that she was pregnant. Police informed CSC that the perpetrator had been seeing his child.

2.7.271 On 24th December the perpetrator called the Jigsaw Team. He said that he had been staying at his child's home, trying to re-build a relationship with her mother, Female 2. He was asked to leave early after an argument about her mother allowing his child to stay with her uncle who, like him, was a registered sex offender. The uncle's ViSOR record was updated with an entry for the Essex Jigsaw Team to follow up. A Merlin was shared with Newham Social Care.

2.7.272 **2018**

2.7.273 In February 2018 the perpetrator was removed from his GP practice because of violence and aggression towards staff. He re-registered with a different GP practice on 19th March.

2.7.274 On 21st April MPS Jigsaw Team reviewed the Risk Management Plan and he remained Level 1 medium risk. He said that he was no longer in a relationship with Female 2 and that he was not seeing his child.

2.7.275 **On 10th May Star was reported missing by her sister as Star had not been seen for two months. She was now getting concerned as people had been calling her raising concerns.**

2.7.276 During the Missing Person Enquiry into Star, on 10th May information was received that the perpetrator had appeared on the call data as one of the last to call Star before her phone usage ceased.

2.7.277 The perpetrator contacted the Access to Adult Social Care Team by telephone on 10th May as he had back pain and difficulties getting in/out of the bath, difficulties with shopping/cooking and keeping his home clean. The contact was screened, and information, advice and guidance were provided. He was signposted to Community Links.

2.7.278 The next day, 11th May, the perpetrator contacted the Access to Adult Social Care Team a second time raising similar issues. He also said that he needed support from someone to take him out. He said that the previous day, he had slipped whilst getting out of the bath, and an ambulance had been called. A face-to-face assessment by a social worker was requested.

2.7.279 The GP was advised that he had been discharged from A and E following a laceration to his chin.

2.7.280 On 21st June the perpetrator did not attend his appointment with the consultant psychiatrist at the gastro-psychiatry clinic and he was discharged back to the care of his GP.

2.7.281 On 26th June a MPU officer attempted, unsuccessfully, to visit the perpetrator.

2.7.282 On 28th June the perpetrator reported to police that he had been stabbed by a female friend, Female 7 in his flat and had suffered a small stab wound to his neck. The Female 7 was arrested, and a kitchen knife was found nearby. In interview, the Female 7 claimed that she had stayed at his address for three days and everything had been OK until they argued. He then attacked her by hitting her with a walking stick and throttling her. She went to leave, and the perpetrator told her if she left, he would stab himself and he was 'going to get her in trouble'. He then stabbed himself in the neck with the knife. She ran out of the address in a t-shirt and underwear with the knife, which she threw into a bush to stop him harming himself further.

2.7.283 In interview Female 7 said that she and the perpetrator had known each other for years and they met by chance at Newham Mental Health Centre three days previously where she was an in-patient, and he was visiting. She moved into his address and as the days that followed, he became controlling and assaulted her.

2.7.284 The perpetrator was attended to by London Ambulance Service for a minor stab wound. The female was charged with ABH, but the case was later withdrawn.

2.7.285 The GP notes that in July he was treated at ED for stab wounds to his face.

2.7.286 On 2nd July the perpetrator was visited at home by the MPS Jigsaw Team. He showed officers stitches in his neck from the incident on 28th June. The Jigsaw officers asked the perpetrator if he had been associating with any other females to which he answered 'no'. They asked about Star having been informed by the Missing Person Unit (MPU) that the perpetrator had appeared on her mobile phone data. The perpetrator told officers that he knew of her through a friend stating that sometimes Star stayed with her. He stated that both females used drugs and were sometimes into prostitution. The Jigsaw Officer told the perpetrator to contact police if he saw Star.

2.7.287 On 3rd July the perpetrator was telephoned by the Access to Adult Social Care Team to advise him of the date and time of his assessment visit. Records show that he could not be contacted on the numbers provided, so a letter was sent to him advising him of the assessment at 2pm on 6th August.

2.7.288 When the Social Worker made a home visit to the perpetrator on 6th August for the previously arranged assessment there was no answer. The Social Worker spoke to his neighbour who said she had seen him the previous day when he seemed fine and that he had possibly attended a hospital appointment. The Social Worker left and returned later but there was still no response. A note was left in his letterbox and a message left on his mobile phone. The perpetrator did not respond, and the assessment request was closed.

2.7.289 On 23rd August the perpetrator called the police and reported that he had been assaulted when he was sitting in his car. He said he was assaulted by a male who he recognised that used to date his cousin's friend. The male had punched him through the open driver's window. Police attended and the perpetrator had a minor cut to his nose for which he declined medical attention. As there were no CCTV opportunities or other useful information, and police were unable to speak to the perpetrator again, no further action was taken.

2.7.290 The perpetrator then called the police again the same day stating that he had a dispute with a member of staff at Morrison's. He alleged that, when he left, a male ran up to his car and called him 'Paki' and his girlfriend a 'white bitch'. His girlfriend was also spat at. An appointment was made to take further details on 28th August. Records indicate that this meeting did not take place and the racial abuse allegation was not investigated.

2.7.291 On 29th August the MPS Jigsaw Team reviewed the Risk Management Plan and he remained at Level 1 medium risk. It was noted that the perpetrator had recently acquired a car.

2.7.292 On 3rd September an elderly neighbour of the perpetrator alleged that he had stolen £60 in cash from a jar in his kitchen. Officers attended the perpetrator' address to arrest him but there was no reply. When visiting the address, a neighbour advised officers that he had heard in the neighbourhood that the perpetrator was 'sofa surfing in Hackney'. After several attempts to contact him, he was circulated as wanted.

2.7.293 The perpetrator was arrested on 21st September after testing positive for drugs whilst driving. He was released under investigation the same day and no further action was taken.

2.7.294 On 27th September police were called by staff at a betting shop as the perpetrator had reported that he had been kidnapped in his car. Police attended and the perpetrator stated

that he had been carjacked by two armed suspects. They had made him drive to various locations and had assaulted him. Whilst investigating this incident, police identified that the perpetrator was wanted for theft. Whilst in police custody, he spat in the face of a police officer. He was charged with theft of the money and assaulting a police officer and remanded in police custody to appear at court on 29th September.

2.7.295 A week later three males were arrested having been seen in the perpetrator' car. They were released under investigation and the case was closed with No Further Action due to evidential difficulties.

2.7.296 The perpetrator was arrested on 27th September for the theft from his neighbour and he was charged on 2nd October. Whilst in custody the perpetrator was assessed by a Mental Health Criminal Justice Liaison. The perpetrator refused to engage in the interview and was processed via the criminal justice pathway.

2.7.297 On 10th October the perpetrator was sentenced to 20 weeks imprisonment for the following offences:

- Burglary of a dwelling on 3rd September 2018 – 16 weeks
- Assault of a Police Officer on 28th September 2018 – 4 weeks

He was, therefore, supervised by probation and they became the lead agency.

2.7.298 On 7th November the perpetrator' RMP was reviewed whilst he was in HMP Pentonville.

2.7.299 The perpetrator was released from prison on licence on 7th December 2018. His licence period was 7th December 2018 to 15th February 2019 with Post Sentence Supervision from 15th February 2019 to 15th December 2019.

2.7.300 The perpetrator attended his initial appointment with his Offender Manger (OM) from Probation on the day of release, but it is noted that he was 'in a rush to get to the doctor's appointment to collect crutches'. The OM explained his licence and began to complete the induction pack. The perpetrator agreed to comply with his licence and supervision contract. No concerns were reported, and his next appointment was made for 12th December.

2.7.301 On 11th December the perpetrator was visited at home by the MPS Jigsaw Team because he had failed, as an RSO, to register his home address within three days of release from prison. There was no reply and no way for them to get access to the premises to leave a message. The mobile phone believed to be owned by the perpetrator was called but did not connect. The officers updated the ViSOR record to say that they would return to the address the following day and that, if he was not present, they would circulate him as wanted for failing to register.

2.7.302 On 12th December the perpetrator was visited at home by the MPS Jigsaw Team and again there was no answer. A letter informing him of his requirement to attend a police station and register his address was put through his letterbox. He was visited again on 13th again and was not seen. The perpetrator had an appointment with his OM on 12th, but he did not attend, and it was rescheduled for 13th.

2.7.303 The perpetrator attended his appointment with his OM on 13th December. He said that he had been unable to gain entry to his flat as his keys were in his car which he alleged was stolen on the day of his arrest when he made allegations about having been kidnapped and his car having been stolen. The OM called housing and they advised that the perpetrator

would need to provide a CAD number for them to be able to help him. He said that he was sleeping in his car at the present time and could not stay with his brother. He asked if probation could provide some financial assistance for him to stay in a hotel. The OM explained that they had no access to funds and that they would have to seek advice. The perpetrator asked for £300 to get the locks changed at his flat.

2.7.304 During the appointment the perpetrator confirmed that he had been to see his GP and had a prescription for his medication. He said he was stressed out trying to resolve the issue with his flat. The OM contacted the JIGSAW team to see if they could assist with obtaining the CAD number so that housing could assist with unlocking the door. Whilst the OM was in another part of the office trying to gather the information required, the perpetrator waited in his car outside the probation office. When the OM went outside to speak to the perpetrator the police were present, having been called by a member of the public (next paragraph).

2.7.305 A member of the public had called police to report the perpetrator and a female taking drugs in his car when parked. Police stopped and searched the perpetrator who was recorded to be very aggressive. Apart from adapted bottles for smoking crack, nothing was found. The female was found to be wanted by Humberside Police and was arrested.

2.7.306 The perpetrator told the probation officer that he did not need to provide a telephone number on which probation could contact him with the CAD number he had requested. In summary, the perpetrator advised that he could not access his flat and was sleeping in his car, he had his medication, his benefits had been reinstated and he should be receiving some money in a few days. His next appointment was made for 17th December.

2.7.307 The perpetrator attended Forest Gate Police Station on 14th December to register his address. This was outside of the time requirement of RSO notification. A failure to comply with notification requirements CRIS report was recorded on 17th December. The Jigsaw Team formulated an interview plan so that he could be interviewed regarding the breach.

2.7.308 The perpetrator failed to attend his appointment with his OM on 17th December and on 18th December a first warning letter was sent to him.

2.7.309 On 20th December the perpetrator called his OM to ask for the date of his next appointment. He was reminded that he had been given an appointment card and he asked if he could report the next day. The OM was not going to be available so advised him to report on 24th December. During the conversation he said that he had access to his flat but had no electricity or gas and needed help. He said he was not receiving his benefits and had no food. The OM agreed to write a letter for the foodbank for him to collect and the perpetrator confirmed that he now had a mobile phone.

2.7.310 On 24th December the perpetrator reported to his OM as required. He reported that he was still struggling for money has he had not received any benefits. He said that he did not wish to engage with mental health services as he said that they do not help him. He said he was OK with the medication he receives from his GP. The initial sentence plan (ISP) was discussed, and the OM was concerned at the perpetrator' lack of motivation. He was failing to attend on time, forgetting his appointments and calling the OM on the day of the appointments. He was unable to stay focused during the supervision sessions for a long period of time. He would make excuses about appointments that he needed to attend to

shorten the sessions. He was reminded that he was registered with JIGSAW and that they were likely to contact him. His next appointment was set for 2nd January 2019.

2.7.311 On 31st December the perpetrator was visited at home by the MPS Jigsaw Team, but he was not present.

2.7.312 **2019**

2.7.313 A home visit was conducted by Jigsaw officers to the perpetrator on 2nd January but there was no reply. He was also due to meet his Probation OM but failed to attend and, at his request, this was rescheduled to the next day, 3rd January.

2.7.314 The perpetrator did not attend his appointment with his Probation OM at 3pm. At 4pm he rang to say that he was unwell, was going to ED and therefore would not be able to attend his appointment. The Probation OM requested evidence of this and advised that a warning letter would be issued. His next appointment was made for 10th January at 2.30pm.

2.7.315 On 3rd January 2019 the GP practice have a thorough documented management plan provided by Psychiatry, from when he was an inpatient. This explained how the surgery should deal with the perpetrator when there was an escalation of aggressive and violent behaviour.

2.7.316 On 7th January the perpetrator did not attend his review with the consultant psychiatrist following a request from his GP. The consultant psychiatrist planned for the perpetrator to continue his prescribed medications and be encouraged to engage with substance misuse support services.

2.7.317 On 9th January it was recorded on VISOR that the perpetrator' address had been attended a few times with no reply on all occasions. It was noted that the perpetrator had attended his probation appointments and that he had registered is address after being reminded by his probation officer. The risk was graded medium, and an action plan was set.

2.7.318 On 10th January the perpetrator attended his appointment with his Probation OM. He reported that he had anaemia and was taking medication but he was unable to provide evidence of this. The OM pointed out that he had been late for the appointment and that he needed to attend on time. He said that he was still unwell. The Jigsaw case manager attended this appointment as the perpetrator was seven days' late signing the register. He was advised that this was a breach of his licence conditions but that he would receive a caution due to his previous compliance. He was given an appointment to attend the police station at 3pm on 13th January.

2.7.319 During the interview, the perpetrator reported that he was struggling for money and asked for support from probation. The OM explained that they were not able to give him money but were willing to assist him in accessing the foodbank. The perpetrator became angry and said that he was going to offend to get money and that no-one was helping him. The OM reminded the perpetrator that they had offered, the previous week, to assist him with his benefits application but he had not attended the appointment. The OM said that the perpetrator needed to attend appointments on time so that support could be given and that he must take responsibility for this. The OM noted that he was obviously getting money from somewhere has he had petrol in his car to attend appointments. The OM began the perpetrator' application for Universal Credit and gave him the phone number that he needed

to call to make an appointment. the perpetrator was in a hurry to leave the session so the OM was not able to complete the task and the perpetrator said that he would do it himself as it was a free phone number.

2.7.320 When the OM asked about the perpetrator' physical and mental health, he said that was not taking his medication for Crohn's disease and had an appointment booked with his GP to sort this out. When asked about his mental health, the perpetrator said that he was schizophrenic, but he was not able to confirm if he had a formal diagnosis or if he was taking medication for this.

2.7.321 In summary, the OM recorded that he remained a medium risk of harm and was not fully engaging with his OM. It was agreed that the perpetrator would call and make an appointment to sort out his benefits, he would attend his GP and obtain a medical certificate to support his claim for Universal Credit. Once he had produced this, the OM would be able to assist him with his claim. His next appointment was set for 16th January.

2.7.322 The perpetrator did not attend his interview at the police station on 13th January. Information was received that he had been admitted to Newham General Hospital for treatment for his Crohn's disease. After he was discharged, officers attended his address, but he was not present. The perpetrator was circulated as wanted for breach of the notification requirement.

2.7.323 The perpetrator did not attend the appointment with his OM on 16th January as he was in hospital which was confirmed by the Jigsaw case manager. He was sent a breach letter on 18th January. On 18th January (presumably before he received the breach letter) he called the duty officer at Probation and advised that he had missed his appointment this week and was worried about his breach. He said that he had been unwell following a car crash. He said that he had full evidence and would provide this to his OM.

2.7.324 On 23rd January the Jigsaw case manager confirmed to the OM that the perpetrator was in hospital. He therefore failed to attend his appointment with his OM on 24th.

2.7.325 On 28th January the perpetrator' address was attended with no reply and on 31st January he was circulated as wanted for Breach of Notification Requirement (BNR). Continued efforts were made to locate him, with continued visits to the home address, intelligence, and financial checks, enquires at alternative addresses he had contact with and contact attempts by mobile phone. Enquires to trace and arrest were recorded onto the EWMS.

2.7.326 The records suggest that from February to June there was a warrant to carry out eviction for rent arrears but that the council were not able to carry out the eviction due to the ongoing police investigation.

2.7.327 On 5th February the perpetrator' OM sent him a text to advise him to report on 7th February at 3pm. On 11th February this was confirmed in an appointment letter and a further text. the perpetrator did not attend on 13th February.

2.7.328 On 13th February LB Newham housing department received a letter from the police asking if they could provide an update on the perpetrator' address as he was currently wanted. The police said that they had been attending the property every day and the flat appeared to be unoccupied. London Borough of Newham advised the police that they were seeking eviction for non-payment of rent and had applied for a 'Notice Seeking Possession'. Neighbours

informed the Neighbourhood Policing Team that the perpetrator had returned to the address but was there only sporadically.

2.7.329 On 14th February the OM sent an email to the Jigsaw case manager to advise that the perpetrator had not attended his appointment. The Probation OM said they were going to begin breach proceedings and asked if Jigsaw would be conducting any more home visits. The Jigsaw Team did continue to visit the address and make enquiries to locate the perpetrator. The OM confirmed that a further appointment had been offered to the perpetrator on 18th February.

2.7.330 On 15th February a Final Warning letter was sent to the perpetrator by his OM.

2.7.331 On 18th February the perpetrator failed to attend a probation appointment and on 22nd a breach summons was issued.

2.7.332 On 26th February a query was raised by Housing with the Access to Adult Social Care Team asking if the perpetrator was known to them as they were applying for a warrant to evict. The information was provided.

2.7.333 On 7th March the perpetrator a summons was issued for the perpetrator to attend a breach hearing on 20th March.

2.7.334 The perpetrator' breach hearing on 20th March was adjourned until 10th April.

2.7.335 On 10th April the case was heard at Thames Magistrates Court, and he failed to attend. A warrant for his arrest without bail was issued. He was further circulated as wanted by police.

2.7.336 **At the end of April the bodies of Hanna and Star were found in the perpetrator' flat.**

Section Three – Detailed analysis of agency involvement

3.1 Agency involvement with Hanna

3.1.1 **In this section we look at each agency's individual involvement with both victims and the perpetrator. We accept that there will inevitably be some duplication between this and the previous section. This is done to allow scrutiny of each agency's involvement without having to refer back to the previous section on multiple occasions.**

3.1.2 **ADULT SOCIAL CARE**

3.1.2.1 On 2nd February 2015 Newham Action Against Domestic Violence referred Hanna to Adult Social Care with the Access to ASC Team. This was because Hanna was homeless and experiencing sexual and domestic violence. The same day Hanna was accompanied by the police to the ASC offices in Newham Dockside as her abusive partner had been bailed to the address that they shared. Hanna was provided with one night's temporary B&B accommodation by the police.

3.1.2.2 The next day, 3rd February, an officer from Access to Adult Social Care contacted Hanna to discuss her plans for the future – where she planned to live in the long term and the option of returning to Hungary was discussed with her as she had no recourse to public funds in the UK. She said that she had been returned to Hungary in August 2013 but returned to the UK in 2014. When asked why she returned to the UK, Hanna said that she wanted a normal life, to set up a business – a tattoo parlour or restaurant in Lakeside – and send for her children. Hanna had no money, clothing, or personal documentation.

3.1.2.3 Hanna disclosed that the person she met when she returned to the UK 3 months earlier had forced her to go on the 'game'. She had then met a second person outside a church in Stratford and she moved into this person's home. She described him as a jealous man who made her lose all contact with her friends. She said that he beat her and was very controlling.

3.1.2.4 Hanna had nowhere to stay. She said that she would go to the Welcome Centre or to the church. Both would provide food but not accommodation. She said she had no money but had a friend in Edmonton who owned a barber's shop and would help her with work. She said that she would walk to Edmonton. When the Access Officer relayed this to the police officers who had accompanied Hanna, they advised that this friend was the person who had 'pimped her out' and was known to the police. The Access Officer said that she would discuss Hanna's situation with her line manager.

The review notes the inappropriate language used by officers when discussing Hanna's situation and questions whether this reflects attitudes that could have led to unconscious bias. Language such as this must be a lesson for learning in this case.

3.1.2.5 Later in the day the Access Officer spoke to Newham Action Against Domestic Violence, but the officer was unable to locate Hanna's file. The Access Officer advised that Hanna would not be provided with housing as she had no recourse to public funds. The Access Officer was advised by Newham Action Against Domestic Violence that because Hungary is part of the EU, Hanna would be entitled to support if she had been working in the country for a year. The Access Officer advised her line manager, and it was agreed that Hanna would be accommodated at the Stratford Hotel for one night only to allow a better assessment of her situation. Hanna was advised that it may be in her best interests to return home to Hungary

but, if she chose not to do this, she would have to find her own accommodation. Hanna was taken to the accommodation by the police after having shared her phone number with the Access Officer (the police had provided her with a mobile phone).

3.1.2.6 When the Access Officer spoke to Hanna later in the day, she said that she was going to her friend in Edmonton but did not want to 'show up with the police as he would be scared'. She also said that she had no papers and although she had told the police it had not been taken seriously. She said she thought her friend would help her out for 2-3 days but if this did not work out, she would contact the Access Officer for help with contacting the Embassy. The Access Officer discussed this with her line manager and was advised that, if Hanna moved to Edmonton there would be no further involvement from the Access Team in Newham and that she would have to present at the Civic Centre in Edmonton. Hanna was advised of this over the phone and thanked the Access Officer for her support.

It is unclear why accommodation was not sought for Hanna in a refuge. Presumably this was because she had no recourse to public funds.

3.1.2.7 On 17th January 2016 Newham Adult Social Care received a Notification of Assessment from Newham University Hospital's Social Work Team. This advised that Hanna was admitted to the Royal London Hospital having fallen from a 5th floor balcony. It was reported that she had suffered domestic abuse and had been held captive by her partner for two days. In fear of her partner, she fled the flat, leading to her falling from the balcony. Hanna sustained a collapsed left lung, five broken ribs, broken left shoulder, right hip fracture, two broken vertebrae and liver lacerations.

3.1.2.8 On 19th January Hanna was referred to nia via the One Stop Shop[37].

3.1.2.9 On 22nd January nia contacted the Hospital Social Work Team to advise that they knew Hanna but that they could not assist her as she had no recourse to public funds. nia asked the Hospital Social Work Team to assess Hanna and take the case forward as they had been unsuccessful in finding a charity that would provide her with accommodation, a task that was allocated at a MARAC meeting held on 21st January.

3.1.2.10 On 25th January a Discharge Access Officer recorded that a notification of assessment had been received on 25th January for discharge planning. Her case was assigned to a Hospital Social Worker for screening. It is noted that the referral did not provide a discharge date.

3.1.2.11 On 26th January the Hospital Social Worker recorded that Hanna was self-caring on the ward and had no social care needs but did have a need for safe accommodation. Hanna was given information about the National Domestic Violence helpline to seek refuge accommodation. There was no further action from the Social Work Team.

Even though Hanna had no recourse to public funds, it is surprising that she was discharged from hospital with no access to food, money or accommodation, despite her being at high risk of harm.

[37] Local domestic abuse service which offers free advice, information and support from a range of agencies

3.1.3 NORTH EAST LONDON INTEGRATED CARE BOARD ON BEHALF OF GP

3.1.3.1 On 3rd March 2015 Hanna saw her GP. Her presenting complaint was her mental health. She was accompanied by her partner. She was offered a follow up appointment in two weeks' time ***which is an example of good practice.***

> There appears to be no steps taken to speak to Hanna alone so that further enquiry could be undertaken into the possible reasons for low mood. This was the first opportunity for the GP to establish that Hanna was not in a safe relationship.

3.1.3.2 Hanna saw her GP again on 26th March 2015 when she disclosed that she had been kicked by her boyfriend and that when 'he gets drunk he acts this way'. She said that the previous night she had slept rough as she had been 'kicked out by her boyfriend' but was hoping for shelter in the welcome centre that night. She was given a further prescription of her medication. A further follow up appointment was arranged.

> At this consultation, there was no investigation into the risks that this relationship may pose to Hanna or to refer her to domestic abuse services.
>
> There was no action taken when Hanna reported that she had slept rough the night before when a referral could have been made to Adult Social Care.
>
> Whilst it is good that Hanna was given a further prescription, it is surprising that the GP gave no consideration to whether Hanna would be able to pay for her prescription.

3.1.3.3 On 4th February 2016 Hanna visited her GP and was accompanied by her support worker. The documentation notes Hanna's move from London to Bristol. The consultation focused on the injuries that Hanna had sustained in the fall from the balcony, her need for a referral to the fracture clinic and that she had a viral infection.

> There is no evidence of any enquiry about Hanna's mental health or emotional health following her fall from the balcony. The consultation focused solely on her physical needs and there is no sense of her voice being heard in this consultation.

3.1.3.4 Her consultations on 18th February and 15th March are described as clinically appropriate, although the review is not advised of the reason for the consultation in March.

Hanna had very limited encounters with her GP but the appointments that she did have were very medically focussed. Opportunities were not taken to ask about domestic abuse or to signpost her to agencies that could safeguard her.

Recommendation

It is recommended that the ICB ensures that all staff are up to date with their domestic abuse training so that they can recognise the subtle signs and seize the opportunities to safely enquire, support, refer, and signpost to agencies that can safeguard.

3.1.4 METROPOLITAN POLICE SERVICE

3.1.4.1 16th September 2014

3.1.4.2 Hanna was found sitting on the platform at Tottenham Hale Underground Station with her legs over the edge of the platform. She was taken to the Station Control Office where she said that she had been on the tracks and in the tunnels looking for her sister. British Transport Police attended and was detained under S 136 of the Mental Health Act 1983 and taken to the mental health unit at St Ann's Hospital. The information was shared with MPS and a CRIMINT (MPS intelligence system) report was recorded.

3.1.4.3 1st November 2014

3.1.4.4 Police were called to a public house in relation to a female acting distressed with bruising visible on her body. Officers spoke to Hanna who said that, whilst staying in the basement of a flat, she had been raped and her property had been stolen. She said that she had drunk alcohol and in the morning the male had sex with her. She informed officers that she was assaulted and showed her bruising.

3.1.4.5 Hanna was taken to a police station where she spoke to a SOIT officer. The SOIT recorded that Hanna presented as 'aggressive', shouting wanting to know who was going to get her property back. She failed to disclose what had taken place and declined the ambulance service being called.

3.1.4.6 Hanna told the officers that she had been diagnosed with a personality disorder in Hungary managed by medication that she declined to take. She told officers that she slept with people to get accommodation and had been a regular drug user.

3.1.4.7 Due to the unsubstantiated allegations, no further action was taken by the police. It was closed with Outcome Code 14 – Evidential difficulties victim based – named suspect not identified – The crime is confirmed but the victim declines or is unable to support further police action to identify the offender.

3.1.4.8 A Rape CRIS report was recorded, and a HOT[38] Risk Assessment was completed. Hanna's suicide attempt and LH admission were highlighted. Officers noted that Hanna was Hungarian and would require an interpreter as she spoke 'limited English'. Concerns for Hanna's safety were noted as she had nowhere to stay, and ASC were unable to help. Officers provided Hanna with a meal, allowed her to shower and gave her contact information for the Hungarian Embassy and a homeless shelter in Islington. ***This is considered an example of good practice.***

3.1.4.9 Supervision and DI Review were completed with actions set. The report detailed that Hanna may have Tourette's Syndrome as she presented with 'tics'. A CRIMINT (MPS intelligence system) report was recorded detailing her mental health with reference to the fact that she

[38] HOT Risk Assessment – risk assessment for a victim, offender and nature of the offence. It was replaced by HAVES (History/Aggravating Factors/Vulnerability/Escalation) Risk Assessment.

had a personality disorder which was impacted by her drug use. An ACN MERLIN[39] was completed and shared with Islington ASC.

3.1.4.10 **8th December 2014**

3.1.4.11 MPS received a call from a member of the public reporting that they had witnessed an assault. Hanna had been seen walking with her partner, Male 1 and a friend of his. An argument occurred between Hanna and the friend. The friend had grabbed Hanna's arm and pulled her hair. Male 1 had separated the two and the three continued to walk down the road. The friend was arrested, and, in interview, he said that Hanna had been rude to him, and he admitted pulling her hair once. A Police Caution for Common Assault was issued.

3.1.4.12 A statement was obtained from the informant who disclosed that, earlier in the day, they had seen Hanna being pushed several times by Male 1. A welfare check was created on CASD and assigned to ERPT to attend the home address of Hanna. She was present with Male 1. She was spoken to and made no allegation against Male 1 and declined a referral to any domestic abuse agencies.

3.1.4.13 Two CRIS reports were recorded, one for the assault on Hanna by the friend and one for the domestic assault on Hanna by Male1 which was re-classified to a Non-Crime Domestic Violence (NCDV). The initial reporting officer used the 'DA proforma' to assist with the recording of the allegation of assault on Hanna by Male 1 highlighting that the two incidents were complicated.

The report records that five-year intelligence checks were completed resulting no trace for Hanna. This is inaccurate as Hanna did have previous contact with the police. It is not known which MPS databases were used for the intelligence checks.

3.1.4.14 Prior to attendance of the officers for the welfare check a risk grading of MEDIUM was recorded although no DASH had been completed. The rationale for this was that 'the suspect is unknown, and the victim welfare has not been checked'. Intelligence checks were repeated and these highlighted that Male 1 was known to police for a number of offences including assault and breach of a non-molestation order on a different female.

Given the known vulnerabilities of Hanna and the history of Male 1, the following actions should have been considered:

- MARAC referral for this new relationship to be discussed
- Disclosure under the Domestic Violence Disclosure Scheme (DVDS) under the 'right to know'

[39] An ACN Merlin report is to be created when three or more of the five the Appearance / Behaviour / Communication & Capacity / Danger / Environment (ABCDE) areas are identified. Only if there are fewer than 3 ABCDE areas identified and there is a cause for concern for the adult an ACN Merlin report should be recorded with rationale. In all cases, the individual's views regarding any consent for referral should be obtained. This is a mandatory field in Merlin report. The ABCDE tool is a part of Vulnerability Assessment Framework (VAF)[39] that assists to identify the vulnerabilities and risk.

3.1.4.15 **28th December 2014**

3.1.4.16 MPS were called by a member of the public reporting a male and female arguing in a park. Officers attended and found Hanna and Male 1 in the park. The officers spoke to Hanna and M1 separately. Hanna told officers that they had been to the mosque for food and were walking back through the park when M1 asked her for a sexual act. When she declined, he became argumentative. He started telling her that he was jealous of her looking at other men. Words of advice were given by the officers.

3.1.4.17 Intelligence checks highlighted Male 1's domestic abuse history. SPECSS+ was completed. When asked if there were any 'cultural issues that make it harder for you to seek help' Hanna answered, 'only through communication'. She spoke of Male 1's jealousy. The risk was graded as STANDARD and 124D[40] was completed. The report was marked for the Victim Support Scheme and was closed under Outcome Code 98[41].

3.1.4.18 **31st January 2015**

3.1.4.19 MPS were called by a bus driver who had witnessed a male slap a female around the face. The Computer Aided Dispatch (CAD) was allocated to ERPT who conducted a search of the area and found Hanna and Male 1 engaged in a heated argument. Officers spoke to them separately. Hanna disclosed that she had been slapped by Male 1. She had visible swelling on the left side of her face and a small cut to her neck just below her chin. Male 1 was arrested for Actual Bodily Harm.

3.1.4.20 Whilst giving her statement, Hanna disclosed that Male 1 had physically assaulted her on 25th January and raped her on 30th January. She was taken to a MPS Safe Haven where the Sapphire Team took over the rape investigation and Hanna provided a VRI.

3.1.4.21 Hanna told officers that she had been with Male 1 since November 2014 having met him in Stratford when she was homeless. From that point, he said that she could stay with him. A DASH risk assessment was completed and recorded as standard during which Hanna told officers that Male 1 controlled her by not letting her speak to people. The abuse was, she said, getting worse and he had previously held a knife to her throat. Intelligence checks were completed highlighting Male 1's Warning Signal Markers and recording that he was a VISOR nominal.

3.1.4.22 Operation Dauntless[42] was noted with it being recorded that Male 1 had been identified as a high-risk offender and this was factored into safeguarding considerations.

3.1.4.23 Officers contacted Newham Housing Officers for accommodation for Hanna. It was explained that as Hanna had no recourse to public funds they were not able to provide her with accommodation. Hanna said that she would spend the night with a friend.

3.1.4.24 Male 1 was bailed with conditions.

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[40] Form 124D - is a booklet that is designed to enable all recording of incidents in relation to evidence gathering, the CRIS record, arrest notes, statements, risk identification and assessment, intervention, safety planning and victims consent issues to be captured in one document to improve investigation, quality of reports and intelligence. It also contains information on national support agencies for victims.
[41] There are a number of Outcome Codes that the MPS use which do not appear in the guidance due to their unique status. Outcome Code 98 is one of those codes which is a code for: Non-notifiable offence – Crime Management Service (CMS) use only.
[42] Operation Dauntless is the MPS focus on and commitment to reducing violence against women and girls

3.1.4.25 On 10th February Hanna called MPS and reported that on 9th February Male 1 had approached her telling her he had letters for her, and she needed to return to live with him. When Hanna told him to leave, he grabbed her. Hanna told police that she had seen Male 1 on the streets on several occasions and believed that he may be following her. Male 1 was arrested. Charging him for breach of bail was considered but, as the rape allegation had not reached the evidential threshold at the time for submission to Crown Prosecution Service for charging advice, he was charged with Common Assault.

3.1.4.26 On 11th June the case was discussed at MARAC.

3.1.4.27 On 15th August a charging authorisation from Crown Prosecution Service was received for rape in relation to Male 1. The assault that was reported to have occurred on 25th January was NFA as the six-month time limit for charge had expired.

3.1.4.28 On 24th August officers attended HMP Pentonville where Male 1 was remanded and charged him with rape.

3.1.4.29 Hanna attended a police station on 12th October and asked to withdraw her allegation of rape, stating that she had made it up and that was now back in a relationship with Male 1.

3.1.4.30 Male 1 was arrested on 20th October and charged with Breach of Court Bail as he had been in contact with Hanna. He was remanded in custody.

3.1.4.31 On 21st October Hanna spoke to the SOIT and DS leading the investigation of rape. She admitted that when she had called to withdraw the allegation of rape, Male 1 had been beside her. She stated that 'she had no-where to stay; no recourse to public funds and had missed her appointment with the Hungarian Embassy to get her passport so that she could claim benefits'. Hanna said that she wanted to withdraw her statement as she did not want to attend court.

3.1.4.32 Efforts were made to contact Hanna, but she did not return them, and police were unable to locate her. As the police were unable to locate Hanna, a 'Notice of Discontinuance' was served in relation to the court case for the rape on 12th January 2016.

The review notes that the rape and assaults were submitted to the Crown Prosecution Service for charging advice on a threshold test[43] with an application to remand Male 1. The Crown Prosecution Service deemed this was not suitable as he had a suitable bail address and Hanna had been safeguarded. In addition to this, Crown Prosecution Service highlighted that the VRI required viewing by a lawyer prior to a decision being made on this case. This led to Male 1 being bailed with conditions and the case subsequently being referred to Crown Prosecution Service who authorised a charge for rape. After unsuccessful efforts had been made to contact Hanna, a Locate/Trace Police National Computer Marker was placed onto her Police National Computer record so should she have contact with police, this would flag to the officers. The Marker was removed on 18/01/2016.

3.1.4.33 **17th January 2016**

3.1.4.34 Police were called by a member of the public who had heard a female scream for help. The female was identified as Hanna and found on a grassed area. She said that her boyfriend

[43] Threshold Test – This is where the Full Code Test for charging decision is not met but the seriousness or circumstances of the case must justify the making of an immediate charging decision, and there must be substantial ground to object bail.

had pushed her from their 6th floor balcony. London Ambulance Service were called. Male 1 ran over and started to try and get Hanna off the ground and he was told by members of the public to stop.

3.1.4.35 Male 1 told officers that Hanna was suicidal and had jumped. Hanna was taken to the Royal London Hospital by ambulance. She had sustained a fractured left shoulder blade, minor fractures of her spine, broken ribs, and bleeding in her abdomen. She provided a statement in which she said that Male 1 had kept her captive and had assaulted her. He was arrested.

3.1.4.36 The Crown Prosecution Service authorised charges for False Imprisonment and Assault by Beating. Male was charged and remanded in custody. The rape charge was reviewed and reinstated by Crown Prosecution Service.

3.1.4.37 On 11th March Male 1 was charged with rape. The court trial for all assaults was listed for 27th June 2016.

3.1.4.38 Efforts to contact Hanna were made but the police were unable to locate her. Hanna did not appear in court on 27th June and so no evidence was offered.

3.1.4.39 A CRIS report was recorded classified for Attempted Murder. No Body Worn Video[44] was recorded.

The review notes that MPS began a pilot of BWV in April 2014, with selected response teams across 10 boroughs being given the necessary equipment and training to test the effects and uses of the cameras. The first phase of roll out of the BWV to officers began in October 2016 with full roll out across the MPS completed by the end of 2017. The BWV policy toolkit provides guidance for BWV use and instructs 'if in position of BWV, it must be activated to record events in the following specific circumstances unless there are legal or operational reasons not to do so'. These specific circumstances include 'When attending DA or suspected DA incidents.'

3.1.4.40 Five-year intelligence checks were conducted. The domestic abuse history was documented, and DASH risk assessments completed grading the risk as HIGH. A DI review was documented, and actions set including advice to be sought from the Homicide Assessment Team (HAT). The rape CRIS report recorded the continued efforts made by the SOIT to contact Hanna with no response to the last communication in March 2016. It does not appear that Hanna was seen in person by SOIT officers on 17th January when she had been pushed from the balcony.

3.1.4.41 On 27th June the SOIT recorded on CRIS that Hanna sent a text message saying, 'Hi (name) is Hanna .just to let u know, I try to call u all weakend and all morning, but I couldn't get trouth, I'm not well that's why I cant come court today. I have tonsillitis and a fevear. Doctor give me sicknote I will give that to u when am coming to London. I contact the court to let they know I cant turn up. I still want to go ahead with the case. Thx to ur susport and help. Will email u or call u thanks Hanna'.

3.1.4.42 **The Investigating Officer recorded that a court hearing on 24th July 2016 was held which they had not been made aware of.** No evidence was offered at the hearing and the case was discontinued. A letter from the Crown Prosecution Service Reviewing Lawyer was sent to Hanna to advise her of this decision.

[44] Body Worn Video (BWV) - *A body-worn device worn in an overt capacity by MPS for the primary policing purpose of recording video and audio evidence.*

3.1.4.43 In 2020 MPS Missing Policy produced guidance on Missing/Not Missing. This details that 'a missing person investigation should not be used to manage instances in which a victim or suspect cannot be traced (eg as result of no trace DV call to police), whether individuals have been identified or remain unknown. Any efforts to locate individuals in these circumstances should be documented in the relevant CRIS report'.

Analysing this contact and considering the current MPS guidance in relation to when a victim of crime cannot be traced, consideration needs to be made to those victims where there are known risks and vulnerabilities. Hanna was known to be homeless, not having access to public funds, extremely vulnerable with no family in the UK. In recent months she had reported numerous assaults that had escalated by a serial domestic abuse offender. Although a text message had been sent, it was not confirmed it had definitely come from her. There had been no communications since March 2016, but she had not been seen since January 2016. It is important that before closure there is victim contact and that evidence-based prosecutions are considered. There is no current guidance around the non-engagement of victims in DA in the current MPS DA Policy Toolkits.

Recommendation

It is recommended that CPIC review the current domestic abuse policy to ensure guidance is available to staff about the actions to take when a domestic abuse victim is not engaging in contact with an investigation.

3.1.4.44 **10th February 2016**

3.1.4.45 MPS received information relating to Hanna from the Salvation Army Modern Slavery Adult Victim Care and Co-ordination Centre in the form of a National Referral Mechanism (NRF)[45]. This identified her as a potential adult victim of modern slavery. This referral detailed an interview with Hanna at the Royal London Hospital in which she had provided history and details of her life with her ex-husband in Hungary, sexual exploitation, and drug exploitation and how she came to the UK. She was described, in the referral, as aggressive, agitated, and impatient when she was spoken to.

3.1.4.46 Details were placed on the CRIS for the attempted murder to bring it to the attention of the Investigating Officer. Information about the attempted murder investigation was shared with the National Referral Mechanism Case Manager at the National Crime Agency (NCA).

3.1.4.47 In the NRM form Hanna gave consent for the form to be shared with support agencies but did not give consent to police involvement. When the information was shared with MPS, it was highlighted that Hanna would not co-operate with any law enforcement investigation.

The review notes that, at the time, if the individual was not willing to engage with police in relation to NRM, instructions were that only a CRIMINT (MPS INTELLIGENCE SYSTEM)[46] should be recorded but that this has now changed.

3.1.4.48 This guidance changed on 3rd June 2019 in relation to the receiving, reporting and allocation of modern slavery referrals from partner agencies. The new policy states that NRM referrals which are being allocated to the MPS by the Competent Authority, are sent to a dedicated modern slavery inbox, which is administered by the Central Specialist Crime: Vulnerability

[45] [45]National Referral Mechanism (NRM) – Framework for identifying and referring potential victims of modern slavery.
[46] CRIMINT (MPS INTELLIGENCE SYSTEM) is the MPS intelligence system

Assessment and Partnership team. This inbox receives from the Competent Authority: new NRM referrals, reasonable Grounds and Conclusive grounds decisions and requests for investigation updates.

3.1.4.49 The Modern Slavery Inbox Coordinator will review each referral using the THRIVE+[47] assessment framework and carry out checks to see whether the matter has previously been reported to the police. They will then assign one of two categories to the referral before forwarding it to the Telephone Digital Investigation Unit (TDIU) for a CRIS report to be created in line with Home Office Counting Rules.

3.1.4.50 **29th September 2016**

3.1.4.51 MPS were called to Upton Park Underground Station by a member of the public who reported that there was a female with her face covered with a headscarf. She was with four males, and all were acting suspiciously.

3.1.4.52 Officers attended and stopped a female and a male outside of West Ham Football Stadium who matched the description provided. The other three males had run away in a different direction. The male stopped was the perpetrator and he admitted to officers that he had purchased drugs and showed them a bag of cannabis. Officers searched both the perpetrator and the female under Section 23 Misuse of Drugs Act 1996, and nothing was found on either of them. The perpetrator was issued with a Fixed Penalty Notice (FPN) for possession of cannabis.

The review notes that a CRIS was recorded for the cannabis possession by the perpetrator. The CRIS did not record Hanna's details indicating only that the perpetrator was with a female when stopped. The CRIMINT (MPS INTELLIGENCE SYSTEM) references are not recorded on the CRIS report to link all three reports, being two stop slips, one of which had Hanna's details and the possession of cannabis crime report.

3.1.5 **nia**

3.1.5.1 nia provide the IDVA service and were engaged with Hanna from 19th January 2016 when they received a referral from the One Stop Shop (OSS). At this point she was in hospital having fallen from the balcony when escaping her partner.

3.1.5.2 The IDVA made several attempts to speak to Hanna on the ward before speaking with her on 21st January. As requested by MARAC, the IDVA made extensive enquiries to seek accommodation for Hanna on her discharge from hospital, but this proved almost impossible as she had NRPF.

3.1.5.3 On 29th January the IDVA made a referral to Catholic Worker's Farm (CWF) and was informed that this was the second referral they had received for Hanna.

Had the IDVA queried who had made the first referral, this would have allowed a contact to have been made with that organisation. This would have prevented the duplication that then followed.

[47] THRIVE+ - is a decision-making framework which works with the National Decision Model (NDM). It's intended to be used dynamically through the whole process of dealing with an incident or investigation.

3.1.5.4 The IDVA worked very hard and managed to secure a place for Hanna at CWF. ***This is an example of good practice.*** However, when the IDVA arranged for the police to collect Hanna to taker her, she had already been collected by the Salvation Army and taken to a safe house in Bristol.

There was duplication in the support being offered to Hanna and, although this was identified by the IDVA who spoke to A from the Salvation Army about this, it is evident that there was no clarity about how they were moving forward.

3.1.6 **VICTIM SUPPORT**

3.1.6.1 Hanna was referred to Victim Support on four occasions, but they had no engagement with her. Each time Hanna was referred by the police following an incident.

3.1.6.2 **8th December 2014**

3.1.6.3 On this occasion Hanna was referred following Assault Without Injury with a DV flag. Three attempts were made to contact Hanna over two days. When no contact could be made the case was closed and referred back to MPS with a request for them to provide their details to Hanna.

3.1.6.4 The case was then reactivated following another referral from MPS. A further attempt was made to contact Hanna but when this was unsuccessful the case was closed. It was noted on this case that it was closed 'as per VARC 14-day policy and as the local Victim Support scheme are not currently taking DV cases for further attempts'. The IMR author searched through all Victim Support's policies during this time and have been unable to find such a policy. It is possible that this was a local agreement which did not feature in national policy.

3.1.6.5 **12th February 2015**

3.1.6.6 Hanna was referred to Victim Support with Assault Without Injury. Three attempts were made to contact Hanna on 12th, 13th, and 16th February. All were unsuccessful and the case was closed.

3.1.6.7 **17th February 2015**

3.1.6.8 MPS referred Hanna following Rape of Female aged 16 or over. The initial call was made the same day with no reply. Two further calls were made on 18th with no reply. Finally, two further attempts were made on 19th which were also unsuccessful. An email was sent to MPS advising them of the unsuccessful attempts and asking them to pass on Victim Supports details to Hanna.

3.1.6.9 A further call was made on 26th February under '14 day follow up'. On this occasion a male answered and the VARC officer asked for someone of a name other than Hanna. The call was then terminated, and the case was closed. ***The review notes the good practice in protecting Hanna's identity in this call.***

The review has asked Victim Support why Hanna received a '14 follow up' on this occasion when this had not happened previously. The review has been advised that this was a localised policy that was added to the service procedure around this time.

3.1.6.10 Two further calls were made under the '14 day call back policy' on 3rd March. The records do not indicate if someone was spoken to on these occasions.

3.1.6.11 **19th January 2016**

3.1.6.12 Victim Support received a referral from MPS recorded as Attempted Murder. The first attempt to contact was made on 2nd February.

3.1.6.13 The second attempt was made on 23rd February, with a third attempt on 1st March and the final attempt on 10th March.

> The review notes that the initial contact was made 32 days after the referral. The IDVA Operating Procedure states that initial contact will be made within 48 hours of receiving a new referral.
>
> There was a further delay in attempting contact.

Victim Support acknowledge that this response is outside of their policy time and will work to seek to work within their policy.

3.1.6.14 The case was closed on 10th March 2016.

3.2 Agency involvement with Star

3.2.1 **METROPOLITAN POLICE SERVICE**

3.2.1.1 **3rd August 2016**

3.2.1.2 Star called police reporting that she had stayed at her friend Male 1's address the previous week. When she woke, her trousers and knickers were on the floor, and he was asleep next to her. She said that she did not remember how this happened and said that she did not feel anything. Star told police that she had made a report against this man the previous year as he had stalked her. She stated that her mother did not know about this incident and explained that she was using her friend's phone providing landline to be contacted on. Officers attend Star's address the following morning and her mother told them that she was with friends.

3.2.1.3 Several attempts were made to contact Star, including through her family and friends. As police were unable to establish contact with Star, on 24th August 2016 a review by the Detective Inspector (DI) was completed and the report was closed with Outcome Code 16 – *Named suspect verified. Victim unwilling to assist police.*

3.2.1.4 The call was graded 'E' (Extended)[48] and an appointment was given for the following morning as Star stated that she was not at her address. A skeleton CRIS report was recorded in line with NCRS[49] due to limited information and difficulties securing contact with Star. Intelligence checks were completed showing a previous report for rape by Male 1 on Star in 2015. No further action had been taken at that time by police due to Star's non-engagement.

3.2.1.5 The Detective Sergeant recorded that the initial report still needed to be completed by the Emergency Response Police Team (ERPT) with the DI following this entry highlighting that Star needed to be spoken to as a matter of urgency with consideration to the forensic timeframes. Attempts to establish contact were made with no prevail.

3.2.1.6 Special Schemes[50] are noted to be placed on Star's address that expired on 3rd November 2016. There is no reason recorded why this safeguarding tool is in position.

3.2.1.7 **25th October 2016**

3.2.1.8 Police were called by a member of public stating that rough sleepers were in the stairwell of a block of flats and were refusing to leave. He provided information that they were an *'Asian male'* approximately 25 years and an *'Asian female'* approximately 20 years and said that he believed that they had taken drugs.

3.2.1.9 Officers attended and found one female present who was Star. She stated that she was waiting for a friend. She was recorded to have concealed her bag inside her jacket. Officers conducted a search under Section 1 PACE 1984. Nothing was found and no further action was taken by police. The search was recorded onto a CRIMINT report. There was no further information regarding the identity of the male. An Airspace[51] report was created.

3.2.1.10 **15th November 2016**

3.2.1.11 A child of Star's called police reporting that a man outside his flat had attacked him. He stated that he knew the man as 'Male 1'.

3.2.1.12 Police attended and spoke to a male known as Male 2 who was known to have just been released from Prison. Officers described this male as being 'drunk'. The police were told that Male 2 and Male 1 had an altercation outside in the street, after Male 1 had gone into the block of flats shouting abuse towards Star, which Male 2 had tried to stop. Star told both males to leave, her child was present and Male 1 had punched him in the face.

3.2.1.13 Officers attended Male 1's address which appeared to be empty. Whilst there, they received a call informing them that Male 1 had returned to Star's flat. Officers returned and saw Male

[48] MPS "Extended Response" E Grade. (NCMS Emergency Contact) - Any call that requires a Police attendance that can be scheduled will be dealt with by appointment that will be agreed with the caller and take place on the day of the call or the day following it, to ensure that an appropriate response is made within 48 hours.

[49] National Crime Recording Standards

[50] This is to alert officers to information that could mitigate risk, whether that be to Officers and Staff, members of the public, or Partner Agencies by putting mid screen comments on specific addresses. Special Schemes will remain on the system for a maximum of 6 months before an email is sent to the IO asking whether the scheme is to be extended or deleted. In April 2020, as a result of an Independent Office for Police Conduct (IOPC) investigation involving a domestic assault, a recommendation has been made that the MPS take steps to make Safeguarding teams and departments aware that special schemes can apply to the addresses of perpetrators of domestic abuse and should be used where appropriate to do so.

[51] Airspace - Airspace Reports was created in order to raise the issue to the Safer Neighbourhood Team. Airspace is the application the MPS uses to record and manage cases of anti-social behaviour (ASB) and engagement with members of Public within Neighbourhood Wards throughout London.

1 walk down the communal stairs of the block having something in his hand which he discarded onto a window ledge.

3.2.1.14 Star and her son told officers that Male 1 had been writing on the walls. Officers noted abusive, threatening words towards Star had been written on the wall in nail varnish. Male 1 was arrested for Criminal Damage and Common Assault. Star was spoken to and told officers that she believed that Male 1 was stalking her. Male 1 was charged with Criminal Damage and Common Assault.

3.2.1.15 The call was graded 'I' (Immediate)[52] and assigned to ERPT. Officers completed a 124D[53] and DASH risk assessment. In the DASH Star disclosed previous rape by Male 1 she had reported to police, and that Male 1 had slapped her a couple of months previously. There was no exploration of the physical assault and no CRIS report recorded for this allegation. Star stated that she was on medication for heroin. The risk was graded as STANDARD. The five-year intelligence checks were completed and highlighted previous Rape, Assault by an ex-partner, Child Protection Plan (CPP) and Threats to Kill crime reports.

The IMR author highlights that the report was reviewed by a supervisor who recorded that the incident did not fall within the Child Abuse Investigation Team (CAIT) remit as Male 1 was not related to Star's child and the investigation was progressed by ERPT. However, within the report Male 1 is described as the 'ex-boyfriend' of his mother Star. The incident should have been progressed by CAIT and a strategy discussion with CSC conducted for a Section 47[54] joint investigation by police and CSC should have been considered.

3.2.1.16 The supervisor highlighted the harassment by Male 1 that Star had reported to officers and advised that this would be allocated to the Community Safety Unit (CSU). An officer contacted Star and spoke to her about the harassment which she stated that she had already reported and '*was unable to give any further evidence to police about the matter'*. Star also *'expressed a need to be re-housed'* to get away from Male 1. The officer recorded that due to not working not to refer the CRIS report to her, they provided the contact details for AANCHAL and Newham One Stop Shop.

In the Intelligence Checks results there is no reference that a harassment had been recorded previously and no consideration appears to have been made to record a harassment crime report in line with NCRS.

3.2.1.17 A PAC MERLIN report was completed for Star's child. It was reviewed by NMASH and [55]BRAG graded RED. It was shared with NCSC on 16th November 2016.

[52] MPS "Immediate Response" I Grade. (NCMS Emergency Contact) - Those calls where the immediate presence of a Police Officer will have a significant impact on the outcome of the incident.
[53] This is a booklet that is designed to enable all recording of incidents in relation to evidence gathering, the CRIS record, arrest notes, statements, risk identification and assessment, intervention, safety planning and victims consent issues to be captured in one document to improve investigation, quality of reports and intelligence. It also contains information on national support agencies for victims.
[54] Section 47 Investigation – Investigation by the Local Authority/Children Social Care where there is good reason to suspect that a child who lives, or if found in their area is suffering or likely to suffer significant harm.
[55] (BLUE, RED, AMBER, GREEN) The London Continum is a model that was developed in consultation with local authorities and key local, regional and national partners developing four levels of classification which the MASH staff use when risk assessing and decision making when reviewing Merlin Reports.

3.2.1.18 **23rd February 2018**

3.2.1.19 Staff at the Women's Refuge contacted police and reported Star as missing. She was last seen on 20th February. The staff told police that Star was taking Methadone and had left the refuge stating that she was collecting her prescription. She had also failed to attend her meeting at Camden City Hall. Concerns were raised that Star may be '*prostituting to get money for drugs'*.

3.2.1.20 Police were notified later in the day by staff at the Refuge that Star had made contact stating that she was in Barking.

3.2.1.21 On 24th February Star returned safe and well. Staff at the Refuge stated that she was sleeping so could not be spoken to by police on the phone. They told police that Star had told them that she had been staying with friends.

3.2.1.22 A MISPER MERLIN report was created, and risk assessment completed graded as MEDIUM. This risk grade remained throughout the missing investigation due to Star being a methadone user, having an association with sex work and being victim of assault when she went missing previously.

A 'safe and well' debrief interview was not conducted by police. At the time MPS missing person policy required 'safe and well' checks to be a 'face to face' encounter with a police officer to ensure the wellbeing of the located individual. This policy has since been updated. 'Safe and well 'debrief interviews have been renamed 'Prevention Interviews'.

3.2.1.23 The MPS Policy states that 'Safe and Well' Interviews now known as 'Prevention interviews' should be carried out in all cases recorded as missing however, proportionality is crucial and will allow the police to decide the most appropriate methodology from the following 3 options for all cases apart from HIGH risk:

- Police liaise via telephone with the parent/carer/medical professional in charge of the subject and confirm wellbeing. (No deployment, follow aide-memoire, Merlin updated)
- Police liaise directly via telephone/video call with subject and confirm wellbeing (No deployment, follow aide-memoire, Merlin updated)
- Police deploy and conduct formal face to face prevention interview (follow aide-memoire, Merlin updated)

The debrief interview was entered on the cancellation page of the MISPER report but due to the PAC (Pre-Assessment Check)[56] button not being ticked, a PAC/Adult Come To Notice[57] (ACN) report was not generated leading to the report not being shared with partner agencies.

[56] Merlin report to Children's Social Care

[57] An ACN Merlin report is to be created when three or more of the five the Appearance/Behaviour/Communication & Capacity/Danger/Environment (ABCDE) areas are identified. Only if there are fewer than 3 ABCDE areas identified and there is a cause for concern for the adult an ACN Merlin report should be recorded with rationale. In all cases, the individual's views regarding any consent for

3.2.1.24 **10th May 2018**

3.2.1.25 Star was reported missing by her sister. She stated that she had not seen Star for two months and was now getting concerned as people had been calling her raising concerns.

3.2.1.26 Star was said to have been staying with her friend Male 1 for the last three months but had left his address after an argument over drug use. She returned to the address on 6th May, but he would not let her in, so she left. The previous rape and assaults by Male 1 were sited.

3.2.1.27 In the report, Star is described as a '*drug user*' who took heroin and was involved '*possibly in prostitution to fund her drug habit*'. It was recorded that she sometimes slept rough and would also beg. Star was recorded to have been diagnosed with anorexia and depression which she had been prescribed medication but did not take. Star had previously told family that she had intended to commit suicide. She had previously swallowed pills and threatened to jump off a bridge.

3.2.1.28 Enquiries were made with previous partners and Male 1. The police liaised with the Women's Aid Refuge that Star had stayed at, Newham Drug and Alcohol services she had used, and her phone data investigated. Intelligence and hospital checks were conducted regularly throughout the investigation and authority was sought from Star's family for Star to be circulated as a missing person via Twitter and Missing People Charity.

3.2.1.29 During the Missing Person investigation, several unsubstantiated sightings of Star were reported throughout England and Wales, and these were investigated.

3.2.1.30 Through the mobile phone data, it was identified that the perpetrator's mobile phone number appeared on Star's call data as one of the last numbers to call her before her phone usage ceased. On 26th June the MISPER IO and Jigsaw[58] Officer visited the perpetrator's address. There was no reply, and a letter was left. Enquiries were made with neighbours with one recalling seeing a '*slim girl*' with the perpetrator a few days previously. When shown Star's photo believed it may have been her.

3.2.1.31 On 2nd July the Jigsaw Officer visited perpetrator's address. He told the officer that he did have a female (F7) staying at his address who had assaulted him. When asked about Star, he stated that he knew her through another female but had not seen her.

3.2.1.32 On 4th July the female that the perpetrator stated he knew Star through was spoken to. She confirmed that she had last seen Star when she stayed with her for two days up to 2nd May. She told officers that they had a minor argument and Star left to get some money. She stated that Star had threatened to take an overdose. She was further spoken to on 27th

referral should be obtained. This is a mandatory field in Merlin report. The ABCDE tool is a part of Vulnerability Assessment Framework (VAF) that assists to identify the vulnerabilities and risk. The VAF is available for police to identify vulnerability in members of public (from victims and witnesses to suspects) that they encounter. The purpose of applying this at the earliest stages is to maximise opportunities for early intervention to prevent someone becoming a victim or suspect at a later stage.

[58] Jigsaw manage Multi-Agency Public Protection Arrangements (MAPPA) offenders living in the community as well as those serving sentences for their relevant offences. MAPPA is the process through which the Police, Probation and Prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community to protect the public. The Central Jigsaw team coordinate the Pan- London response (with our legislative partners) providing the police response to the strategic overview for MAPPA.

November and told officers that she believed that Star was dead because she would not leave the area and not contact anyone.

3.2.1.33 Concerns were reported that Star might have been killed with Male 1as a key person named. An action was also set to visit the perpetrator again. On 21st August the IO contacted the perpetrator who stated that he had not seen or heard from Star in a few months and could not remember the exact dates.

3.2.1.34 Investigation and lines of enquiry actions continued by the Missing Person Unit (MPU). Dental records for Star were obtained and comparisons were made with unidentified bodies. Consultation with the National Crime Agency (NCA) UK Missing Person Bureau was sought, and actions were created including review of her notebook that had been seized and organising an underwater search of nearby docks.

3.2.1.35 A meeting with Star's family was held on 28th January 2019. A review on the CRIS documented that although the NCA had not conducted a full and thorough review, and their overview *'reinforces the strongest current hypothesis that Star is no longer alive'*.

3.2.1.36 On 10th February a Supervisor Review considered the working hypothesis highlighting facts gathered for and against Star being alive.

The IMR author notes that the initial phone call by Star's sister to report her missing was graded 'S' and assigned for initial reporting. Two further calls to police by Star's sister raising concerns about Male 1 followed and were graded 'R'. It is noted on the CAD that the information was to be updated on the MERLIN report and officers assigned were made aware.

The MISPER MERLIN report was recorded and graded MEDIUM highlighting that Star was a drug user and had previously spoke of harming herself. It was recorded that Star had a *'chaotic lifestyle'* and did not stay in one place, however the fact that she had not been seen for this period of time was *'out of character'*. On 5th July 2018 a DI review did consider increasing Star to a HIGH risk MISPER should there be no contact on her child's birthday which she had never missed. On 9th July after a further review, the DI concluded that the risk should remain as MEDIUM and further actions were set. Although risk categorisation was reconsidered throughout the investigation, Star maintained the grading of MEDIUM risk.

Recommendation

It is recommended that all NE BCU SLT remind staff of the MPS Missing Person Policy around homicide consultation and that risk grading is not a barrier to seeking advice from colleagues in other MPS units.

3.2.1.37 During this investigation Newham Borough transitioned and became part of the NE BCU covering two boroughs (Newham and Waltham Forest). This change of formation led to changes within the MPS Missing Policy around early risk decisions and streamlined ownership with the implementation of the Local Resolution Team (LRT)[59] process. Training was delivered on the policy and new processes to staff before the BCU went live by the CPIC for Missing Persons.

[59] Local Resolution Team (LRT) – The role of the LRT is to triage CADs passed to the BCU from MetCC and where it is necessary for police to respond undertake an effective initial response.

3.2.1.38 NE BCU became responsible for the missing investigation for Star from 17th October 2018. The new IO had knowledge of the case and had previously been involved when the investigation had been led by the MPU Newham Borough.

3.2.1.39 The MPS Missing Person Policy advises that Missing person cases can become homicide investigations. It is vital that the initial stages of all missing person investigations should begin on the basis that the investigation may escalate into a serious crime enquiry. The circumstances of a person's disappearance must be examined carefully, and it is good practice for investigators to think homicide from the outset. If the BCU Senior Investigating Officer (SIO) believes that the missing person has been murdered, or is likely to be murdered, SCO1 Homicide Command must be consulted. Through consultation with specialist departments' investigation advice, further actions and results can be achieved.

Although within review a consideration had been made to consult with the Homicide Command, this had not been done. Any reluctance to action may have been due to the risk grading of Star assessed as MEDIUM not HIGH. However, the grade of risk does not determine the consultation with MPS units and should not be a barrier to seeking advice.

The review is aware that the Missing Person investigation of Star identified a number of organisational learning issues which had been addressed within an MPS Internal Critical Incident Review and Directorate of Professional Standards and IOPC[60] review.

3.2.2 CHANGE GROW LIVE

3.2.2.1 Star began accessing treatment on 6th August 2014 and was provided with a bridging prescription having been transferred from the previous provider of drug and alcohol support services in Newham.

3.2.2.2 Star completed three treatment episodes with Change Grow Live as follows:

- 21st May 2015 – 29th September 2016 – referred by a relative
- 16th January 2017 – 19th April 2017 – self-referral
- 28th December 2017 – 30th April 2018 – self-referral

3.2.2.3 On each occasion Star accessed Change Grow Live with a self-determined goal of wanting to achieve abstinence from illicit opiate and crack cocaine use and, on each occasion, Star left the service in an unplanned way. All attempts to re-engage with Star were unsuccessful.

3.2.2.4 Star was accessing treatment for support with opiate (heroin) and crack-cocaine use. Her last report of use was on 23rd February 2018 when she completed a Urine Drug Screening (UDS), and it was positive for heroin and crack-cocaine. Star was provided treatment through psychosocial and clinical interventions. She completed one-to-one sessions with her Recovery Worker and attended Criminal Justice groups.

3.2.2.5 Star was also in receipt of Methadone 30mls, via daily supervised consumption. Her last prescription was provided on 24th February 2018 until 2nd March 2018. Furthermore, Star was provided with a safe storage box on 28th December 2017 to secure her medication.

[60] Independent Office of Police Conduct

3.2.2.6 In the final three months of treatment, it was identified that Star was at risk of harm from others and at risk of reduced tolerance/overdose. Star disclosed to staff at Change Grow Live that she was fearful for her safety as was being coerced and controlled by several males. She said that she was being forced to engage in sexual activity and they were also controlling her drug use. In response to this, Change Grow Live made referrals to Newham MARAC and local domestic and sexual violence services. Star was provided with immediate safety planning advice to support her until she was provided with a refuge space outside of the borough. ***This is an example of good practice.***

3.2.2.7 Star later left this refuge in an unplanned way. The circumstances around why she chose to leave this accommodation remain unknown.

3.2.2.8 Star was at risk of overdose due to reduced tolerance because of not maintaining her Opiate Substitute Therapy (OST) prescription and continuing with illicit drug use. Star was offered Naloxone by staff at Change Grow Live on numerous occasions, but this offer was continually declined. Flexibility around offering Star rapid access to OST prescribing was also provided where appropriate, along with regular harm minimisation advice around reduced tolerance and overdose risk.

3.2.2.9 **23rd February 2018**

3.2.2.10 This was last time that Star was clinically assessed by Change Grow Live. She presented at the service in an unplanned way but was accommodated and reviewed by Nurse Medical Prescriber due to the ongoing concern regarding her safety following her disclosure of domestic and sexual violence.

3.2.2.11 At this appointment Star reported that she had been provided with emergency refuge accommodation in the Kilburn area but was struggling to settle into her new area as she felt isolated and had a lack of money. Star had not engaged with the local drug service and therefore was not in receipt of OST (opioid substitution therapy) and was using illicit opiates to prevent withdrawals. Star was reminded that a transfer of her care to Change Grow Live Camden had taken place and she was informed of how she could access support. Star reported that she was smoking approximately £30 heroin and £20 crack cocaine daily. Clinical observations were taken, and a decision made to commence Star on a titrating dose of Methadone 20ml-30mls via Daily Supervised Consumption (DSC) to be collected at a pharmacy near to her temporary accommodation in Kilburn. Star was directed to attend Change Grow Live Camden on 26th February to continue the OST prescribing and onward treatment and care. Star was provided with appropriate harm minimisation advice around poly substance use and reduced tolerance.

3.2.2.12 Star attended Change Grow Live in an unplanned way on 26th April to request a food voucher due to a lack of income. She was provided with a food bank voucher. This was the last time that she seen face to face at Change Grow Live.

3.2.2.13 **Multi-agency communication and support**

3.2.2.14 The review is aware that, as Star was a complex service user with diverse needs who required additional support, Change Grow Live made several referrals to other agencies, and welcomed input from external agencies into their care plans with Star to ensure that they were robust. ***This is an example of good practice.***

3.2.2.15 These referrals included MARAC, Street Links and Thames Reach the One Stop Shop domestic abuse service.

3.2.2.16 Once Star was identified as being at risk in Newham, Change Grow Live assisted her in relocating to a Women's Aid hostel. This included following up the referral and providing a reference to support her application. During the transfer process, Change Grow Live worked closely with Solace whilst the transfer was being completed, including ensuring that her prescription was maintained. ***This is an example of good practice.***

3.2.2.17 Change Grow Live communicated with external agencies when any risks to Star were identified. For example, they contacted her GP and social services when she fully disengaged from treatment to ensure that there was no further risk. A joint home visit was conducted with the MASH on 8th November 2017.

The review notes that Change Grow Live identified that Star was, at times, hard to engage and therefore used a variety of pathways to support her through clinical and psychological interventions. For example, she was provided with contact details for external support agencies, including out of hours numbers for Change Grow Live's out of hours service. She was also encouraged to access support in the community such as Narcotics Anonymous and SMART groups. As Star accessed the needle exchange, this was used by Recovery Workers as an opportunity to check on her welfare and provide advice on harm minimisation. Star was provided with a Naloxone[61] kit and was trained in its use.

> Star had a pattern of disengagement and the Recovery Worker felt this needed to be addressed for her to be completing treatment to its entirety and to be receiving the full benefits. Therefore, a one-to-one session was arranged with the Recovery Worker and Star to discuss this and generate a care plan that she was invested in as it was thought that this would improve her engagement. However, Star did not attend these meetings.

In light of Star's death, Change Grow Live has reviewed its re-engagement process. A new policy has been adopted that will ensure that a uniformed approach is taken to re-engaging service users. The policy ensures that, if followed, all avenues are exhausted before a service user is finally discharged from treatment.

3.2.3 NORTH EAST LONDON INTEGRATED CARE BOARD ON BEHALF OF STAR'S GP

3.2.3.1 Star did not have many encounters with her GP practice between July 2015 and February 2018. In July 2015 when she called to book an appointment, she was advised that she has missed six appointments in the past and that if she missed the one being made, she would be issued a warning letter and removed from the list.

> There appears to be no enquiry to understand the reasons that Star did not attend or consideration of potential safeguarding reasons as being a cause. Removal of a patient from the GP list for not attending appointments is not part of the GP contract.

[61] An opiate antagonist medication that supports in preventing opiate overdose

The review considers that it is very likely that this may have created a barrier to Star accessing services in the future.

Recommendation
It is recommended that the ICB ensures that all GP practices are clear about the contractual requirements regarding deregistering patients.

3.2.3.2 On 28th September Star saw her GP with a range of symptoms - anxiety, depression, insomnia, not eating well or putting on weight, a cough and headache. She was examined and prescribed with amitriptyline and nutritional supplements.

There is no documented enquiry into factors in her life that may be causing her mental health and physical symptoms.

3.2.3.3 In January 2017 Star's GP received a request for blood results, problem list[62] and current medication from Change Grow Live.

3.2.3.4 At the end of March 2017 Change Grow Live advised Star's GP that she had disengaged from the service.

There is no evidence that the GP followed this up with Star and sought to offer her support.

3.2.3.5 Star visited her GP in October. The consultation notes record a history of sleep problems and drug addiction. The GP noted that Star was thin and emaciated and said she had no current symptoms. It is not clear why Star went to the GP

There is no evidence that the GP explored Star's mental health, her support network or why she had disengaged from Change Grow Live and if she would like to re-engage with the service.

The review notes that the interactions with Star were entirely medically focused. There were several opportunities when the GP could have explored what was going on in Star's life and whether this may be contributing to her drug use.

Whilst the GP records record her drug use, there is no understanding of her chaotic lifestyle and how this might be contributing to or precipitating her drug use.

Recommendation
It is recommended that the ICB ensures that all practices are up to date with mandatory safeguarding training.

[62] This is a list of medications and history that are pertinent for CGL

Recommendation

It is recommended that the ICB uses this case to provide a briefing to GPs, reminding them of the need to spend time understanding the patient in front of them and employing professional curiosity particularly in relation to patients who are subject to multiple disadvantage.

The review is aware that the ICB has submitted a bid for funding to implement IRIS in the borough. This is welcomed by the review as the benefit that IRIS[63] brings to outcomes for victims is well documented[64]. However, the review is aware that, even if this bid is successful, this will only provide funding for one year.

Recommendation

It is recommended that, if the bid is successful, the ICB identifies long term funding for the programme. If the bid is unsuccessful, it is recommended that funding is secured to introduce IRIS to the borough.

3.2.4 MARAC – ADMINISTERED BY HESTIA FROM OCTOBER 2017

3.2.4.1 A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. After sharing all the relevant information that they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.[65]

3.2.4.2 Meeting One – 1st February 2018

3.2.4.3 Star was referred by Change Grow Live and nia[66]to MARAC based on professional judgement and the assessment that she was high risk. The referral stated that there were three alleged perpetrators of abuse although Star's relationship to them was not clear.

3.2.4.4 Star's case was heard at MARAC on 1st February. Change Grow Live reported that they were concerned that Star had been living with someone who was giving her money for 'sexual favours'. They said that they believed there were other perpetrators, but they did not have the details. The IDVA reported that Star had been rehoused 'yesterday'[67]. It was reported that Star had said that she was paying for her accommodation in the past by sex work and had been abused, beaten, raped, held against her will and given alcohol by force. The IDVA also reported that she had been expecting a telephone call from Star, but this did not happen, and the offer of accommodation was withdrawn. Star's whereabouts was not

[63] https://irisi.org/

[64] https://irisi.org/wp-content/uploads/2022/03/IRIS-National-Report-2020-2021.pdf

[65] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

[66] nia provide the Independent Domestic Violence Advocates (IDVA) service

[67] This is assumed to be 31st January 2018

known. The risk was agreed as life threatening. The action agreed was for the IDVA to contact Star and identify the other perpetrators.

> The minutes suggest that the discussion was neither thorough or specific, but the review cannot be certain if that is the case or if the minutes just did not reflect the discussion.
>
> There was only one action agreed and there were no actions directly related to how agencies could attempt to minimise the risk to Star.

> The IMR author has identified that there is not a final approved version of the MARAC Operational Protocol that would have been valid in 2018.

Whilst the MARAC process was undertaken in line with the MARAC Operational Protocol, the review questions the added value that the meeting brought to safeguarding Star.

3.2.4.5 On 8th February the IDVA advised MARAC that the action had been completed. The IDVA had received a text message from Star.

> Only part of the action was completed. There was no indication that the other perpetrators had been identified.

Recommendation
It is recommended that the MARAC Steering Group ensures that the protocol is updated to ensure that multiple part actions are recorded and monitored for completion separately.

Recommendation
It is recommended that the MARAC Steering Group monitors the introduction of this change in order that the CSP can be assured that it is being implemented consistently.

3.2.4.6 **Meeting Two – 21st June 2018**

3.2.4.7 On 30th May Star was referred into Newham MARAC by Change Grow Live based on professional judgement.

> It is noted that referral form is dated as signed on 7th February 2017 and there are references to 2017 throughout. However, the DASH -RIC is dated 30th May 2018, but with safeguarding referral date of 7th February 2017. There are multiple alleged perpetrators noted, although only two named. It is not clear how this error occurred.
>
> The referral is very unclear – it is not known what information is historic, what the actual risk was, and when the referring agency had spoken to Star.
>
> There is nothing in the MARAC minutes to suggest that this discrepancy was either noticed or discussed at the meeting.

Recommendation

It is recommended that further training is provided to referring agencies which highlights the importance of clear, concise information around the current risks being provided and separated from historic, background information

3.2.4.8 On 21st June 2018 Star's case was heard at Newham MARAC. Change Grow Live shared that Star had said that she has no fixed abode, was sleeping rough or staying with men in crack houses. Star had reported that she had been sexually assaulted on multiple occasions and had been locked in a bin chute by a perpetrator. Star had reported that she was due to go to court following a rape which would have been in March 2017[68]. Star said she was not being romantically involved with any of the alleged perpetrators. It was noted that Star had stayed in a refuge in Camden, but "did not engage" and subsequently left. Change Grow Live reported that Star usually had telephone contact with friends and family, but this had stopped, and that Star's sister has said that she believes that one of the alleged perpetrators had killed her.

As noted at the previous meeting, the minutes are not detailed enough to indicate whether the suggestion by Star's sister that she had been murdered, were discussed. If it was discussed, there is no indication that the discussion was risk focused, given the severity of the concerns raised. It does not appear from the minutes, that this was discussed by agencies.

3.2.4.9 The IDVA (nia) shared that Star had engaged in December 2017 and was placed in Camden refuge but believed that she had been evicted. The IDVA had called a number linked to Star and reached a male (not known perpetrator) who had advised he had not heard from Star recently. The police advised that Star had been reported missing.

3.2.4.10 The risk factors identified by MARAC was that Star was missing and there was a need to find out if she was safe.

3.2.4.11 It was agreed that the IDVA would contact the refuge in Camden to find out why Star had left. This was to be completed by 28th June.

3.2.4.12 It was agreed that the police would, by 28th June, provide an update from the missing persons unit.

Whilst the actions were SMART, they are very limited given the necessity to contact Star.

3.2.4.13 Both actions were completed, but not within the timescales set.

At the time, the number of actions that were outstanding, across all MARAC cases, was very high and this was discussed at the MARAC Steering Group in November 2018.

[68] No police record can be found therefore it has not been able to verify what Jan was referring to

3.2.4.14 The IDVA confirmed that Star left the refuge on 9th March and that the refuge had not been able to contact Star since then. They were not aware of her plans after departure.

3.2.4.15 It was also noted that the IDVA had been in touch with the police on 19th July, 29th July, 20th August and 21st August to provide all information held to by the IDVA service.

3.2.4.16 It is not known when the update from the missing persons unit was provided but the update was that Star had been found deceased and the investigation was ongoing.

3.2.5 IDVA SERVICE PROVIDED BY nia

3.2.5.1 Star had contact with the IDVA service that is outside of the scope of this review. Due to its importance to understanding Star's vulnerability it is included.

3.2.5.2 On 1st June 2015 the IDVA service transferred from Aanchal to nia. Staff were transferred by TUPE to nia and, at this point, had not been inducted into nia. The staff were, at this time, in training.

3.2.5.3 On 31st May 2015 Star was referred to the IDVA (service provided by Aanchal on this day) by the police. Star had been a victim of stalking and was homeless. The perpetrator, Male 2 was an ex-partner who she no longer wished to be in a relationship with. There was domestic abuse in the relationship. Star said that she had been homeless for two weeks and was hiding from the perpetrator (on the streets and in sheds). She said that he knew her friends and family and kept going to the family home address to try and find her. A risk assessment was undertaken. The score of 18 indicated a risk level of high. The perpetrator had made threats to kill which Star said had been overheard by the police officer at the station. Star said that there was no sexual relationship, but that he would hold a knife and screwdriver to her and question why she does not want to sleep with him. She said he strangled her daily. She was very scared and wanted a refuge space.

3.2.5.4 The Aanchal IDVA referred the case to Newham Housing. In a phone call the housing officer asked more questions and then advised that, based on the information provided, he did not think that Star qualified for housing. He did agree to provide accommodation for one night only as his opinion was that Star is not experiencing domestic violence.

3.2.5.5 Star was accommodated in a hostel in Ilford and encouraged to attend the One Stop Shop in the morning and the One Stop Shop advocates would seek refuge space. A phone number was requested from Star who said that she would call back later to provide it as she was calling from the police station.

3.2.5.6 On 1st June 2015 the case transferred to the nia IDVA. The Aanchal IDVA called Star at the hotel to advise that a nia IDVA would be in touch. In the handover from the IDVA at Aanchal to the IDVA at nia, the Aanchal IDVA said that as Star is not in a relationship with the perpetrator, this was not domestic abuse.

The IMR author notes that the referral should have been assessed by Housing and IDVA service based on 'stalking' and accepted as a form of VAWG. Even if Star was not in a relationship with the perpetrator, there was sufficient evidence to support the view that he believed that she was in a relationship with him, and he had already displayed threats, installed fear and behaviours of ownership which placed her at high risk.

3.2.5.7 The case was accepted by nia's IDVA service and a refuge search revealed that there were no spaces. The nia IDVA liaised with housing link for the service who advised Star to present at Housing/Out of Hours Housing. As it was too late for Star to present at housing a request was made to access contingency funds (discussion between nia IDVA & Aanchal Advocate) and it is not clear from the notes who held that fund, or the process for applying to it/refusal. Star was advised to present at Forest Gate Police Station and contact out of hours housing. She was assured that the refuge search would continue the next day.

3.2.5.8 During the nia IDVA's conversation with Star she confirmed that she had been friends with the perpetrator, Male 2 for a year. She said that their friendship broke down when the Male 2 wanted their friendship to develop into an intimate one. Star said that Male 2 had become aggressive towards her. On two occasions he had threatened her with a pair of scissors to her stomach, a screwdriver to her neck and her continued to stalk her. As a result, Star felt threatened by his behaviour. She said that he told her to *'keep looking over her shoulder, even if he ends up in prison, he'll send his friends after her'*. Star said that she had lost a lot of weight due to all the stress the prolonged situation has caused her and that her GP had recommended a special diet to help her gain some weight. The nia IDVA asked Star several times if she had ever been in a relationship with Male 2 and she stated that they were only friends. From this point the IDVA referred to is employed by nia who are now providing the service.

3.2.5.9 The refuge search was unsuccessful as Star needed to remain in London to maintain contact with her children. The IDVA advised Star to attend the local service centre or go to Forest Gate Police Station for supportive temporary accommodation. The IDVA said she would contact Star the next day (2nd June). A MARAC referral was completed.

3.2.5.10 The IDVA called Star on 2nd, 3rd and 4th June but there was no answer. The IDVA spoke to an officer in the Community Safety Unit at Forest Gate Police Station. She was advised that the case was still open, and that Male 2 had been spoken to and warned not to contact Star. The IDVA was advised that Male 2 had been released on police bail and was due to return to the police station on 28th July.

3.2.5.11 The IDVA called Star again on 5th June (x2), 12th June and 15th June (multiple times) without success. On 15th June the case was closed as the IDVA was unable to engage with Star.

3.2.5.12 **January 2018**

3.2.5.13 CGL referred Star to the IDVA service. The perpetrator named on this referral is not the perpetrator in this case.

3.2.5.14 On 30th January the IDVA attempted to contact Star but was unsuccessful. On 31st January, the IDVA spoke to Star and a RIC was completed with a score of 20. Star outlined her situation to the IDVA. She said she was currently living in a house and had been locked in for a couple of hours. She said she felt safe as the person told her they were locking the door and they would be back soon. She had stayed there the previous night but did not have anywhere to go that night.

3.2.5.15 Star said she had been homeless for about a year. Her oldest two children were with her mum and the youngest was in care. She said she was able to visit the oldest but only during

the day and she could not stay overnight at her mother's house. She said that she had not seen the baby since she was removed. Star said that when she no longer had the children with her, her benefits had changed, and she had lost her housing.

3.2.5.16 Star said that she had not received benefits for a year. She said that she was addicted to heroin but that she did not drink alcohol.

3.2.5.17 Star explained that she had been paying for accommodation with sex, which has resulted in her being severely and repeatedly abused. She listed being punched in the face, beaten, strangled, had cigarettes burned on her, being locked in house for two days and fed only alcohol, being made to stay naked and raped without protection. Star said she was not on contraception and hadn't been checked for STDs. She said, *'I have come to expect it now, I'm just numb to it.'*

3.2.5.18 She said she was depressed but she had not tried to take her own life as she was living for her children. She explained that she used to be a dance teacher and has had a string of abusive relationships before becoming homeless. She said that she had anorexia and the GP has given her high nutrition shakes to help boost her body weight. She had been provided with foodbank vouchers by Change Grow Live.

3.2.5.19 Star said she wanted to get out, to get clean and be safe. The IDVA explained about refuges and Star is very keen to go into one. The IDVA said she would investigate them and call back in a few hours. When the IDVA asked Star about housing, she said that the council had declared that she was intentionally homeless and so they would not provide her with emergency accommodation[69]. Star also said she had reported to the police a few times, but it only made things worse, so she had stopped reporting the abuse.

3.2.5.20 The IDVA conducted a refuge search and found one space available.

3.2.5.21 The IDVA attempted to call Star four times without success, so sent a text and left a message with Star's mum and her number for Star to call back when she could.

3.2.5.22 The IDVA made a referral to London Exiting Advocacy (LEA) which is a nia service that supports women to exit sexual exploitation through prostitution. A MARAC research form was completed in preparation for the MARAC meeting. This included a overview of the current situation from the point of the initial referral.

3.2.5.23 The IDVA attended the MARAC meeting on 2nd February and was tasked with contacting Star's grandmother to see if she had heard from her and making a referral to Pause[70].

3.2.5.24 On 5th February Solace emailed to the IDVA to say that they had tried to contact Star, but she was not picking up the calls. The reason for them trying to contact her was to advise that the place in the refuge was no longer available.

3.2.5.25 The IDVA picked up a text from Star on 5th February that had been sent on 3rd (the weekend) in which she says, '*Hiya [name} I'm sorry I haven't ot back to you as I lost my phone straight after I had spoken to you. I found my phone this morning I tell you all about i please please please can ou call me I hope and pray that you haven't given up on me if you can't get throw*

[69] This decision was made on 20th January 2011 when Jan was evicted
[70] https://www.pause.org.uk/

to me on my phone then can ou call me on this number it's me [name] hope you still remember me. waiting for your call please god'. The IDVA tried to ring Star but as there was no reply, she sent a text that said, '*Hi - I'm sorry but only received your texts today as don' work on weekends. I have tried to call both of your numbers but there's no reply - is there a good time for me to cal you tomorrow? I really hope you're ok and please don't worry - we are here to offer you support. [name].'*

3.2.5.26 On 7th February the IDVA contacted Change Grow Live to advise that initially engaging well she was now unable to contact Star. She told her about the text she had received over the weekend. The worker from Change Grow Live replied to say that she was having the same difficulty in seeing Star. She said she was in touch with Star's mother who said that she was OK and that she had seemed very excited at the prospect of a hostel when they had spoken the week before. She said she would try again the next day to contact Star and let the IDVA know the outcome.

3.2.5.27 On 8th February the IDVA advised MARAC that the action had been completed. Change Grow Live advised the IDVA that Solace had been in touch as they wished to offer Star a place in refuge. The IDVA spoke to Star who confirmed that she had received a voicemail from Solace a couple of days ago and so she had left them a message that morning. She told the IDVA that Solace had called her back and, after doing a referral over the phone, they needed to speak to a key worker. Solace confirmed to the IDVA that the space had not been offered and they needed to speak to Change Grow Live before accepting her. The IDVA notes that on 9th February that Solace had advised Change Grow Live that they were considering offering Star a place, but it was dependent upon her attending a GP appointment with them that day and being scripted.

3.2.5.28 On 12th February the IDVA is advised by Solace that Star is in refuge.

3.2.5.29 On 30th May Change Grow Live contacted the IDVA and asked her to make contact as they had received reports from her family that Star was missing, and they were unsure that this was the case, or they just did not know her current whereabouts in refuge. The IDVA called Star and 'a lady called Jo' picked up and said that she was Star's friend, and that Star was missing. She said that Star had been asked to leave the refuge as she did not stick to the house rules, but she had nowhere else to go. When the IDVA spoke to Change Grow Live about the conversation with Jo, she came to believe that she had in fact spoken to a man who was named on the original referral. He was a man who allowed vulnerable women to stay with him. The IDVA updated the police on the phone call.

3.2.5.30 The IDVA tried to call Star on 21st June, but it cut to an engaged tone. The IDVA tried to call Change Grow Live but there was no reply.

3.2.5.31 On 25th June the IDVA was in touch with the Solace refuge and was advised that Star moved out of the Solace refuge with no reference to her plans. Staff at the refuge had tried to contact Star and her mother since she had left but had been unsuccessful.

3.2.5.32 On 19th July the IDVA emailed Change Grow Live to enquire if anything more was known about Star, as is concerned for her safety. Change Grow Live had no updates either about her whereabouts and safety and stated that they believe that she was still considered a missing person and the Police were still looking for her and would keep the IDVA updated.

3.2.5.33 On 19th July the IDVA emailed Change Grow Live to enquire if anything more was known about Star, as is concerned for her safety. Change Grow Live had no updates either about her whereabouts and safety and stated that they believe that she was still considered a missing person and the Police were still looking for her and would keep the IDVA updated. The IDVA sent an email to the MARAC Chair (MPS) with their concerns about the information that they had received from different sources and asked for an update on the investigation. The MARAC Chair responded by asking the IDVA for clarification about the information she had shared. The IDVA assisted by asking the source of information to speak to the police, and she agreed.

3.2.5.34 The IDVA contacted the police for a further update on 20th August. The officer advised that he was no longer in the Missing Persons Unit and provided the details of the OIC. The IDVA was advised that the loft at the home of Male 1 had been searched but nothing was found. The officer took the IDVA's number and agreed to update with any developments.

3.2.5.35 On 20th February the IDVA closed the case as all notifications had been made to the police and they had promised to advise of any updates.

The review is advised that, because of cases of Star and other women, nia has developed a new of role of Substance Use Advocate as part of a new exiting-prostitution service, The Anita Project. The purpose of this service is to provide specialist support to women using drug and alcohol services, and to those who are abused through 'survival sex'. Part of the role is to forge links with drug and alcohol services to ensure maximum engagement and take up of services from women who are being sexually exploited. The review is advised that there is no long-term or assured funding for this post to continue.

3.3 Agency involvement with the perpetrator

3.3.1 NORTH EAST LONDON INTEGRATED CARE BOARD ON BEHALF OF GP

3.3.1.1 The perpetrator has a significant medical history. He has complex Crohn's Disease for which he required surgery (including bowel resection and stoma) in 2011, 2015, and 2018. He has required multiple primary and secondary care involvement with variable engagement and compliance with treatment.

3.3.1.2 He has pain due to Crohn's Disease and back pain following a trauma in 2007 when he fell from scaffolding. In 2013 it was noted that it was suggested that he was addicted to benzo diazepam due to his back pain.

3.3.1.3 The perpetrator has a mental health diagnosis of:

- Dissocial personality disorder
- Substance misuse – cannaboids, drug seeking behaviour of controlled drugs prescribed by GP has been noted on his records. His complex Crohn's Disease would be a condition that illicited significant pain.
- Paranoid schizophrenia has been alluded to, however from his primary care records it is not clear if this has an established diagnosis or suggested.

3.3.1.4 The perpetrator has a history of violence and aggression which was experienced by staff resulting to him being removed from one surgery in February 2018. He then re-registered with another practice one month later.

3.3.2 **LONDON BOROUGH OF NEWHAM – ADULT SOCIAL CARE – HOSPITAL SOCIAL WORK TEAM**

3.3.2.1 Adult Social Care received three notifications regarding the perpetrator' admissions to hospital between 2013 and 2015. He self-discharged on two occasions and no services were required or provided by Adult Social Care.

3.3.2.2 The perpetrator referred himself to Access to Adult Social Care on two occasions.

3.3.2.3 **10th May 2018**

3.3.2.4 The perpetrator said that he was experiencing back pain and difficulties getting in/out the bath, shopping/cooking and keeping his home clean. He was screened and given information, advice, and guidance. He was also signposted to Community Links.

3.3.2.5 **11th May 2018**

3.3.2.6 The perpetrator made contact raising similar issues as the previous day. He requested a face-to-face assessment.

3.3.2.7 He was advised, by letter, of an assessment on 6th August at 2pm. When the social worker arrived for the assessment, the perpetrator was not in. The social worker went away and came back later.

Despite having been advised by the police of the risks that the perpetrator posed, this was a lone visit by a female social worker and there were no precautions taken in light of the intelligence that was held about him.

In December 2019 the Lone Working Policy and Procedure for Adult Social Care Operations was updated and relaunched. This included the provision of 'Skyguard' GPS devices for all frontline workers.

A key learning point for staff was the importance of checking the full case file on a client before visiting and, where necessary, following the Council's Cautionary Contacts procedure. This learning has been disseminated to all staff in the directorate.

3.3.3 **METROPOLITAN POLICE SERVICE (MPS)**

3.3.3.1 Given the number of interactions that MPS had with the perpetrator, this section considers those incidents that require additional comments to the information in the chronology.

3.3.3.2 **16th April 2005**

3.3.3.3 Police were called to report an assault of a 14-year-old girl who had recently had a fight and fallen out with Female 2. She informed officers that she had been walking in the street when she saw the perpetrator and Female 2. the perpetrator had shouted out to her and told Female 2 to hit her. He then swung out and hit her in the face causing her to sustain a bruised eye. He then threatened her stating that if she touched his girlfriend again, he would 'shove a knife up your arse' and spat at her. The victim and her parents asked that the perpetrator was spoken to and warned about his behaviour. A harassment letter was sent to the perpetrator, and the investigation was closed.

3.3.3.4 The review notes that there is no requirement under the Protection from Harassment Act 1997 that a warning be given prior to any arrest being made. Some forces have adopted the warning scheme as policy but there is no legal requirement to do so. The MPS did use the First Instance Harassment Warning (FIHW) Scheme within their policy at the time of this incident, however since 31st January 2020 FIHW have been removed from the MPS Policy Toolkits with consideration to arrest, non-molestation orders[71], Domestic Violence Protection Notices (DVPNs)[72], Domestic Violence Protection Orders DVPOs)[73], Anti-Social Behaviour Injunctions[74] and civil injunctions such as Restraining orders[75] to be used.

The review notes that the report was recorded and classified as ABH. The report was allocated to the MPS Beat Crimes Unit[76] to progress. Within the report it was highlighted that there were current investigations open to police in relation to the perpetrator. There is no evidence of intelligence checks contained within and no detail to indicate whether a statement or VRI was obtained from the victim.

There were delays in investigation updates within the report. This was identified by a supervisor who was conducting a review of all crimes due to an 'overwhelming increase in caseloads'. The Investigating Officer of the report was on long term sick leave and as a result the investigation was re-allocated. It was then recorded that due to an MPS Operation, the DCI had asked for a review of all current investigations by the unit, providing direction to close all but the most serious cases, as the staff from the unit were being alternatively deployed due to operational necessity. It was deemed that this matter did not reach the criteria for continued investigation and the case was closed.

3.3.3.5 **29th May 2005**

3.3.3.6 On 29th May 2005 the perpetrator reported to police that he was grabbed by a male, placed in a headlock, and forced inside a property. He managed to escape through a window and had sustained cuts to his hand and pain to his body. Officers took the perpetrator to hospital. When spoken to, he admitted experiencing mental health and said that he had not been receiving treatment for his 'schizophrenia since January'. At hospital he was referred to their

[71] Non – Molestation Orders – Section 42 of the Family Law Act 1996 creates provisions concerning 'non-molestation orders' granted by the courts. It is sought by a victim of domestic abuse against their abuser. Breaching a non-molestation order is a criminal offence.
[72] Domestic Violence Protection Notices (DVPNs) – A notice that may be issued by an authorised Police Superintendent which sets out prohibitions that bar a suspected perpetrator from returning to a victim's home and /or contacting the victim (Governed by sections 24 to 33 of the Crime and Security Act 2010 (CSA).
[73] Domestic Violence Protection Orders (DVPOs) – A order applied and authorised at Magistrates Court following the issue of a DVPN (Governed by sections 24 to 33 of the Crime and Security Act 2010 (CSA)).
[74] Anti-Social Behaviour Injunctions – A Civil Injunction order that can prohibit the respondent from doing anything described in the injunction and require the respondent to do anything described in the injunction. It can carry a power of arrest.
[75] Restraining Orders - Section 5 allows for the Magistrates and Crown Courts following conviction, and at the time of sentencing, to issue a restraining order. This is an order used by the court to protect a person, business, establishment or entity.
[76] Beat Crimes Unit – MPS local unit that investigates crimes with less complexity. This unit is no longer in existence.

mental health team. After being discharged, the perpetrator was taken to Tottenham Police Station. Intelligence checks were conducted showing that he had been arrested two days previously for a GBH by BTP.

3.3.3.7 The perpetrator admitted to officers he had not been telling the truth because he was scared. He then provided two further differing accounts. Enquires were made with BTP and it was established that the male had admitted to assaulting the perpetrator in response to racial abuse. CCTV also showed the perpetrator under the influence of alcohol and sustaining injuries after falling to the ground following being punched.

3.3.3.8 It was ascertained that he had attended a party with the male. At the party he was found to have stolen items. A fight ensued between him and the male this account was supported by other witnesses. The Investigating Officer made numerous attempts to contact the perpetrator to progress the investigation including sending out a letter asking the perpetrator to contact him in the next 14 days. Due to non-engagement from the perpetrator, the report was closed.

3.3.3.9 On 29th May 2005 the perpetrator reported to police that he was grabbed by a male, placed in a headlock, and forced inside a property. He managed to escape through a window and had sustained cuts to his hand and pain to his body. Officers took the perpetrator to hospital. When spoken to, he admitted experiencing mental health and said that he had not been receiving treatment for his 'schizophrenia since January'. At hospital he was referred to their mental health team. After being discharged, the perpetrator was taken to Tottenham Police Station. Intelligence checks were conducted showing that he had been arrested two days previously for a GBH by BTP.

3.3.3.10 The perpetrator admitted to officers he had not been telling the truth because he was scared. He then provided two further differing accounts. Enquires were made with BTP and it was established that the male had admitted to assaulting the perpetrator in response to racial abuse. CCTV also showed the perpetrator under the influence of alcohol and sustaining injuries after falling to the ground following being punched.

The IMR author identified that, at the time of this incident, the perpetrator was a suspect in several reports for MPS, although at this time the perpetrator had not been circulated as wanted for the offences in relation to Female 2. Full intelligence checks would have shown the current investigations where he was a suspect and the numerous arrest enquiries conducted to locate him.

The IMR author has identified, throughout the 15-year period that the IMR covers, delay in PNC circulation for an outstanding suspect where there are known risk such as DA, Violence to Females and known RSO appears to be a common theme.

In November 2020 the Predatory Offender Unit (POU) were implemented within the BCU Public Protection (PP)[77] strand. The POU was formed to tackle the highest harm offenders who pose a safeguarding risk to either adults or children. Some BCUs have also created Risk Reduction Team (RRT) or Risk Management Team (RMT) for the management of DVDS, DVPOs and DVPNs. The team also controls the Sexual Harm Prevention Orders (SHPO), MARAC and outstanding offenders and the Emerald Wanted Management System

[77] Public Protection – MPS Department previous known as 'Safeguarding' that investigates DA, Crimes involving sexual abuse, sexual and online exploitation of children and adults and missing persons.

(EWMS)[78]. Considering the common theme within this report of circulation delays of wanted offenders with high risk attached and the implementation of units to address risk management and outstanding suspects, review of circulation timeframes and management would ensure circulation guidance is being followed and highlight any areas for learning and development that can be introduced into the new PP units and Jigsaw Team.

Recommendation
North East Basic Command Unit (NE BCU) Level
It is recommended that NE BCU Senior Leadership Team (SLT) dip-sample the outstanding suspects within the Public Protection and those on ViSOR to ensure circulation guidance is being followed for wanted offenders.

3.3.3.11 **June 2005**

3.3.3.12 On 13th June Female 2 was reported missing from her mother's address. On 30th June Female 2's father reported to police that he had found her, and she was at King George's Hospital. Female 2 told officers that on 13th June she had received a telephone call from the perpetrator asking to see the scan pictures of their baby. She agreed to meet him which led to her being held against her will and assaulted by him. She stated that he said if she left, he would 'Do her and fuck the baby up' and he would commit suicide. She disclosed that she had engaged in sex with the perpetrator and although she did not want to, she did not say no as he had hit her once previously when she had refused his advances.

3.3.3.13 On 3rd October the perpetrator was arrested at KGH. He denied the offences in interview stating he believed Female 2 to be over 16 years old. the perpetrator was charged with False Imprisonment x 4, ABH and Sexual Activity with a Child.

3.3.3.14 On 15th May 2007 the perpetrator was convicted of Sexual Activity with a Child, and Common Assault at SCC. He was sentenced to 30 months' imprisonment on both charges concurrent and ordered to be placed on the Sex Offenders Register for life.

3.3.3.15 The review notes that an investigation strategy was outlined, and early advice was sought from CPS about proceeding with an evidence-based prosecution where a victim is unable to support the case. A Missing Person (MISPER) MERLIN report was recorded when Female 2 was reported as missing. The report was risk assessed and graded as medium. From the outset, MPS liaised with Children's Social Care and a Strategy meeting was scheduled. At this meeting, CSC indicated that they would be considering an Interim Care Order.

A number of arrest enquiries were made at the perpetrator' address, locations he frequented and with the Department for Work and Pensions (DWP). He was not circulated until 22nd September. Difficulties with the administration process of the circulation were documented on 21st September. There was a period of five month's delay in circulating the perpetrator as wanted by Police. During this period the perpetrator had contact with Female 2, subjecting her to further harm. He also assaulted a female ex-

[78]Emerald Warrant Management System (EWMS) – System that records offenders that are currently circulated as wanted by police and the investigative and pro-active actions that are being taken to trace/locate them.

friend of Female 2 and formed a new relationship with a 14-year-old girl and assaulted her.

The review notes that the MPS Policy for circulating a Suspect as Wanted provides direction that officers must complete a number of checks prior to circulation. The checks are provided within a guide for officers to follow. Where an offender is deemed HIGH RISK, the circulation can be done prior to completion of all checks.

3.3.3.16 **8th December 2010**

3.3.3.17 On 7th December 2010 the police were notified that the perpetrator was due for release from prison that day. The next day, 8th December, the police received a report setting out the perpetrator' licence conditions. He was under licence with probation until 22nd April 2013 with conditions not to enter (designated geographic area) and to inform his probation officer of any intimate relationships with women. Two CRIMINT reports were created and one stated that the perpetrator 'is clearly a significant danger to young females and there are serious concerns he will commit again'.

3.3.3.18 Prior to his release from Prison an Offender Assessment System (OASys)[79] risk assessment was conducted by the National Probation Service (NPS) concluding that the perpetrator was considered high risk to known females and medium risk to the public. A risk assessment was completed by the Jigsaw Team using the Risk Matrix 2000[80] and he was graded as medium requiring him to be subject of six-monthly visits and notification requirements for address changes.

A Warning Signal Marker[81] was recorded on his PNC record for the GBH on Female 4 with free text 'GBHd Female Vict using Hammer'. However, this does not truly give the indication that the perpetrator was a repeat DA offender and a risk to females. If a marker highlighting either that he was a repeat DA offender or Violent towards persons having a protected characteristic, in this case, females, this would have flagged at every contact with the perpetrator and led to risk assessment and safeguarding considerations if the perpetrator was in company of a female.

The review agrees with the IMR author's observation that this was 2010 and since that time there have been many incidents of organisational learning leading to significant improvements within the MPS.

The review is also aware that the Domestic Abuse Act introduces important measures which help raise awareness of domestic abuse and will go some way to providing additional support to DA victims and helping to challenge perpetrators' behaviours. The Act will lead to the inclusion of Serial Domestic Abusers and Stalkers in MAPPA. Guidance will be provided by NPCC and College of Policing in regard to this.

Recommendation

[79] Offender Assessment System (OASys) – This is a tool used by the Probation Service to assess the likelihood of the risk of serious offending and risk of serious harm. It applies to all offenders, aged 18 years and over using static and dynamic indicators.
[80] Risk matrix 2000 – risk assessment tool.
[81] Warning Signal Markers – Markers of indication of behaviour, ailments that could highlight risk.

MPS Continuous Policing Improvement Command (CPIC)

It is recommended that upon guidance from NPCC and College of Policing in relation to Serial Domestic Abusers and Stalkers being tracked, monitored, and managed under MAPPA and ViSOR being received, consideration for a Warning Marker on PNC is given to reflect such status. Consideration should be given to learning from this review which highlights the potential for such to have improved the Police response to incidents.

3.3.3.19 **31st December 2010**

3.3.3.20 On 31st December 2010 the perpetrator was stopped with a female in relation to a theft of low value items from Iceland. Searches were conducted but nothing was found. When further checks were undertaken at the police station, it was found that the female had given false details and she was shown as wanted. Officers attended the last known address for her and there was no reply. An arrest inquiry was created. No further action was taken in relation to the perpetrator.

3.3.3.21 The review has asked why officers did not check if the perpetrator was in a relationship with the female he was with. The review has been advised that this information was from a Stop and Search after they had been stopped in relation to a theft from a shop. Nothing was found and officers recorded a CRIMINT information report. No one was arrested at the time. It was after returning to the police station and further checks were completed, that an arrest enquiry was created for the female as she was shown as wanted. There is no information recorded about the association between the perpetrator and the female, and if they were in a relationship. The review notes that, if the perpetrator were in a relationship with this female and had not informed his probation officer, he would have been in breach of his licence conditions.

3.3.3.22 **2nd March 2012**

3.3.3.23 The perpetrator was arrested for a residential burglary that had been reported on 26th February. A male and a female had knocked on the door asking if the occupants wished to buy a laptop. When the occupants said no and went to close the door, the female and male entered the property and took items. The female had provided her name as RA. Through intelligence checks officers noted that the female had been in company of the perpetrator during a previous stop and search. Both individuals matched the descriptions that had been provided and were subsequently arrested.

3.3.3.24 Due to the vulnerability of the victims, a VRI was obtained, and a support worker arranged to attend the Identification Procedures with them. The victims failed to identify the female and the perpetrator. The investigation was reviewed, and no further action was taken authorised by the DI.

The review notes that this report was incorrectly classified as a robbery. This should have been classified as burglary and the report should have been reclassified in line with National Crime Recording Standards. In the report it states that RA is the perpetrator' girlfriend, and it is not recorded if this information was shared with this probation officer and the Jigsaw Team.

3.3.3.25 **15th June 2013**

3.3.3.26 The perpetrator was reported missing by staff at the Newham Centre for Mental Health after he failed to return after 3 hours unescorted leave. At the time he was a patient on Opal

Ward under Section 2 of the Mental Health Act 1983. He returned of his own accord the next morning and said that he had been in the West End drinking with friends.

A MISPER report was recorded, and risk assessment completed. The assessment highlighted the perpetrator Crohn's disease, paranoid schizophrenia and RSO'. The 'Safe and Well' debrief interview was entered on the cancellation page of the report. A Pre-Assessment Check (PAC)/ACN report was not generated leading to the report not being shared with partner agencies.

3.3.3.27 **29th January 2014**

3.3.3.28 Police were called by staff at an assisted living accommodation regarding trouble they were having with Female 5 who was a former resident. Officers were told by staff that Female 5 and the perpetrator had attended the venue after the perpetrator had stated his friend had touched his penis whilst he had been sleeping. Female 5 had not believed the perpetrator so attended the venue to confront the friend who admitted to having touched the perpetrator' penis on one occasion. Staff told officers that this male had severe learning difficulties and it was not in his best interest to be arrested. Officers attended the perpetrator' home address and spoke with him, and he confirmed the sexual assault reporting it had taken place on 20th January. He had delayed reporting it as Female 5 shared a bank account with the friend. Due to the suspect having severe learning difficulties, it was deemed not in the public interest to proceed with any prosecution.

A HOT risk assessment was completed. The risk assessment did not identify the previous incident of the perpetrator's overdose and association with the friend.

The DS recorded he had emailed the reporting officer to direct that further enquiries should be made with the victim, the joint account held between Female 5 and the suspect and the staff at the living accommodation. Not all these enquiries appeared to have been progressed. A decision was made not to arrest due to the suspect's 'severe learning difficulties'. The report did not elaborate further regarding the 'severe learning difficulties' or what they consisted of. There is an entry considering use of an appropriate adult, but this does not appear to have been explored further. CRIMINT was recorded and the report was closed with no further investigation.

3.3.3.29 **16th March 2014**

3.3.3.30 Police were called by a member of the public stating that her neighbour had knocked on her door saying that she was scared of her boyfriend. She told them that her boyfriend believed that she was knocking on the door to ask for money for cigarettes. She asked for the police to be called.

3.3.3.31 Female 5 and the perpetrator were walking to his address when the officers arrived. Officers stated that they needed to speak to Female 5 about a complaint in their vehicle. The perpetrator was asked to wait inside his address. Female 5 explained to officers that she was scared of the perpetrator and that she could no longer stay with him. She told officers that he shouted at her every day, was confrontational in his body language calling her names, threatening to hurt her and family. She believed that he was getting more volatile as the

relationship progressed. Female 5 informed they had been together for seven months, and he would not let her go anywhere on her own. He smashed her mobile phone, so she did not have contact with friends and family, having to give his number as a contact.

3.3.3.32 Officers took Female 5 to her parent's address which was an address unknown to the perpetrator. Target Hardening advice[82] was given. The following day police were called by Female 5's sister as Female 5 had returned to the perpetrator' address**.**

3.3.3.33 The CRIS report was classified as Criminal Damage with a DV flag. The officer recording the allegation used the DV '20-point plan'. The 124D was completed in the DASH, Female 5 informed police she had seen the perpetrator with a 'handgun', he had threatened to hurt her child and family. She also recorded that the perpetrator 'throws cat at the wall and swings her by her tail'. The supervising officer highlighted the answer of Threats To Kill (TTK) towards Female 5's family in the DASH asking for this to be explored this and graded risk as MEDIUM. The TTK was assessed by an Inspector who reviewed the allegation and DASH. They referenced the controlling behaviour and recorded 'that it is escalating and that there is a continued risk of contact at the home address without police knowledge if the victim is persuaded to return'.

3.3.3.34 Although Female 5 was removed from the address, the perpetrator was not arrested at the time. He was not arrested until 21st March. There is no rationale for this recorded on the report. During this time Female 5 had returned to him. Although shown as a suspect, he was not circulated as wanted.

3.3.3.35 The Jigsaw officer managing the perpetrator recorded within the report that after disclosure regarding the perpetrator' conviction was made to Female 5, both the perpetrator and Female 5 had failed to engage in appointments. Female 5's mental health key worker was updated, and a MARAC referral was made. It is recorded that there was a delay in Social Care referring this case to adult services. A Referral was made to the RSPCA in light of the allegations of abuse to the cat.

Although Female 5 had been informed of the perpetrator' RSO history, it is not clear if Female 5 was aware of his DA history and there is no reference to considerations to utilise the Domestic Violence Disclosure Scheme (DVDS) which had recently been introduced.

Note: *The DVDS, known as 'Clare's Law' came into force in England and Wales on International Women's day on 08/03/2014 (**Appendix M**). The scheme allows:*

- *'Right to Ask'- A member of the public may make an application regarding a current or ex-partner. A disclosure can also be requested by a third party - a family member, friend, colleague or neighbour to protect someone they believe to be at risk.*
- *'Right to Know'- A disclosure can be made where police or a partner agency comes across information that indicates an individual is at risk of domestic abuse and where the proactive decision is made to consider disclosing information in order to protect a potential victim.*

3.3.3.36 **17th March 2014**

[82] Target Hardening advice – crime prevention and safety advice.

3.3.3.37 Police were called to the perpetrator' address by the sister of Female 5. The sister explained that she had fostered Female 5's child and had earlier attended a CSC appointment where she was told that the perpetrator was an RSO. She was told that whilst Female 5 was in a relationship with the perpetrator, Female 5 would not be able to have contact with her child.

3.3.3.38 The attending officers spoke to Female 5 who informed them in the DASH questions that she was one month pregnant with the perpetrator' child. She told officers that she was aware that the perpetrator was a RSO. Female 5 was asked if she wanted to leave with her family or the officers, but she refused remaining at the address with the perpetrator. She stated that she would consider her options if her relationship with the perpetrator would lead to her not seeing her child. The perpetrator was spoken to and informed that Female 5's family did not approve of their relationship.

3.3.3.39 The initial investigating officer recorded that they were not aware of the incident the day before as it had not been mentioned by either party and checks had not been conducted on MPS indices until after their attendance. They had conducted checks on PNC at the address, but the perpetrator had not been circulated as wanted for arrest.

A 124D and DASH were completed with the risk assessment graded as STANDARD which was endorsed by the supervisor. Taking into consideration the previous incident, Female 5's vulnerability with her mental health, pregnancy and that she was still in the company of the perpetrator who was shown as an outstanding suspect for DA Criminal Damage involving Female 5 justification for standard risk assessment is unclear.

In the report the Jigsaw officer recorded that after noting that Female 5 was seeking custody of her child, they made contact with Thurrock CSC (TCSC) and information was disclosed to them that Female 5's current partner the perpetrator was a RSO. It was explained that Female 5's family were not aware as it 'had not been necessary to disclose this stage'. After this incident, the Jigsaw officer contacted TCSC who stated that after they had been told about the perpetrator' RSO status, they believed that it was in the public domain. As a result, TCSC called Female 5's sister and although they stated that they did not 'openly state he was a registered sex offender' information of the RSO status was disclosed to the sister by them. **It was agreed that the disclosure should have been conducted in a more controlled manner.**

3.3.3.40 **26th April 2014**

3.3.3.41 Police were called by Female 5's sister reporting that Female 5 had been beaten by her boyfriend. Police received a further call from the perpetrator reporting that Female 5's sister had made a racist remark to him.

3.3.3.42 Officers attended the perpetrator' home address to find Female 5 and her sister outside. Officers were informed that Female 5 had been walking with the perpetrator when she saw her sister in the street and disclosed the assault to her. Female 5 stated that she was assaulted on 20th April after an argument with the perpetrator over him forcing her to become an 'escort'. the perpetrator had thrown a plate at her, repeatedly slapped, punched, and kicked her. He threw a mobile phone at her, hitting her nose. When Female 5 attempted to leave he pulled her by her hair. She had visible injuries. the perpetrator was not at the address. He was circulated as wanted and an arrest enquiry was created on CAD.

3.3.3.43 The call was graded 'S' Significant[83] grade for response and allocated to Emergency Response Police Team (ERPT)[84]. An ABH CRIS was recorded and DV flag added. A 124D and DASH assessment were completed with risk graded as MEDIUM. Officers have recorded managing the risk by bringing Female 5 to the Police Station to obtain a statement and contacting Emergency Housing which could not be obtained. Alternative accommodation and safeguarding were obtained a women's refuge through AANCHAL.

3.3.3.44 In the DASH assessment, Female 5 detailed the assaults escalating with him 'now hit me with weapons' and answers 'no' to pregnancy. The Jigsaw Team were notified. The pregnancy recorded in previous reports does not appear to have been explored.

3.3.3.45 When Female 5 took the overdose, she discharged herself from NGH before receiving treatment and returning to the perpetrator' address. A closing risk assessment was graded as standard and an ACN MERLIN report was recorded.

3.3.3.46 **5th September 2014**

3.3.3.47 Female 5 reported that she had been repeatedly raped by him between 27th March 2014 and April 2014. She said that she had met him when they were both hospital patients and that they had a relationship for 7 months. During the relationship, the perpetrator had assaulted her, prevented her from going out, raped her, and threatened to kill her. She was not able to provide a statement as she said she was not ready to talk about what had happened and need counselling first. the perpetrator was not arrested or spoken to in relation to this allegation as an account was not obtained from his girlfriend. The report was closed until such time as Female 5 felt able to provide a report. A referral to MARAC was made.

The review notes that the report was closed under the Home Office Counting Rules (HOCR) Outcome Codes[85] using outcome code 16 - *Evidential difficulties suspect identified but victim does not wish to pursue or support police action.*

The review also notes that, from December 2020, changes were made to the way Outcome Code 16 is being recorded in respect of reports of rape and serious sexual offences. The aim of the new amendment is to specifically help identify the reasons why victims are not willing to support police action. When closing a sexual offences crime report under outcome code 16 officers must now also record within the message tab of the CRIS detailing the reason for the withdrawal.

[83] MPS "S" Significant Response Grade. (NCMS Emergency Contact) – These are priority calls. The Police contact handler acknowledges that there is a degree of importance or urgency associated with the initial Police action, but an Emergency response is not required.
[84] Emergency Response Police Team (ERPT) - Emergency Response Police Team – Uniformed Police Unit.
[85] Outcome Codes - Introduced in April 2013 Outcome Framework was introduced replacing how the crime detections previously recorded. The full broader outcome framework was introduced in April 2014 and since October 2015 quarterly data on outcomes is now updated.

3.3.3.48 **22nd June 2015**

3.3.3.49 Police were called by Security Staff at the Excel Centre stating that they had a female who was reporting that she had been held captive. When officers attended, they spoke to a female who identified herself as Female 6. She stated that she had been in an on/off relationship with the perpetrator and approximately one month ago she went to his address. Whilst at the address, he had beaten her, had thrown food on the floor before making her eat it and poked her with a broom handle. Female 6 had a visible bruise to the left side of her head, arm, inner thigh and back. She told officers that the perpetrator' brother had witnessed her being assaulted on one occasion. Female 6 had escaped the perpetrator when they and his brother had come to the EC. LAS attended and took Female 6 to Newham General Hospital.

3.3.3.50 An arrest enquiry at the perpetrator' address was conducted but he was not present. He was circulated as wanted for the offences and arrested. Numerous contact efforts were made by officers to speak to Female 6 and obtain a statement from her, this included efforts being made with the assistance of the NGH mental health team. Female 6 did not attend the appointments or return contact. Due to insufficient evidence and Female 6 not engaging, no further action was taken by police.

3.3.3.51 **16th February 2017**

3.3.3.52 The perpetrator called the police regarding the female associate who he said had returned and was knocking on his door. Police attended but she had left. the perpetrator said he believed that she was under a Community Treatment Order. the perpetrator was given the number of the Community Safety Unit and was advised to call the police if she returned.

The call is recorded as 'R' (Referred)[86]. The Grip and Pace Command (GPC) Supervisor highlighted that the perpetrator was a repeat caller and to prioritise any intelligence checks and inform the relevant Neighbourhood Policing Team (NPT). Intelligence checks would have shown that this female was Female 6 an ex-partner who had previously reported an assault by the perpetrator.

3.3.3.53 **24th December 2017**

3.3.3.54 The perpetrator called the Jigsaw Team. He said that he had been staying at his child's home in Rochford, trying to re-build a relationship with her mother, Female 2. He was asked to leave early after an argument about her mother allowing his child to stay with her uncle who, like him, was a registered sex offender. The uncle's ViSOR record was updated with an entry for the Essex Jigsaw Team to follow up. A Merlin was shared with Newham Social Care. ***This is an example of good practice.***

[86] MPS "R" Referred Grade (NCMS Emergency Contact) - This grade will continue to be applied to calls received that do not require the attendance of a Police Officer. Resolution without deployment.

Although it was good practice to liaise regarding the uncle, there is no evidence that there was any safeguarding or risk consideration about the perpetrator seeking to rebuild his relationship with Female 2.

3.3.3.55 **28th June 2018**

3.3.3.56 The perpetrator reported to police that he had been stabbed by a female friend, Female 7 in his flat and had suffered a small stab wound to his neck. The Female 7 was arrested, and a kitchen knife was found nearby. In interview, the Female 7 claimed that she had stayed at his address for three days and everything had been OK until they argued. He then attacked her by hitting her with a walking stick and throttling her. She went to leave, and the perpetrator told her if she left, he would stab himself and he was 'going to get her in trouble'. He then stabbed himself in the neck with the knife. She ran out of the address in a t-shirt and underwear with the knife, which she threw into a bush to stop him harming himself further.

3.3.3.57 In interview Female 7 said that she and the perpetrator had known each other for years and they met by chance at Newham Mental Health Centre three days previously where she was an in-patient, and he was visiting. He moved into his address and as the days followed, he became controlling and assaulted her.

3.3.3.58 The perpetrator was attended to by London Ambulance Service for a minor stab wound. The female was charged with ABH, but the case was later withdrawn.

Female 7's history and vulnerability were highlighted by the Investigating Officer, but no ACN MERLIN report was recorded. Whilst on bail from the court, Female 7 was reported missing by her mother on 18th August, but she was located at her bail address on 25th August.

The IMR author considered recommendations in relation to MARAC and ACN MERLIN reports. However, it is known that in two recent NE BCU DHR reviews, MARAC and ACN MERLIN reports had been raised as potential areas for concern resulting in recommendations being made. This resulted in all NE BCU staff being reminded of their responsibilities under the framework for vulnerable adults to refer incidents to partner agencies via PAC reports. In addition to this the NE BCU conducted local health checks to ensure compliance of ACN completion. The health checks conducted by the Dedicated Inspection Team (DIT) are now incorporated in the quality, ethics, and risk assessment checks. These audits are conducted at 3–6-month intervals which creates opportunities for any errors to be rectified by the NE BCU and to ensure quality control of submissions.

A dip-sample of MARAC referrals was completed and in November 2020 NE BCU established a risk management team to ensure that cases like this would not be missed in the future. Additional training was provided to supervisors, and duty officers now receive a handover regarding all DA calls and the actions taken. A regular dip sample system is also now in place to ensure no referrals are missed which should be made.

Based on this recent work, the review agrees that it is not necessary to make further recommendation as a result of the observations from this review which pre-dates those changes.

3.3.3.59 **23rd August 2018**

3.3.3.60 The perpetrator called the police and reported that he had been assaulted when he was sitting in his car. He said he was assaulted by a male who he recognised that used to date his cousin's friend. The male had punched him through the open driver's window. Police attended and the perpetrator had a minor cut to his nose for which he declined medical attention. As there were no CCTV opportunities or other useful information, and police were unable to speak to the perpetrator again, no further action was taken.

3.3.3.61 The perpetrator then called the police again stating that he had a dispute with a member of staff at Morrison's. He alleged that, when he left, a male ran up to his car and called him 'Paki' and his girlfriend a 'white bitch'. His girlfriend was also spat at. An appointment was made to take further details on 28th August. Records indicate that this meeting did not take place and the racial abuse allegation was not investigated.

This allegation does not appear to have been investigated further. The CAD which was graded 'E' (Extended) was allocated an appointment for officers to speak to the perpetrator. However, there was no further update on the CAD in relation to this other than a CRIS reference number which related to an unconnected GBH assault. There was no detail of the identity of the 'girlfriend' recorded in the CAD.

No CRIS report was recorded which does not follow MPS Standard Operative Procedures (SOPs) and NCRS. The perpetrator was with a female who was also a victim of crime, and the identity of the female was unknown. This is concerning not only in relation to the incident but also as the perpetrator was a known RSO who posed a risk to females and had recently been a victim of GBH by a female who was on bail for the assault against him.

Recommendation

It is recommended that NE BCU conduct a dip sample of CADs relating to Public Protection crimes where scheduled appointment have been booked to ensure the correct action is being taken by officers in completing CRIS reports where appropriate. Any identified deficiencies should be incorporated into BCU training.

3.3.3.62 **3rd September 2018**

3.3.3.63 An elderly neighbour of the perpetrator alleged that he had stolen £60 in cash from a jar in his kitchen. Officers attended the perpetrator' address to arrest him but there was no reply. When visiting the address, a neighbour advised officers that he had heard in the neighbourhood that the perpetrator was 'sofa surfing in Hackney'. After several attempts to contact him, he was circulated as wanted.

3.3.3.64 Officers noted that the victim lived within the same block of flats as the perpetrator and provided crime prevention advice to the victim and their child who had attended to assist initial reporting.

3.3.3.65 A HOT risk assessment was completed highlighting the victims' vulnerability. The Investigating Officer liaised with the victim's child and Newham Council Housing Officer who advised them that they would be arranging to visit to discuss security and safety. ***This is an example of good practice.***

An ACN MERLIN report was not completed.

There was a significant delay of 21 days in circulation. Police also had contact with the perpetrator where he was arrested for a separate matter. As the perpetrator was not circulated, it was not flagged to officers he was outstanding for an offence.

3.3.3.66 **11th December 2018**

3.3.3.67 Having failed, as an RSO to register his home address within three days of release from prison, Jigsaw officers attended his address. There was no answer at the door and no way for them to get into the premises to leave a message. Officers called the perpetrator' mobile number which did not connect. The officers updated the ViSOR record that they would attempt the address again the following day and if he was not present, he would be circulated for failing to register.

Although continued efforts to locate the perpetrator were made by Jigsaw officers, he was not circulated for the failure of notification until 28th January 2018

3.2.2.68 **Changes in practice over time**

3.2.2.69 Over the time covered by this review, MPS has transitioned from MPS Boroughs to MPS BCUs. In 2018 the MPS merged its 32 policing boroughs to form 12 BCUs. This has brought reviews and changes to MPS departments and MPS SOPs. This includes the merger of CAIT, Sapphire, CSU, MISPER and Online Child Sexual Abuse & Exploitation (OSCAE) teams to form the BCU PP, and most recently the PP's implementation of the POU and RRT/RMT.

3.2.2.70 The POU was formed to tackle the highest harm offenders who pose a safeguarding risk to either adults or children. This because it has been 'recognised that there was no dedicated proactive capability on BCUs to tackle high harm safeguarding offenders. Whilst some BCUs had ad-hoc teams focused on single issue offenders (e.g. Dauntless/Domestic Abuse or Jigsaw RSOs), the new POUs provide a consistent staffing level across all BCUs and a consistent remit. There will also be improved intelligence support to drive activity. In short, by virtue of the individuals who will be targeted, the POUs will have a positive impact on protecting some of London's most vulnerable victims'. The RRT/RMT manages risk overseeing the DVDS, DVPOs and DVPNs in DA.

3.2.2.71 **Delays in circulation when wanted for arrest**

3.2.2.72 There has been a constant theme within this review that there were significant delays in circulation when wanted for arrest. In 2007 the perpetrator was wanted for assault and False Imprisonment, on his then 14-year-old girlfriend. Although enquires were being completed to locate/trace him, he was not circulated for 5 months. During this time, he was reported for sexual activity with a child in relation to the girlfriend, further assaults on her and assaults on two other females as well as beginning a relationship with another 14-year-old girl.

3.2.2.73 In 2015 the perpetrator was reported for criminal damage where his girlfriend stated that his behaviour towards her had become threatening and volatile. Although present he was not arrested, and he was not circulated. This led to officers attending the address the following day when concerns of the girlfriend returning to him were reported and he was not arrested as he had not been circulated on PNC.

3.2.2.74 In 2018 he was not circulated for a theft for 21 days. He also was not circulated until 18 days after he failed to notify his address under his RSO notification requirements. Although circulation guidance does instruct 'prior to circulating a Suspect as Wanted Officers must complete the checks listed in Phase 1 of the Phased Enforcement Guide'. The guidance does also advise that if 'an offender is deemed HIGH Risk they can be circulated prior to Phase 1 Checks being completed but the checks must be undertaken immediately after circulation and documented on both EWMS & CRIS'.

3.2.2.75 On the occasions that the perpetrator was outstanding as a suspect, the risk was high due to the offence committed, his offending history, mental health and his RSO status. Due to delays in circulation, he went on to cause further harm to females.

Recommendation

It is recommended that NEBCU SLT dip-sample that NE BCU SLT dip-sample the outstanding suspects within the Public Protection and those on ViSOR to ensure circulation guidance is being followed for wanted offenders.

3.2.2.76 **Use of Warning Signal Markers**

3.2.2.77 In 2008 when the perpetrator was released from Prison, risk assessments were completed by NPS grading him as a high risk to females and medium risk to the public. The Jigsaw Team risk assessed him as medium, and he remained risk assessed as medium throughout. He had ten Warning Signal Markers on his PNC record consisting of his RSO, MH/Suicidal, Self-Harm, Ailment for his Crohn's disease and Violent for his GBH conviction and spitting at a Police Officer.

3.2.2.78 Warning Markers are placed on the PNC to provide information and warning indicators to officers about the individual that they are in contact with. Although these markers provide an indication of the perpetrator' offending history they do not highlight or inform officers that he is a repeat DA offender and a risk to females. If a marker of this description was recorded on his PNC, it would have flagged at every intelligence check encouraging risk assessment and safeguarding considerations to any female the perpetrator was in company of. This is an important factor in this review as after the perpetrator' release from prison in 2008, he was reported for violence against three further women and killed two women. Having this marker may have also led to the perpetrator being considered as a 'key person' in Star's missing person investigation when he was identified as one of the last individuals to have been in contact with her.

3.3.4 **BARTS HEALTH NHS TRUST**

Before we look at the hospital's involvement with this perpetrator, we need to make the following clear. This report spells out the risk that this perpetrator posed and how he targeted vulnerable women. There is clear evidence that he brokered a number of relationships with women whilst they, and he, were in hospital. Hanna was one such victim. Hospitals must use this case to scrutinise whether vulnerable patients, such as Hanna, are not exposed to further danger from predatory sex

offenders within their hospital environment. We recognise that this is a difficult balance between the freedom of choice for a patient such as Hanna to visit other parts of the Hospital but it is clear that this perpetrator actively targeted women within hospital settings and as such it should be a wake-up call for all hospitals to ensure patients are protected.

We can find no evidence that those treating him in hospital were aware of the fact that he was on the sex offender's register and thus no plans were in place to recognise the danger he presented to other vulnerable female patients (see section 3.3.5.12 onwards for further information).

It is with this in mind that we make the following recommendation:

Recommendation
It is recommended that the Hospital Trust (and others across London) reviews its hospital security against this case to ensure that it is aware of dangerous patients, particularly registered sex offenders, who may be within their environment and does all it can to prevent the targeting of vulnerable patients within their care.

Recommendation
It is recommended that MPS and London Probation Service reviews the systems in place so that relevant information about MAPPA nominals who are known to pose a risk to others is shared with acute health services.

3.3.4.1 The perpetrator was well known to the gastroenterology team from 2014 until he was detained in prison. During the review period he had five inpatient admissions to hospital due to Crohn's disease. On each occasion there were referrals to RAID mental health team due to either his behaviour or disclosure of self-harm and suicidal ideation. His engagement with these services was not consistent.

3.3.4.2 From his second admission onwards, there are reports of increasing difficult behaviour and verbal aggression towards the ward staff, the ward staff are majority female, on one occasion it was recorded that the verbal aggression was towards a female nurse. There were reports of him being intimidating towards staff also.

3.3.4.3 In April 2016 the perpetrator also reported to the clinical team that his 'partner' was going to give him his injection at home and a few days after this call there was a voice-message left by his 'girlfriend' on the IBD answer phone. There is no record of this partner's name.

3.3.4.4 Whilst the perpetrator was portrayed as a challenging patient due to his aggressive behaviours it does not appear that he was viewed as a vulnerable patient with his own care and support needs. In completing the review of his records there is no evidence to suggest a referral to safeguarding has been completed. There is evidence of self-neglect in the way he managed his own health needs, and this is a potential missed opportunity.

The IMR author noted that, in completing the review of his records there is no evidence to suggest a referral to safeguarding has been completed. There is evidence of self-neglect in the way he managed his own health needs given this it is reasonable to expect that this would have been done.

The review is advised that there have been changes and improvements in the safeguarding pathways since 2015-2018 so where this has been identified as an improvement required at this time it is expected that if this situation/case was to happen now there would be a referral to safeguarding.

There is no evidence that the discharge letters sent to the perpetrator' GP set out the safeguarding risks that had been identified in hospital

Recommendation

It is recommended that GP letters should contain information regarding any safeguarding risks identified in hospital as well as the discharge arrangements.

3.3.4.5 In March 2017 the perpetrator disclosed to the dietician that he had no contact with his biological mother as she had sexually abused his and tortured him as a child.

This information was not shared with partner agencies to ensure that necessary support was being provided to the perpetrator.

3.3.4.6 There are a number of occasions when girlfriends or partners are mentioned but their names are not recorded.

There is a lack of professional curiosity seen in the lack of questioning and/or recording of the names of partners. To ask and record the names of partners would be good practice.

3.3.5 EAST LONDON NHS FOUNDATION TRUST – NEWHAM ADULT MENTAL HEALTH DIRECTORATE

3.3.5.1 The perpetrator had multiple episodes of inpatient care, community care and treatment from Newham's Community Recovery Team South (secondary care community mental health team for service users with severe and or complex mental health needs) and the Psychiatric Liaison Mental Health Teams based at Newham University Hospital and Royal London Hospital.

3.3.5.2 The perpetrator presented with complex mental health and physical health needs complicated further by illicit drug use. The perpetrator presented in crisis on multiple occasions and posed a high risk both to himself and others. These crises and risks were managed effectively by offering him inpatient care which he accepted voluntarily on occasions, but when he did not Mental Health Act assessments were undertaken, and compulsion used when necessary and proportionate. Inpatient care mitigated the immediate risks both to the perpetrator and the others. Post-discharge from hospital the perpetrator was followed up and treated by the CMHT. ***This was an appropriate way to manage the perpetrator.***

3.3.5.3 In addition to the perpetrator' complex presentation around his mental health, he also suffered from Crohn's disease, which led to frequent attendances at local acute hospitals

(Newham University Hospital and the Royal London Hospital) and admissions to the acute general Ward. The perpetrator received comprehensive specialist mental health care whilst he was an acute hospital patient by the Psychiatric Liaison Mental Health Teams who worked collaboratively with both with the acute Trust and community mental team colleagues. ***There was effective communication and documentation between services.***

3.3.5.4 **Effectively treating the perpetrator**

3.3.5.5 On 29 September 2013 a plan was made by the inpatient clinical team that a forensic psychiatric assessment would be requested and undertaken. This would entail a request being made to a specialist Forensic Consultant Psychiatrist to undertake an assessment of the perpetrator and a review of his care and treatment, to offer an expert opinion and make recommendations for his future care, treatment, and risk management.

A request was made for the assessment to be made (confirmed on 24 November 2013, however, the Forensic Consultant Psychiatrist was unable to assess as the perpetrator had been discharged from the Ward). The assessment did not occur and does not appear to have been followed up after the perpetrator was discharged.

3.3.5.6 On 10th March 2015, due to the perpetrator' poor concordance with prescribed oral antipsychotic medication and his continued reports of auditory hallucinations, a decision was made to trial an anti-psychotic intramuscular depot injection with the goal of improving concordance and the perpetrator' mental state. Such an approach is indicated for service users experiencing psychotic disorders and whose concordance is poor. the perpetrator defaulted on his depot injection and upon review on 30th March 2015 was re-prescribed oral anti-psychotic medication. At this review, a decision was made by his consultant psychiatrist to increase the level of support that the perpetrator received from the Community Recovery Team by allocating him a Community Psychiatric Nurse/care coordinator and him becoming subject to the Care Programme Approach, which is care planning process for service users with complex needs.

3.3.5.7 Between 2013-2019, the perpetrator' attendance and engagement with community mental health services was sporadic. In accordance with the Trust's Did Not Attend policy, he was discharged on 9th March 2017. Prior to the discharge the treating clinician contacted the GP to discuss and agree the discharge and advise around re-referral pathway. ***This is an example of good practice.***

3.3.5.8 When the perpetrator contacted the service to ask to receive a service, a flexible approach was taken, and he was taken back on without a referral from his GP. ***This is an example of good practice.***

3.3.5.9 In 2013, the perpetrator was detained under S3 of the Mental Health Act, 1983, which triggers a S117 after care duty for the CCG and the local authority to provide aftercare services.

It does not appear that, upon discharge a S117 meeting was held to formally discuss the perpetrator' aftercare needs and jointly agree what would be provided by ELFT or other relevant health providers (on the CCG's behalf) and the local authority. Subsequently, the

perpetrator had his healthcare needs reviewed at outpatient clinic and as a recipient of the Care Programme Approach.

3.3.5.10 In 2014 the S75 agreement between the London Borough of Newham (LBN) and ELFT ended and the integrated health and social care model for adult mental health services ceased. Since then, a non-integrated health and social care model has operated, with health and social care being delivered separately by ELFT and LBN respectively.

3.3.5.11 It is now a locally agreed process that a S117 review template is used for Newham residents who are detained under S3 at the Newham Centre for Mental Health for the discharge of S117 after care planning meeting to ensure the after-care needs are assessed and planned for.

The review is assured that this system ensures that a person's after-care needs will be formally assessed as this is the policy on acute inpatient wards.

3.3.5.12 **Managing the risk that the perpetrator posed**

3.3.5.13 Most of his multiple admissions were under the compulsory powers of the Mental Health Act, 1983. These admissions and detentions were proportionate and necessary given the needs and risks he presented to himself and others. Assessing professionals followed the statutory guidance of the Mental Health Code of Practice to inform their decisions.

The perpetrator' offending history is well documented in the health records, and it informs part of the clinical risk assessment, however, it is not clear from the electronic health record whether this information had formally come from the police via a formal request to ensure that the information was accurate, comprehensive, and covered both arrests and convictions.

Mental health Teams may make requests to the police to share information with regard to arrests and convictions for a person via a formal request (completion of a Form 3022) providing that it relates to a 'policing purpose' under the Police Acts and APP Management of Police Information (MoPI) statutory guidance, is necessary in order to ensure that policing duties and powers are exercised fairly in the public interest and according to the rule of law: protecting life and property, preserving order, preventing the commission of offences, bringing offenders to justice, any duty or responsibility arising from common or statute law.

Recommendation

It is recommended that teams across the Directorate are briefed on the process for requesting police records check for arrests and convictions where there are concerns around a service user's offending/arrest history and it is proportionate and necessary for the Police to share this information.

3.3.5.14 On 24 April 2014, a female service user disclosed that the perpetrator had been physically abusing her, coercing her to use illicit drugs and to engage in sex work.

A safeguarding concern (this pre-dated the Care Act, 2014, however, safeguarding adult practice would have followed the Pan-London Safeguarding guidance) was not raised for the victim. The safeguarding concern or alert should have been sent to the local authority (Newham Council) who would then have made a decision as to undertake a safeguarding adult enquiry.

3.3.5.15 The female was supported to engage with domestic violence support services and to move out of area to a women's refuge to escape the perpetrator.

3.3.5.16 The allegation was recorded in the perpetrator' Care Programme Approach risk assessment ensuring that the information was available to all practitioners. ***This is an example of good practice.***

3.3.5.17 On 24th November 2014 the Directorate's Dialectical Behavioural Therapy service made the decision that the perpetrator was not appropriate for their therapeutic group programme due to other vulnerable female service users in attendance and due to concerns around the risk he posed to women given his conviction for rape, his alleged assault and abuse of a female patient earlier that year. ***This decision was appropriate given the perpetrator' risk history.***

3.3.5.18 In June 2015 a female service user alleged that the perpetrator had held her hostage and abused her. the perpetrator denied that this had occurred. A Safeguarding Adult concern was raised, and a safeguarding enquiry undertaken.

A plan was made for the perpetrator to receive a forensic psychiatric assessment; however, it is not recorded in the records whether this was conducted, and if so, what the recommendations were. ELFT's Forensic Mental Health Directorate's Forensic Outreach Service offers a consultation/liaison service to other secondary care mental health teams and professionals for service users from the service's catchment area. This service would have offered specific expertise and opinion on the perpetrator as a service user thought to pose a significant risk to others by reason of their mental disorder**.**

Whilst this would not necessarily have changed the care and treatment plan that the perpetrator received it may have led to a greater understanding of his condition and the most appropriate way to treat him.

Recommendation

It is recommended that Teams across the Directorate understand the Forensic Outreach Service process for requesting a forensic Psychiatric assessment and that there is a local process for ensuring the assessment is conducted and documented.

3.3.6 **VICTIM SUPPORT**

3.3.6.1 Although contact was made with the perpetrator no meaningful work was undertaken as he was unable to keep arranged appointments and then disengaged from support.

The review notes that the perpetrator was supported under the 'multi-crime' side of the service and all contacts were in line with the contact timescales for that part of the service.

3.3.7 **PROBATION SERVICE**

3.3.7.1 The Probation Service were involved with the perpetrator from 1st January 2016 to 19th April 2019. He was on the Register of Sex Offenders (see Appendix One) but at the time of his offence he was not managed by MAPPA. As he was not managed by MAPPA a Serious Further Offence review was not undertaken. The perpetrator was assessed as medium risk of harm.

Section Four – What do we know about Hanna and Star?

4.1 Analysis of Hanna and her situation

4.1.1 BACKGROUND

4.1.1.1 Hanna was born in Hungary. She reported to the Welcome Centre that she had been sexually abused by her stepfather. She said that when she confided in her mother, she refused to believe her or protect her. It is not known if this was reported to the Hungarian authorities.

4.1.1.2 In 2004 Hanna married and had two children. The couple separated in 2007 and their marriage was annulled in 2008. Hanna's mother-in-law became the children's legal guardian.

4.1.1.3 Following the breakdown of her marriage, Hanna initially lived with friends in Hungary whilst her divorce progressed, and she sought access to her children. In 2011 she met a man who promised to help her and to get her work. He took her to Germany where she said that 'drugs were taken, and women sold for sex'.

4.1.1.4 Hanna first came to the UK in 2012. She discovered that she was pregnant so returned to Hungary in 2013. Here she gave birth to the baby and placed the baby for adoption.

4.1.1.5 After having been trafficked to Birmingham on 16th September 2014 by her 'partner' Hanna was forced into prostitution in a house that she shared with four other women. Whilst Hanna said that she had escaped whilst out on a train, it is unclear how she came to London. She said that when she went to the Embassy as she had no documents or ID she was told that they could not help her and she made her way to Stratford. Here she was street homeless and begged for money, doing odd jobs here and there.

4.1.1.6 Hanna met Male 1, and they moved in together, although it is not known when this was. From 2014 to 2016 Hanna reported numerous domestic incidents including imprisonment and rape by Male 1.

4.1.1.7 Hanna disclosed that she had sex with people in return for accommodation and was a regular drug user.

4.1.2 EVIDENCE OF DOMESTIC ABUSE

4.1.2.1 Hanna was subject to domestic abuse from a number of men – her partner in Hungary, Male 1 and the perpetrator. She had also spoken of meeting a second man outside a church and moving in with him. She said that he was a jealous and controlling man who had beaten her and she had lost contact with all her friends.

4.1.2.2 Physical abuse

4.1.2.3 In December 2014 Hanna had been pushed several times by Male 1 as well as being assaulted by his friend.

4.1.2.4 In January 2015 police were called to a report of Hanna and Male 1 fighting in the street and Male 1 having slapped her. Hanna said that he had slapped her and she had a visible swelling

on the left side of her face and a small cut on her neck. Male 1 was arrested for Actual Bodily Harm.

4.1.2.5 Hanna told her GP in March 2015 that Male 1 had been kicked and that when 'he gets drunk he acts this way'.

4.1.2.6 On 17th January was found on a grassed area outside the flat that she shared with Male 1. She said Male 1 had pushed her from the sixth-floor balcony. Whilst they were waiting for an ambulance, Male 1 tried to get Hanna off the ground.

4.1.2.7 **Sexual abuse**

4.1.2.8 Police were called in November 2014 as Hanna was in a public house in a distressed state. She said that she had been raped and had her property stolen.

4.1.2.9 The police were called to a park in December 2014 after reports of a man and women arguing. Hanna disclosed that she and Male 1 had been to the mosque for food and were walking home when Male 1 asked for a sexual act. When she declined, he became argumentative.

4.1.2.10 Whilst making her statement in relation to the assault in January 2015, Hanna disclosed that Male 1 had physically assaulted her on 25th January and raped her on 30th January.

4.1.2.11 **Coercion and control**

4.1.2.12 When spoken to by the police in December 2014 about an assault by Male 1 that had been witnessed, she did not make an allegation and declined a referral to domestic abuse agencies.

4.1.2.13 After Hanna had left Male 1 he approached her, in February 2015 in the street and said that he had letters for her and that she needed to return to live with him.

4.1.2.14 In October 2015 Hanna withdrew the allegation of rape against Male 1 as she was now back in a relationship with him. A few days later she disclosed to an officer that she had done this because Male 1 was standing beside her.

4.1.2.15 **Imprisonment**

4.1.2.16 When Hanna was interviewed after the fall from the balcony she disclosed that Male 1 had kept her captive for two days and had assaulted her.

4.1.2.17 **Stalking**

4.1.2.18 Hanna told police, in February 2015 that, having left Male 1 she had seen him following her on a number of occasions.

4.1.2.19 Whilst in hospital following the fall from the balcony, Hanna met the perpetrator. She left hospital to go to a safe refuge in Bristol. On 17th March 2016 she left to go and live with the perpetrator.

4.1.2.20 **Abuse from the perpetrator**

4.1.2.21 As part of the murder investigation the police found several notes written by Hanna. These paint a picture of the abuse that Hanna suffered from the perpetrator. Some of the notes are dated and others are not. The first dated note was written on 23rd May 2016, a matter of weeks after Hanna moved in with the perpetrator and read, 'Dear [perpetrator] Hope one day you gone wake up in a good mode, not in the boxing ring side. Doesn't mather what did I saying to you or how hard I try to take care of U ….. sometimes you just don't give a thing …..Still love you but start loosing my faith and my patience with you!!!

4.1.2.22 Five days later, Hanna wrote,

But match better an easyer just call you in my man "Zee man"!!!
So the day is today the day when you my love telling me the true about your love4me is really so deep. You gone Marry me or not???
On the better thing's if I gone marry you back in my country in your birthday???!!!
No lie more about no way's ok???
Not from my side and [the perpetrator] is well!!!!!
+not from yur sick
We are bouth people from the Book!!!
Answer my question soon as possible!!!
Love you lot's
Your crazy bunny woman,
Hanna
PS Don't tell me every again am a ….'

4.1.2.23 At the beginning of June, Hanna wrote,
'Let me tell you something about how I feel for you!!!
Really love you and I mean it!!!
Bottom of my heart, to the stars and back!!!!! I didn't wana loose you, and I wont that ever happen!!! This is true!!! Just wana LOVE you!!! and all what I', wanting back is love!!! Need to say thank you for the keep me away from all the trouble and madness!!! Thank you to pull me out from the dirty road where my life was going. Sorry about the piss what ever I done, never ever gona do dirty agin on you!!! Will learn more to keep my mouth shut whe I need to listen, and talk up when I need …. Sorry to fuck up your night today 2016/01/06 23^{00} I didn't ment to do it….. And I did turn around and say sorry!
Still love you 4ever!!!! Your mad silly girl'

4.1.2.24 Hanna wrote on 14th September 2016:
'I was brake down so many promises so mutch damage even if I don't mean to 1 – 2 world answers.
No so many times lie
Not being nice
Give him attitude when he don't deserved
Be wrongen so many times

I didn't give him back what he done
towards to me
Broke my own promises

Broke my morning promises. I
didn't wake up in time was wrong and I
didn't change my close in time. I did
make [the perpetrator] angry because I didn't listen
to him when he try to do he's best for me.
Am sad and broke and feel low now.
Learn my lesson today again.'

4.1.2.25 We can see from Hanna's words how the perpetrator has convinced her that she is responsible for the way he behaves towards her. We can see, from the following note, written on the same day, that Hanna was trying so hard not to make the perpetrator angry.

'Make a plan to get to foodbank every
day – check witch day where they give a food out.
Make a do list. Point to point follow all instructions.
Don't get upset and angry to fast. Believe in self,
bee a real woman. Not a jock in every one eyes.
Stand up for my self let hear my voice! Be positive
make nice easy day out, look afther myself and
put my loved once before me!! Don't make empty
promises, don't be shy to ask for help and if I don't
understand say if need to explain better or
different but not made way!!! Let things happeing
give a break and give a chance. Stop back chat
and let another talk. Be more patient and show
the best intermes. If I brake down menthali try to
focus on fast first good right stand up move.
Move on and admit when am wrong,, so e straight!!
Stop to be horrible with the people who give me help!!'

4.1.2.26 On 18 or 19th September 2016 Hanna wrote:
'Thanks to Allah again for nice night!!! Thanks for
wake up to a new day. Thanks to give me a
chance to help my situation an try to get back
stronger in my feat!! Need to ask more forgiveness
to Allah because my old life and forgive me to my
bad mind. Please Allah keep my inside in a good way!! Help
me to be more stronger to bee there the only one
friend and my everything what life is in this
country. Allah help me.'

4.1.2.27 The note below, that is not dated, allows us to hear how Hanna saw herself and low her self-worth was:

Am Hanna
Write this letter to [the perpetrator] to give promotion to
fuck me over, what he want because he hade enough about me and I'm in He's property
without any incoming. Most of the Time am
Good for a nothing to him …For my self am just
a lil bitch from the hospital who try to be a Girl
for him, but I never gone be good enough!!

4.1.2.28 This following note was dated 13th September 2016 and written in Hungarian:

How can love turn into hatred just like that? Everything
you promised is no more than a shattered dream. I got
disillusioned as a result of some really big slaps in the
face!!!! When I admitted my sins, you judged and expelled me from the inner circle and planted poison in my broken heart that was anyway stone-cold by then.
This poison has been tormenting and burning me. I'm
afraid of dying and. don't want to hate you!!!!!!!! It's hard to
say good-bye, but it's no longer possible for me to
remain and suffer, tolerating the hatred you display
towards me [words missing] from life, who [words missing]
13.09 AID [words missing] MY CLOSEST FRIEND
[words missing] IS WELL. Glory to ALLAH for
awakening me to another wonderful day. Thank Allah for
granting me the opportunity to breathe and live, even if
in squalor and bitterness but as soon as he receives my
body after my death, everything will be better. I am
imploring you, Allah, for forgiveness!!! Please, forgive
me for my impure and perverse sins committed in the
clutches of [word missing] and drugs. Please, absolve
me of my sins committed during [word missing] and give
me a chance to pray again if [words missing] the one and only

4.1.3 MENTAL HEALTH

4.1.3.1 Hanna had said that she had been diagnosed with a personality disorder in Hungary which was managed with medication that she did not take.

4.1.3.2 Unsurprisingly given her life experience, there is evidence to suggest that, at times, Hanna contemplated suicide. In September 2014 she was found by British Transport Police sitting on the edge of the Victoria Line platform. Hanna was detained under S136 of the Mental Health Act and taken to hospital. A warning marker was placed on the police system to indicate 'suicidal'.

4.1.3.3 On 3rd March 2015 Hanna saw her GP about her mental health.

4.1.4 TRAUMA

4.1.4.1 Trauma is a broad and varied concept but is broadly described as a severely distressing or disturbing experience that has an impact on an individual or their broader social network

(Mind, 2020, Substance Abuse and Mental Health Services Administration, 2014[87]). It can be a one-off event or a series of similar events or, as we see in women with complex needs, a combination of a series of diverse events.

4.1.4.2 Research[88] indicates that trauma can rewire the brain structure through conditioning resulting in a permanent state of arousal i.e. fight, flight, freeze and so on. The impact of trauma may not be evident until months or years later.

4.1.4.3 The Substance Misuse and Mental Health Services Administration (2014)[89] says that trauma may impact differently on the individual with outcomes including, but not limited to:

- Addiction (including substance abuse or alcoholism)
- Sexual problems
- Inability to maintain healthy close relationships, friendship, and social interactions
- Hostility and/or anti-social behaviour
- Social withdrawal
- Self-destructive behaviours
- Impulsive behaviours
- Reactive thoughts
- Feelings of depression, shame, hopelessness, or despair

4.1.4.4 It is important to note that the effect of trauma is not cumulative (i.e. the more trauma that you experience, the more you are impacted) or type dependent (the more severe the trauma, the more sever the impact).

4.1.4.5 There is good evidence of the strong link between traumatic experiences and poor mental health. For women, trauma is frequently associated with experiences of abuse and violence. More than half the women who have experienced extensive abuse and violence across their lives have a common mental health condition like depression or anxiety[90].

4.1.4.6 There has been increased emphasis over the past few years on services becoming 'trauma-informed'. This review believes that key to being a trauma-informed service is moving from asking 'what is wrong with you?' to asking, 'what has happened to you?'. This is a shift not only in policies and procedures but, more importantly, a shift in mindset by all involved. When we read the chronology of the engagement with both women with services it is too easy to get a sense of the problems that they present and lose sight of what has happened to them in the past that has brought them to the place where they were. The trauma that Star experienced led her to develop coping strategies and behaviours that may appear to be harmful and dangerous[91].

4.1.4.7 Many professionals will be seeking to work in a way that is 'trauma-informed'.

There is a sense of the term 'trauma informed' being used by both commissioners and practitioners without a shared understanding of what this means. Even for those who believe that they understand trauma informed care, there is a sense that is not yet something that comes naturally and automatically but is still something that must be given specific focus. Improving the local

[87] Cited in Trauma-informed practice, Her Majesty's Inspectorate of Probation, July 2020
[88] Fox et al, 2014 cited in Ibid
[89] Ibid
[90] A sense of safety, Centre for Mental Health, November 2019
[91] Sweeney et al, 2018 cited in A sense of safety, Centre for Mental Health, 2019

understanding of, and response to, trauma across all services, is vital, accepting that this will take time to embed into everyday practice.

The review is advised that Public Health have commenced work in 2023 to embed the trauma-informed approach in Newham.

Children and Young People's Services is developing a Early Help offer that will include co-ordinating all early help services including parental support, perinatal mental health, family help, children's centres and 0-19 health services a part of the community based family hub networks. This new approach will include a trauma informed approach to families' needs.

4.2 Analysis of Star and her situation

The notes from Star that have been added to this report will be anonymised and reduced where needed for the final version of the report

4.2.1 STAR'S VULNERABILITY

4.2.1.1 Star had been a victim of domestic abuse in several of her relationships. As early as June 2007 Star fled her home and lived with her mother due to domestic abuse. Star's family recollect that her life began to go downhill in 2010 and it is believed that she began taking crack cocaine in 2011[92].

4.2.1.2 In 2011 Star came to the attention of CSC when her children were not attending school regularly and she had not attended a couple of appointments at the school in November 2011. After the school had made an unannounced visit, they made a referral to CSC. CSC found that there were no concerns with Star's parenting capacity and their basic needs were being met by Star, with support from her mother. Support was put in place with a view to the children's attendance at school improving.

4.2.1.3 Early in 2013 CSC reported that it was not possible to gauge the impact of the Early Intervention support that was provided to Star as, over a period she did not engage, and she did not inform the school of absences which had been an ongoing concern.

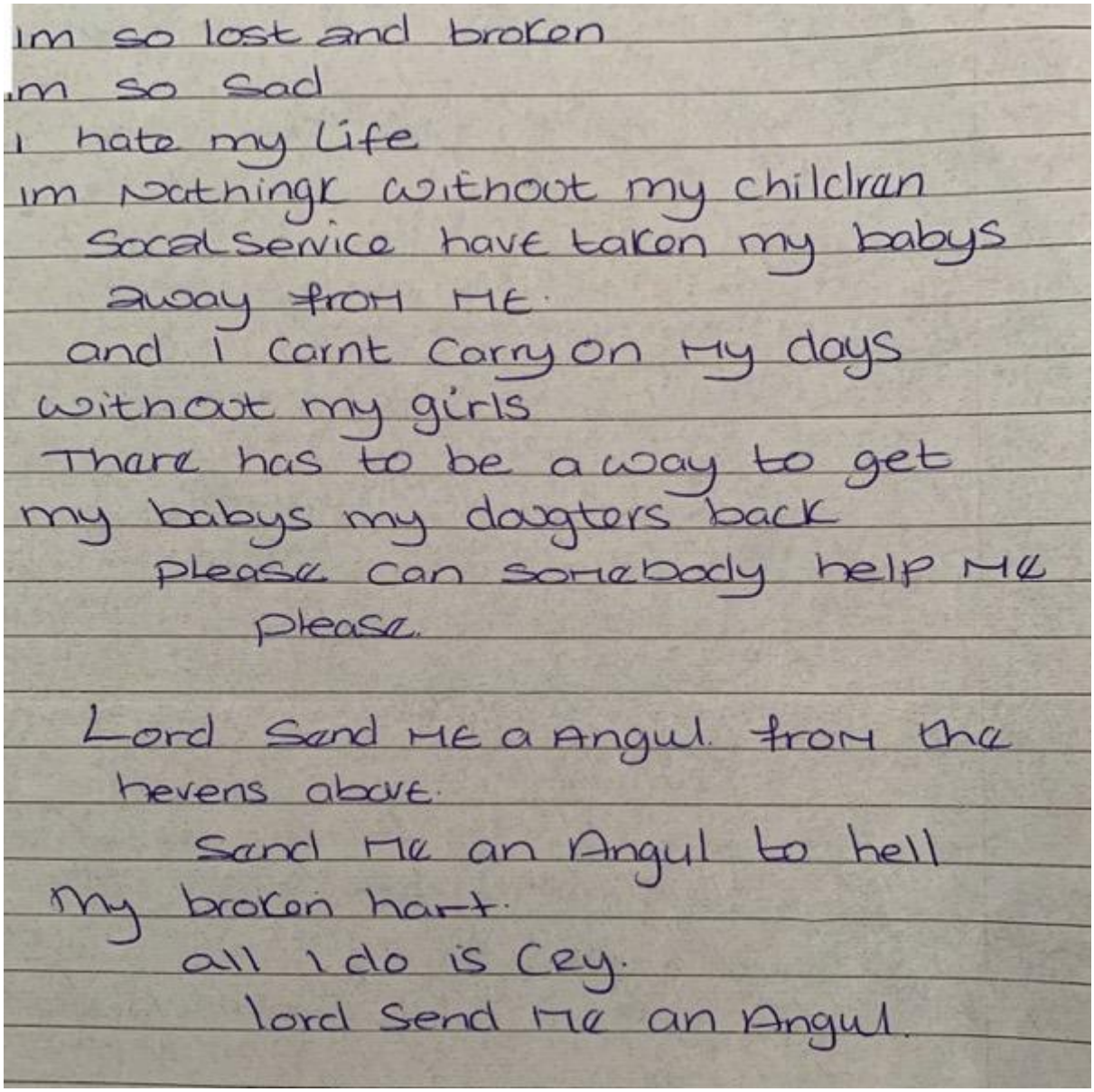
Bearing in mind that this is historic engagement with Star, the review does note that the work undertaken with Star was focused on school attendance and did not consider the history of domestic abuse and the possible impact that this had on her parenting ability.

4.2.1.4 At the end of 2013 Star was subject to domestic abuse by her partner, the father of her new born baby. Star's substance misuse and inability to prioritise the children was becoming an issue at this time and in January 2014 the children were placed on a Child Protection Plan (CPP).

4.2.2 CHILDREN TAKEN INTO CARE

4.2.2.1 Star's older children were placed in the care of her mother and her youngest child was adopted. The impact that this had on Star cannot be underestimated. We can hear Star's own words from notes that her family have provided to the review:

[92] As disclosed by Jan to CSC in 2013



4.2.2.2 Research by Lancaster University found that over 11,000 women had more than one child removed between 2007 and 2014. One in four women who has a child removed through the family courts is likely to have another removed and that number increases to one in three if they are a teenage mother. Four out of ten women who have had multiple children removed have been in care themselves. A further 14% lived away from their parents, in private or informal arrangements, while many more have experienced disruptive or chaotic childhoods[93].

4.2.2.3 Where the state intervenes to remove children, birth mothers experience loss but this is magnified where this is repeated yet there has been little research into understanding the experiences of these women. Broadbent's research found that, for birth mothers who have their children removed from their care, the interval between one set of care proceedings

[93] https://www.pause.org.uk/why-pause/the-data/

and the next may constitute a vital window for recovery. However, the timeframes were out of sync with what is known about realistic recovery from problems such as mental health or addiction – the problems that frequently characterise the lives of women whose children are removed (Sidebotham and Heron, 2006; Brandon et al, 2008; Bockting et al, 2015[94]). Broadhurst et al noted that a sizeable percentage of women reappear in the family court, sometimes multiple times, because their problems are *repeated* not *resolved.*

4.2.2.4 When a child is taken into care, there is no statutory obligation for support to be offered to the mother and, as has been suggested by some, once the child has been removed the mother's need does not meet adult services threshold for intervention and support (Ashley, 2015[95]). Interviews undertaken by Dr Karen Broadhurst, of Manchester University, with over 60 birth mothers in five local authority areas in a study for the Nuffield Foundation, found that 'mothers feel completely abandoned after their child has been removed. There would be more attention paid to your rehabilitation if you were a criminal'[96].

4.2.2.5 The review is aware of the work of Pause (https://www.pause.org.uk/) that works with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care. The aim is to prevent the damaging consequences for women and to work with them to give them the chance to take back control of their lives.

4.2.2.6 It is noted that this service is no longer available in Newham. Some members of the panel expressed concerns about the methodology of this project.

Recommendation

It is recommended that this DHR is shared with Safeguarding Children's Board who consider if the support provided to women in the borough whose children is taken into care is sufficient and meets their needs.

4.3 DYSLEXIA

4.3.1 Star's family have informed the review that she suffered with dyslexia and did not finish her education. She found reading official letters very difficult. There is no evidence that any organisation was aware of this condition. It is understandable that Star may have not been confident to share this information.

4.3.2 There is also no evidence that agencies routinely ask, when someone presents at a service for the first time, if they have any particular needs such as difficulty with reading and writing.

The review believes that organisations should be asking, and recording, when someone first presents if they have any difficulties, for example with reading and writing

4.4 SUBSTANCE MISUSE

4.4.1 Star engaged with substance misuse services provided by CGL on three different occasions between 2015 and 2018. On each occasion Star was clear that she wished to achieve abstinence from illicit opiate and crack cocaine use. Star's family believe that her

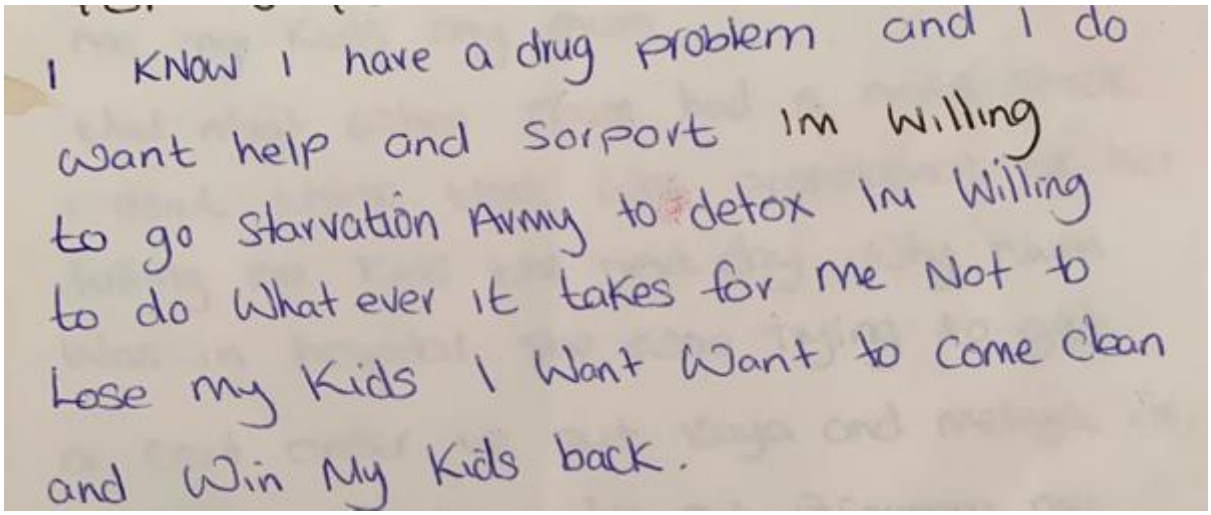
[94] Cited in Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al, 2015

[95] https://www.theguardian.com/society/2015/apr/25/are-we-failing-parents-whose-children-are-taken-into-care

[96] IConnecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al, 2015

relationship with CGL was important to her. In her belongings were found several letters from CGL sent to her.

4.4.2 The review believes that, whilst Star was determined to become abstinent. It is well-known that substances are often used as a form of self-medication – to blot out unwanted thoughts and emotions. The pressures Star was facing particularly the exploitation by different men and the trauma she had faced, just made this too difficult for her. This is clear from her notes below:



4.5 MENTAL HEALTH

4.5.1 Star saw her GP with a range of symptoms - anxiety, depression, insomnia, not eating well or putting on weight, a cough and headache. There is no evidence that the cause of these symptoms was explored with her.

4.5.2 Research has demonstrated that, for at least some conditions, there is a bidirectional causal association between mental disorders and domestic abuse[97]. One systematic review reported three times increase in the likelihood of depressive disorders, four times increase in the likelihood of anxiety disorders and seven times increase in the likelihood of post-traumatic stress disorder (PTSD) for women who have experienced domestic abuse. Significant associations between intimate partner violence and symptoms of psychosis, substance misuse and eating disorders have been reported[98] Research suggests that women who experience more than one form of abuse are at an increased risk of mental disorder and comorbidity[99].

4.6 TRAUMA

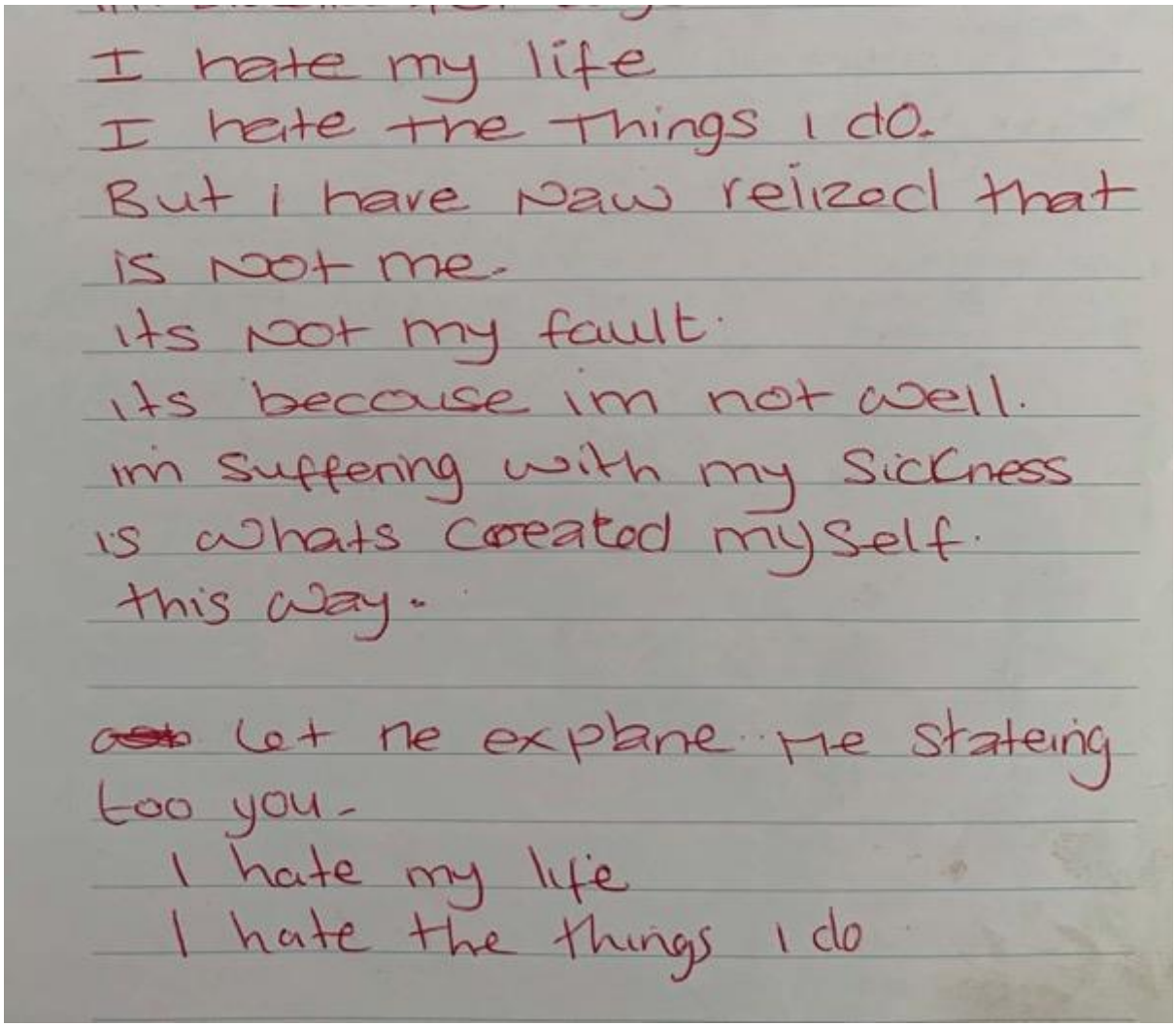
4.6.1 Clearly Star had experienced trauma in her life and continued to do so up until her murder. The impact of trauma was discussed earlier in relation to Hanna.

[97] Devries KM, Mak JY, Bacchus LJ, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med 2013; 10: e1001439. Cited in Violence against women and mental health, Oram et al, The Lancet, 2017

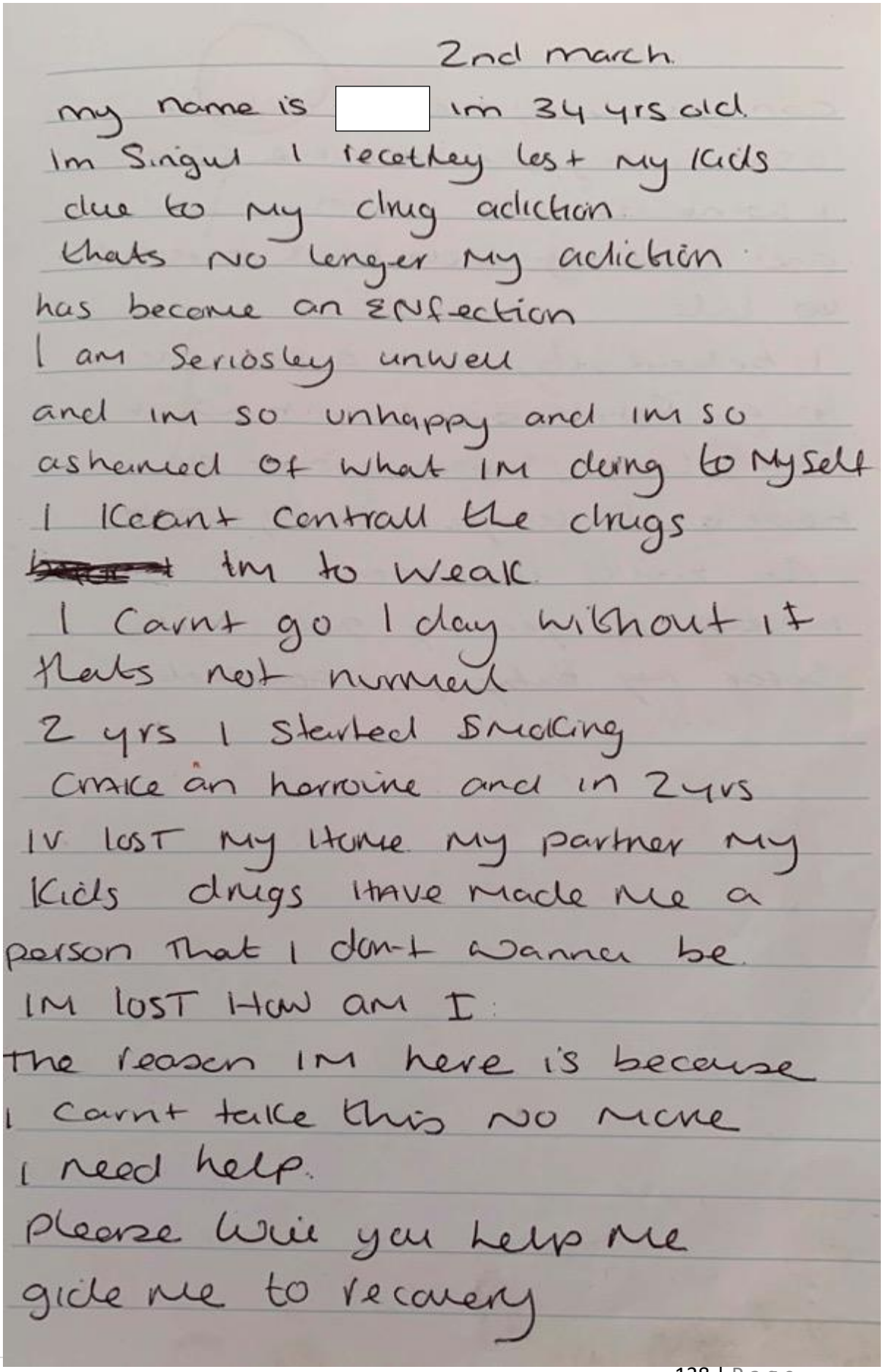
[98] Oram et al, The Lancet, 2017

[99] Romito P, Turan JM, Marchi MD. The impact of current and past interpersonal violence on women's mental health. Soc Sci Med 2005;60: 1717–28 cited in Violence against women and mental health, Oram et al, The Lancet, 2017

4.6.2 There is no doubt from the notes that Star has written that she regretted the choices that she had made and wanted her life to be different.

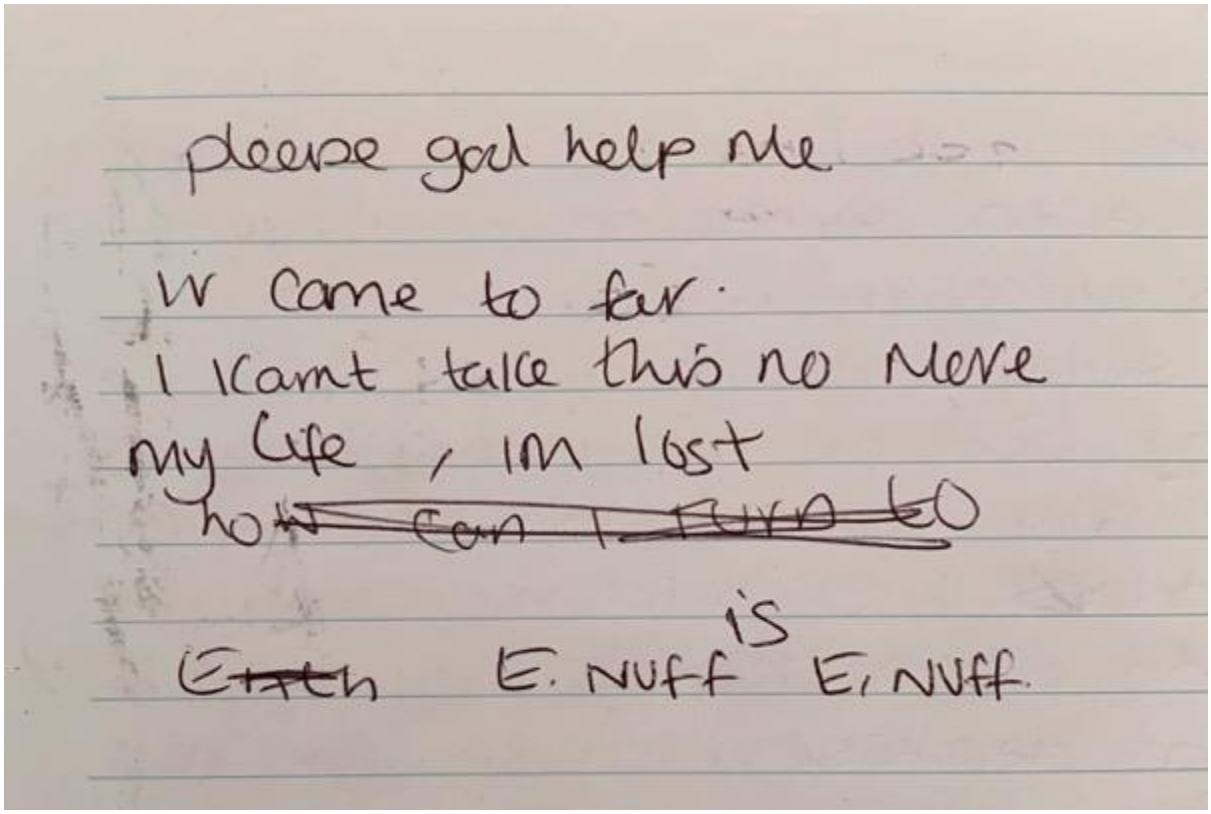

I hate my life
I hate the Things I do.
But I have Now reiized that
is Not me.
its Not my fault.
its because im not well.
im suffering with my sickness
is whats Created myself.
this way.

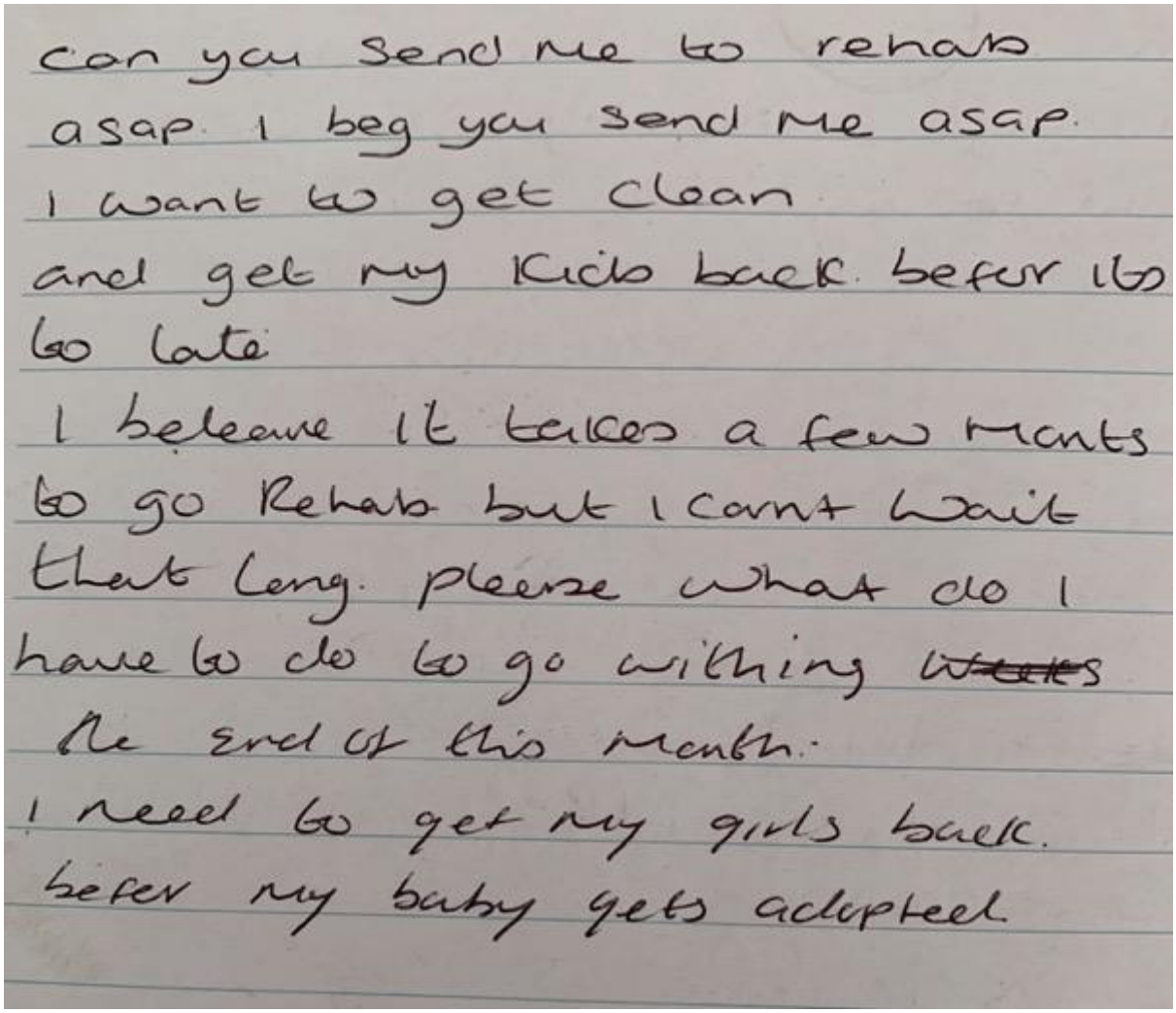
~~ask~~ Let me explane me stateing
too you.
I hate my life
I hate the things I do



2nd march

my name is [redacted] im 34 yrs old
Im Singul I recetley lost my kids
due to my drug adiction
thats no lenger my adiction
has become an ENfection
I am Seriosley unwell
and im so unhappy and im so
ashamed of what im doing to Myself
I Iceant contrall the drugs
[redacted] im to weak
I Carnt go I day without it
Feels not normell
2 yrs I started Smoking
Crack an horroine and in 2yrs
IV lost My Home My partner My
Kids drugs Have made Me a
person That I don't wanna be
IM lost How am I
The reasen IM here is because
I carnt take this NO More
I need help.
Please Will you help Me
gide me to recavery


please god help Me
W came to far.
I Icamt take this no More
my Life , im lost
ho~~w Can I turn to~~
E~~tch~~ E. NUff is E, NVff.



can you send me to rehab
asap. I beg you send me asap.
I want to get clean
and get my kids back. befor I do
to late
I beleave it takes a few months
to go Rehab but I cant wait
that long. please what do I
have to do to go within ~~weeks~~
the end of this month.
I need to get my girls back.
befor my baby gets adopted

Section Five – Analysis of the perpetrator

5.1 HISTORY OF DOMESTIC ABUSE

5.1.1 Domestic Homicide Reviews are charged with looking for a trail of domestic abuse. It is not clear when Star met the perpetrator although her family believe it was only a matter of weeks before her murder. It is not there possible to examine their 'relationship' in detail. There is, however, extensive evidence of the domestic abuse perpetrated by the perpetrator in this case. Therefore, the review will explore the evidence of this abuse.

5.1.2 The judge, in sentencing, described the perpetrator as 'an arch deceiver' who 'spent a lifetime destroying lives'. 'From his teenage years when you flattered impressionable young girls and tried to control them, until their families rescued them from you …. you have preyed upon the vulnerable with superficial charm.'

5.1.3 The perpetrator first came to the attention of the police in 2001 when he was 16 years old, and his mother reported that he was engaging in sexual activity with his underage sibling. His underage sibling confirmed that this had occurred but was not able to pursue the case. He was arrested and interviewed but it was deemed that there was insufficient evidence for a prosecution to occur.

5.1.4 **Female 1**

5.1.5 In 2001, Female 1, who was 16 years old and in a relationship with the then 16 year old perpetrator became pregnant and gave birth in 2002. She reported a history of violence towards her, including in 2004 (18 months after giving birth) the perpetrator putting his hands around her neck and threatening to send her and their child to Pakistan.

5.1.6 The perpetrator was married in 2002/2003. This female was subjected to violence from the perpetrator including having a cigarette held on an arm that caused a permanent scar.

5.1.7 **Female 2**

5.1.8 At some point in 2004, Female became involved with the perpetrator. At this time, Female 2 was 14 years old, and the perpetrator was 19 years old. In August of that year, Female 2 reported being assaulted by the perpetrator. She said that he had grabbed her round the throat, banged her head against the wall and refused to let her go. He was charged with Actual Bodily Harm (ABH) and False Imprisonment. He was found not guilty at court.

5.1.9 Police were called to the perpetrator's address on 31st March 2005 by a member of public after seeing a girl hanging over the balcony being pulled back inside by a man. The girl, who was 14 years old, told officers that she had been staying at the address with her boyfriend, the perpetrator. They had an argument and she wanted to go home. The female told police that she and the perpetrator were not engaged in a sexual relationship. Officers took the female to the police station and her mother was called. When her mother attended, she reported that the perpetrator had attended their home the week before and had taken jewellery. The assault and theft reports resulted in no further action by police.

5.1.10 On 5th April 2005 police received a report from Female 2's mother that her 14-year-old daughter was 7 weeks pregnant, and that the perpetrator was the father. Initially Female 2

was reluctant to speak to police due to her experience at court the previous year and so she had 'lost faith' in the criminal justice system. Female 2 was still seeing the perpetrator.

5.1.11 In April 2005 the perpetrator assaulted a female who had fallen out with Female 2. He had shouted at her and told Female 2 to hit her. He then hit the female in the face causing her to sustain a black eye. He then said to her that he would 'shove a knife up your arse' if she touched Female 2 again and spat at her. The victim and her parents asked that the perpetrator was spoken to and warned about his behaviour. A harassment letter was sent to perpetrator, and the investigation was closed.

5.1.12 At the end of April Female 2 was stopped by security in a supermarket for taking a sandwich. The perpetrator ran off. She said that she had been held against her will and the police were called. During a Video Recorded Interview (VRI) Female 2 described the sexual relationship, pregnancy, physical assaults, and false imprisonment by the perpetrator.

5.1.13 Female 2 was reported missing from her mother's address in June. Her father reported that he had found her and was at King Georges Hospital (KGH) at the end of June. She described how the perpetrator had made her meet him and then said to her that he said if she left, he would 'Do her and fuck the baby up' and he would commit suicide. She disclosed that she had engaged in sex with the perpetrator and although she did not want to, she did not say no as he had hit her once previously when she had refused his advances.

5.1.14 During the investigation, it was disclosed that over a three-week period the perpetrator had repeatedly beaten and raped Female 2 (vaginal, oral, and anal) in various hotel/hostels. He also assaulted her, held her against her will, assaulted her with a hammer and a shower pole.

5.1.15 In February 2007 the perpetrator was convicted of Sexual Activity with a Child contrary to Section 9 of the Sexual Offences Act 2003, after he had engaged in sexual activity, as a 19-year-old, with a 14-year-old girl (Female 2) on 10th June 2004. He was sentenced to 30 months' imprisonment and placed onto the Sexual Offenders Register subject to notification requirements for life, thereby falling under MAPPA[100] management.

5.1.16 **Female 3**

5.1.17 On 7th September 2005 it was reported to police that the perpetrator had been in a relationship with a 14-year-old girl, Female 3 for the past four months. The perpetrator was now 21 years old. She disclosed that she had been sexually and physically assaulted by him. She said that on 19th August she had attended Whipps Cross Hospital with him after he had self-harmed. After the hospital had asked him to leave, he threatened that he would kill himself if Female 3 did not run away with him.

5.1.18 It was also reported that, on 20th August, the perpetrator had booked a hotel room under a false name and whilst there he had assaulted her, on the first night, with a curtain pole. The following night he had beaten her and then tied her hands and feet to each corner of the bed and then raped her (vaginally and anally) and had forced a bottle and television remote control into her. The girl suffered internal injuries and lacerations to her wrists. She said that he had repeatedly raped her at various hotels and hostels. He had taken her to see prostitutes telling them that she wanted to start sex work. Female 3's parents had not reported her missing as he had allowed her to contact them every evening.

[100] Multi-Agency Public Protection Arrangements - https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

5.1.19 When she managed to get away and call her sister, Female 3's mother was told by the perpetrator that if she called the police she would be shot. A third party reported to the police that perpetrator had thrown a mobile phone at Female 3's head. He was arrested and charged with ABH, False Imprisonment and Sexual Activity with a child.

5.1.20 When CPS were consulted about these offences and the perpetrator was charged with 29 offences, consisting of Rape, Sexual Activity with a Child, False Imprisonment, Assault by Penetration, ABH, Wounding, Common Assault, Possession of an Offensive Weapon and Robbery on 25th January 2006. At court the case was acquitted after Female 3's evidence was deemed to be unreliable.

5.1.21 **Female 4**

5.1.22 On 25th August 2007 the perpetrator was arrested for beating and sexually assaulting a 17-year-old, Female 4. It was reported that he had beaten her with a hammer, punched her several times to the face and used various implements to insert inside her vagina. The female reported that she had been beaten on several occasions since July 2007. She had extensive bruising across her body, several small stab wounds to her thigh and finger. Her left arm was broken. He was charged with GBH, ABH and wounding. He was sentenced to 4 years 9 months for GBH x3 and ABH.

5.1.23 **Risk assessment**

5.1.24 When he was released from prison at the beginning of December 2010, the perpetrator was assessed as being of high risk of harm. Two CRIMIT reports were created and one stated that the perpetrator 'is clearly a significant danger to young females and there are serious concerns he will commit again'.

5.1.25 **Female 2**

5.1.26 In August 2011 Female 2 called the police as the perpetrator had been to her flat to see his child. He had wanted to stay over, and she refused so he returned the next morning. When they were then all leaving the flat to go their separate ways, he made an excuse about stomach pain and needed the toilet. She allowed him to stay for that reason. When she had returned to the flat a few hours later, he had been in her bedroom and stolen items to the value of £2000. The police completed a risk assessment with Female 2 and her replies indicated:

- When they were together six years earlier, he had threatened to throw her off a balcony. As they were near the balcony, she believed him.
- When she was 13 years old, he had strangled the victim
- There had been many previous incidents of violence
- When she had been pregnant, he had punched her in the stomach causing injury to the unborn child

5.1.27 **Female 5 – Relationship began in August 2013**

5.1.28 Female 5 was identified by officers as being vulnerable with mental health issues. She had met the perpetrator when they were both patients in hospital.

5.1.29 In March 2014 Female 5 knocked on the door of a neighbour as she was scared of the perpetrator and asked for the police to be called. She said he believed that she was asking money for cigarettes. She told officers that she was scared of the perpetrator and that she could no longer stay with him. She told officers that he:

- Shouted at her every day
- Was confrontational in his body language
- Called her names, threatening to hurt her and family
- Was getting more volatile as the relationship progressed
- Would not let her go anywhere on her own
- Smashed her mobile phone, so she did not have contact with friends and family, having to give his number as a contact

5.1.30 Female 5 was taken to her parents but returned to his address the next day. She did not feel able to provide a statement as she said they had resolved their issues. The police took no further action as there was insufficient evidence.

5.1.31 The next day Female 5's sister called the police as the family were concerned about the relationship. Female 5 was not able to have contact with her child because the perpetrator was a RSO. When the police spoke to her, Female 5 said she was one month pregnant with his child. She said she would reconsider the relationship if it led to her not being able to have contact with her child. A month later, the perpetrator's flat was broken into as Female 5's sister was concerned that she had not been seen. They found the couple in bed together and Female 5 withdrew her statement saying that he had promised never to hit her again.

The review believes that it is highly probable that the perpetrator manipulated or coerced Female 5 to stay with him and not support police action.

5.1.23 On 25th April the perpetrator was visited by police for a regular home visit and Female 5 was present. He had not advised the police of this relationship as was required in his reporting requirements. The next day the police were called by Female 5's sister as she had been beaten by the perpetrator. Officers attended and found Female 5 and her sister outside the perpetrator's address. In the conversation Female 5 disclosed that:

- The perpetrator had been assaulted on 20th April after an argument
- The argument had been about the perpetrator forcing her to become an 'escort'
- The perpetrator had thrown a plate at her, repeatedly slapped, punched, and kicked her
- He had thrown a mobile phone at her, hitting her nose
- When Female had attempted to leave, the perpetrator had pulled her hair

5.1.24 Female 5 then took an overdose. The perpetrator was charged with ABH and bailed by the court for trial on 19th August.

5.1.25 On 5th September Female 5 reported that she had been repeatedly raped by the perpetrator between 27th March 2014 and April 2014. She said that he had:

- Assaulted her
- Prevented her from going out
- Raped her
- Threatened to kill her

5.1.26 Female 5 was so traumatised that she did not feel able to make a statement until she had undergone counselling.

5.1.27 **Service user at ELFT**

5.1.28 In April 2014 a female service user at ELFT disclosed that the perpetrator had punched her in the chest and forced her to take crack cocaine. She feared being hit and being pressured into sex work. She was moved to a women's refuge for her safety.

5.1.29 **Female 6**

5.1.30 The DASH undertaken highlighted Female 6's mental health and psychosis. The perpetrator had met Female 6 when they were both patients on Opal Ward at Newham Centre for Mental Health.

5.1.31 In June 2015 security staff at the Excel Centre contacted the police as they had a female who was reporting that she had been kept captive. Officers spoke to Female 6, and she said that she had been in an on/off relationship with the perpetrator and approximately one month ago she went to his address. Whilst at the address, he had beaten her, had thrown food on the floor before making her eat it and poked her with a broom handle. Female 6 had a visible bruise to the left side of her head, arm, inner thigh and back. She told officers that the perpetrator's brother had witnessed her being assaulted on one occasion. Female 6 had escaped when they and his brother had come to the Excel Centre.

5.1.32 The safeguarding concern raised by ELFT identified that Female 6 had been held hostage for three weeks.

This was the 8th female since 2001 that the perpetrator had been reported to have been violent and controlling towards. The females were either young and vulnerable though age or vulnerable through mental health and drug use.

5.1.33 **Hanna**

5.1.34 Hanna was in hospital from January 2016 and whilst in hospital she met the perpetrator.

5.1.35 Hanna moved from hospital to a refuge but maintained contact with the perpetrator. She remained in regular contact with him and in March 2016 left the refuge to be with him.

5.1.36 After Hanna's body was discovered a number of notes written by her were found. The last was dated 24th September 2016. In these notes Hanna disclosed domestic abuse at the hands of the perpetrator. Examples include her saying that she knew that she did much wrong and that she would be different and look after him and herself. In May she begged him to tell her if he was going to marry her. She told him that she was grateful that he had 'pulled out from the dirty road where' her life was going and then says that she will learn to keep her mouth shut and listen. In another note she said that she must keep her distance from him and 'follow the things point to point what he says'. In September she said, 'I did make [the perpetrator] angry because I didn't listen to hm when he try to do he's best for me'. She also said that she should 'stop being retarded'. Another note said, 'write this letter to [the perpetrator] because he hade enough about me and I'm in He's property without any incoming'. She also said that although she tried to 'be a Girl for him' she was 'never gone be good enough'. On 13th September Hanna wrote 'How can love turn into hatred just like that?

Everything you promised is no more than a shattered dream. I got disillusioned as a result of some really big slaps in the face!!!!'.

5.1.37 It is clear from these notes that Hanna was subject to abuse, both physical and mental at the hands of the perpetrator.

5.1.38 **Female 2**

5.1.39 On 4th December 2017 Female 2 contacted Essex Police. She was two months' pregnant, and the perpetrator was present and overstaying his welcome. The police attended and confirmed it had been a verbal argument. It was agreed that they would leave the flat together and then he would return to London.

5.1.40 Female 2 had to call the police again on 9th December as the perpetrator was again at the flat and refusing to leave. When the police arrived, he left.

5.1.41 On 24th December he told officers that he had been staying with Female 2 trying to rebuild a relationship with her. He said that she was now pregnant.

5.1.42 **Star**

5.1.43 On 10th May 2018 the perpetrator was one of the last to call Star before her phone usage ceased.

5.1.44 **Female 7**

5.1.45 Female 7 first came to notice by the police when, on 28th June 2018 when the perpetrator reported to the police that had been stabbed by her. Female 7 was arrested, and in interview disclosed that she had stayed at the perpetrator's address for three days and everything was fine until they argued.

5.1.46 She said that he:

- Had attacked her by hitting her with a walking stick
- Throttled her
- Told her, when she tried to leave, that he would stab himself and that he was 'going to get her into trouble'

5.1.47 He had then stabbed himself in the neck with the knife. She had run out of the address in a T-shirt and underwear with the knife, which she threw into a bush to stop him harming himself further.

5.1.48 In interview she said that she had known the perpetrator for years and that they had met, by chance, at Newham Mental Health Centre three days previously when she was an inpatient, and he was visiting.

5.1.49 **HOUSING**

5.1.50 Discussions within the panel identified that when the perpetrator was provided a tenancy by Newham Council his history and status was either not known or was not recorded on his file in such a way that, many years later, within the scope of this review there is no evidence to suggest that this was known by housing officers. This, in turn, meant that they were not

able to manage the risk that he posed in the community or, conversely, the risk that the community potentially posed to him if his status as a registered sex offender became known.

5.1.51 The review has concluded that there is no benefit in going back and reviewing the allocation but that it is important that the review is reassured that the system now works effectively.

5.1.52 Following a number of meetings held by the Report Author with the MAPPA Co-ordinator and senior managers in housing, it has been established that housing is now fully engaged in the MAPPA process by:

- The senior manager from the Homelessness Prevention and Advice Service attends monthly MAPPA meetings called to discuss Level 1, 2 and 3 MAPPA offenders
- Individual meetings are held with MAPPA lead officers and senior housing staff to discuss issues that arise
- Newham Council has a representative on the MAPPA strategic management board

The review is satisfied that Newham Council housing department are fully engaged with the MAPPA process and are part of the risk assessment and management processes.

5.2 MEDICAL HISTORY

5.2.1 The perpetrator had a significant medical history:

- Complex Crohn's disease for which he required surgery (including bowel resection and stoma) in 2011, 2015, 2018 , and had required multiple primary and secondary care involvement, with variable engagement and compliance with treatment.
- Mental health diagnosis of:
  - Dissocial personality disorder
  - Substance misuse – cannaboids, drug seeking behaviour of controlled drugs prescribed by GP has been noted in his records. It should be recognised his complex Chrohn's disease would be a condition that caused significant pain
  - Paranoid schizophrenia
- Pain due to Crohn's disease and back pain due to a trauma in 2007 when he fell from scaffolding.
- In 2013 benzo diazepam use was noted and it was suggested that there may be addiction due to his back pain

5.2.2 In January 2015 when the perpetrator was reviewed by RAID on 2nd January 2015 it was noted that he did not have schizophrenia but some maladaptive personality traits, secondary to difficult childhood circumstances.

5.3 ETHNICITY

5.3.1 The Perpetrator's parents came to the UK from Pakistan before he was born.

5.4 THE DANGER THAT THE PERPETRATOR POSED

5.4.1 The perpetrator had consistently moved from one relationship to another and his abusive behaviour began when he was 16 years old.

2001	Female relative	No action as insufficient evidence
2002	Female 1	No action

2004	Female 2	Found not guilty at court
2005	Female 1	No action
2005	Female 1	Harassment letter
2005	Female 1	No action
2005	Female 3	Charged with 29 offences but acquitted as evidence level unreached
2007	Female 2	**30 months in prison** **Sex Offender's Register for life**
2007	Female 4	**4 years and 9 months in prison**
Gap due to the perpetrator being in custody – released and considered to be high risk of harm		
2011	Female 2	No further action
Started a relationship with Female 5 in 2013 – no information on any relationships in the two-year intervening period		
2014	Female 5	No further action due to insufficient evidence
2014	Female 5	Charged with ABH and bailed for trial
2014	Patient of ELFT	Moved to refuge to escape him
2015	Female 6	No action
2016	Hanna	No reports to police
2017	Female 2	No action
2018	Star	No reports to police
2018	Female 7	No action

5.4.2 There was a pattern of serious abuse that the women experienced, and this was very similar with each woman reporting similar abuse:

- False imprisonment
- Forced to have sex when did not want to (raped)
- Forced to have sex with men for money (exploited for sex)
- Gaslighting – 'never good enough'
- Physical abuse including:
  - Banged head on wall
  - Beaten with hammer
  - Burned with cigarette
  - Punch to face
  - Punched in stomach when pregnant causing harm to unborn baby
  - Stab wounds
- Raped:
  - Forced bottle and TV remote, and other items, inside women
  - Tied hands and feet to corners of the bed
  - Vaginal, oral and anal
- Sexual activity with a child (x 3) including sexual assault, physical abuse and forced marriage.
- Smashed phone so could not contact family and friends
- Threat to kill
- Threats – for example, to 'shove a knife up your arse'
- Threats to hurt family
- Threw food on the floor then made her eat it
- Throttled and grabbed by throat[101]
- Verbal abuse – called her 'retarded'

[101] Strangulation is discussed in more detail in Section Six – Further Analysis

- Would not let her go out on her own

The level of dangerousness that the perpetrator posed and the number of cases that were not charged and therefore did not proceed to court enabled him to continue to behave as he wished without any consequences. These reports, however, were known, albeit as intelligence rather than convictions but to say that the true risk that the perpetrator posed to any woman with whom he became involved was not identified is an understatement.

5.4.3 When the perpetrator was released from prison on 9th June 2013 with no probation supervision, he was subject to management, for the purposes of MAPPA, by the police at level 1. The risk that he posed was assessed as Level 1 medium risk based on RM2000[102].

5.4.4 Most offenders are managed at Level 1 when there is no need for formal MAPPA meetings. The lead agency will have sufficient powers to manage the offender effectively, but information sharing with other agencies is still required, and professionals' meetings are still be held, if required. The Risk Management Plan (RMP) should be sufficiently robust to manage identified risks, and any barriers to the implementation of multi-agency actions can be resolved via line management. Unresolved barriers should be referred to Level 2 or Level 3.

5.4.5 As the perpetrator was being monitored at Level 1 by the MPS Jigsaw Team, they were responsible for setting his risk level. This is done using a combination of actuarial tools (Risk Management 2000), OASys and Sexual Re-offending Predictor) and dynamic tools (ARMS) and professional judgement for risk assessment.

5.4.6 Under the Level 1 Risk Management Plan (RMP) the monitoring of the perpetrator was set out as:

(1) Ensure home visit (H/V) every 6 months, consider additional visits should there be information or intelligence to warrant it
(2) Ensure intelligence checks every month and record any significant intelligence
(3) Ensure compliance with RSO notifications and take appropriate action where there are any breaches
(4) Ensure subject's RMP is reviewed every 4 months or less as circumstances dictate
(5) Complete further risk assessments should there be any significant changes in circumstances and consider disclosure issues where appropriate
(6) Monitor subjects' relationships as this is where he has offended previously (against a partner)
(7) Consider disclosure to females that subject may associate with

5.4.7 By 23rd October the perpetrator had been sectioned and his risk assessment remained the same with the addition of the following actions:

(8) Liaise with Newham Centre for Mental Health
(9) Home visit to be carried out when released from hospital

5.4.8 When the perpetrator was visited at home on 22nd January 2014 his girlfriend (Female 5) was found in his room. He had not informed the police. By 20th July 2014 the perpetrator had been arrested on several occasions and had been charged with ABH on his Female 5. There was no change to the RMP.

[102] This assessment is based on RM2000 which was the police risk assessment tool at that time and measures the risk of re conviction as opposed to reoffending or harm

5.4.9 In December 2014 his RMP remained as medium despite Female 5 making several allegations of harassment, breaching his court order not to contact her and rape. Some allegations related to Wolverhampton where she was staying in a refuge. Whilst this was not proceeded with as the perpetrator provided evidence that Female 5 had been contacting him and had told him where the refuge was, this, in the view of this review, demonstrates that the perpetrator' pattern of behaviour continued, and he had no regard to the restrictions placed on him.

5.4.10 The perpetrator' behaviour continued, and he was arrested in June 2015 for False Imprisonment and ABH. Still his RMP remained at medium. This pattern continued:

- October 2015 – remained at medium despite an allegation of assault by the perpetrator which was not proceeded with as she did not feel able to make a statement
- March 2016 – remained at medium after he had become angry at Police Offender Manager and refused to engage
- December 2016 – remained medium despite the perpetrator cancelling four appointments to complete ARMs
- April 2017 – remained medium after a report from the hospital of the perpetrator being aggressive to the sister of the ward and the police being called
- December 2017 – remained medium despite the perpetrator saying he was back in a relationship with Female 2 and that she was pregnant. It was known that there had been a call to a domestic incident involving him at her address.
- April 2018 – intelligence checks showed that the perpetrator had come to the attention of the police and that Female 2 now had an injunction against him and the risk remained as medium

The review believes that at this point, although the perpetrator was being seen twice a year he continued his life, and relationships, while his abuse towards women escalated, with little or no challenge. The review considers that, given the perpetrator' history, these interactions should have prompted his risk being raised to high.

The review is advised that the OASys Sexual Reoffending Predictor (OSP) is a new actuarial risk assessment tool used by HMPPS and Police to assess all adult males convicted of a current or previous sexual or sexually motivated offence. Both the Probation Service and Police started using OSP on the same day, 1st March 2021. It has replaced the Risk Matrix 2000, which ceased being used from this date. The review is advised that it is more predictive than Risk Matrix 2000 and requires no formal training. Police officers will complete a simple spreadsheet, which will automatically calculate the risk level. All offenders who are Police led cases should have an OSP conducted at their next scheduled ARMS review. New offenders who are pending sentence and not under Probation supervision should have an OSP calculated upon first visit.

5.4.11 From December 2018 the perpetrator went out of his way to avoid the police entering his home address. They attempted, unsuccessfully, to visit on 11th, 12th and 13th December. the perpetrator then attended the police station on 14th December.

5.4.12 Further home visits were attempted on 31st December 2018 and 2nd January 2019. When a third home visit was unsuccessful on 31st January 2019, he was circulated for breach of notification requirements.

The review assumes that the perpetrator avoided police entering his flat as he had the bodies of his victims there.

5.4.13 Although the perpetrator was a Registered Sex Offender which allowed a framework in which he could be monitored, this raises the question about how agencies manage the risk that individuals such as the perpetrator pose and how this is managed when there are a limited number of convictions but a raft of reports or intelligence.

5.4.14 Whilst the review understands and agrees with the need to protect the confidentiality of all of us, it is considered that the pendulum has swung too far in favour of the 'offender' rather than the victim or potential victims. Agencies are concerned about breaching data protection and are fearful of challenges from individuals, therefore positive action is sometimes not taken out of fear of a legal challenge.

5.4.15 Whilst it would be easy for this review to recommend that agencies are less risk averse and consider the victims when making decisions about risk management, the review believes that this is a matter for the government to review the unintended consequences of data protection and legislation those who are vulnerable to predatory offenders like the perpetrator.

Recommendation

it is recommended that the Government commissions an independent review into the impact of data protection legislation on the ability of agencies to protect the public from predatory offenders.

5.4.16 The review also believes that there needs to be a review of all of the tools and powers available to manage men such as the perpetrator who may not have a long history of convictions but are clearly posing a risk to the public and those who are vulnerable in particular.

Recommendation

It is recommended that the College of Policing and HMPPS work together to provide comprehensive guidance into the management of manipulative individuals who do not have a long list of offences thereby excluding them from current systems such as MAPPA.

5.4.17 The review has considered whether the mental and physical conditions that the perpetrator had impacted on the risk that agencies considered that he posed. There is no doubting that the perpetrator' physical and mental health was complex. He had suffered with Crohn's Disease which necessitated operations and numerous emergency admissions to hospital. He experienced chronic pain from a trauma in 2017. The perpetrator was diagnosed with dissocial personality disorder and possible paranoid schizophrenia. the perpetrator was also known significantly abuse substances including cannaboids and prescription medication.

5.4.18 We are aware that when he was at the Mental Health Unit, the Jigsaw manager at the time attended and met with staff to carry out a disclosure check regarding his offending. This was also done when he was admitted to the hospital for surgery and issues with his Crohns. This was in accordance with the policy at the time.

5.4.19 Whilst he was, much of the time, in pain this does not excuse the violence and aggression that he posed to staff in both primary and secondary care settings. However, the review believes that these threats to staff and patients were possibly excused due to his presentation and diagnoses.

5.4.20 The review is not suggesting that staff both in health settings and those responsible for managing his risk, deliberately excused his behaviour but unconsciously his presentation may have led to staff unconsciously doing so.

Section Six – Further analysis

6.1 Analysis relevant to both Hanna and Star

6.1.1 STRANGULATION

6.1.1.1 The perpetrator had a history of strangulation of his victims and given the seriousness of this abuse and the recent changes in legislation this is discussed here in more detail.

6.1.1.2 The risk that strangulation places on victims is enormous. Research has found that a history of strangulation presents a seven-fold risk of death[103]. Loss of consciousness can occur within 5-10 seconds and death within minutes[104]. It is important to note that in many cases, even where the victim is killed, there is no external sign of injury[105].

6.1.1.3 Following a survey undertaken by Stand Up to Domestic Abuse[106], Professor Monckton Smith produced a report[107] from the data gathered. She highlighted that any kind of strangulation one of the strongest markers of future homicide.

6.1.1.4 On 7th June 2022 a new offence came into force. This made non-fatal strangulation and suffocation a specific offence as part of the Domestic Abuse Act 2021. The offence applies to British nationals abroad so perpetrators can be prosecuted in England and Wales for offences committed abroad. The offence will be triable in either a magistrates' court or the Crown Court. The maximum penalty on summary conviction in the magistrates' court will be 12 months' imprisonment and/or an unlimited fine. On conviction on indictment in the Crown Court, the maximum penalty is five years' imprisonment, giving it the same maximum penalty as Actual Bodily Harm (ABH) but , for the particular circumstances of strangulation and suffocation, does not have the same evidential requirements as ABH, that has posed problematic prosecuting in such cases[108].

6.1.2 USE OF VICTIM BLAMING LANGUAGE

6.1.2.1 The Chair and Report Author have observed in reports submitted to the review and, in part, in meetings, language used that could be described as victim blaming. For example, Star is referred to as a 'sex worker' when, in reality, she was a vulnerable woman who was being exploited and coerced into having sex. This was also seen in relation to several the women who had encountered the perpetrator.

The review believes that a simple change of language can have a substantial effect upon thinking – if we refer to them as 'women who have been exploited' then the fact that they have a chaotic lifestyle, or may be difficult to engage with, comes into the correct context or disappears altogether. This then changes the way in which view the support that they need.

[103] Glass et al, 2008, Non-fatal strangulation is an important risk factor for homicide of women cited in Centre for Women's Justice, Submission for Domestic Abuse Bill, January 2021
[104] Taliaferro E, Hawley D, McClane GE and Strack G, 2009, cited in Ibid
[105] Strack G B, McClane G E and Hawley D, 2001, cited in Ibid
[106] https://sutda.org/nfs/
[107] https://sutda.org/wp-content/uploads/Non-fatal-strangulation-Survey-June-2020-.pdf
[108] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/strangulation-and-suffocation#how-are-we-going-to-do-it

6.1.2.2 Below is a table that was used at a seminar given by Standing Together and provides examples of phrases used in MARAC meetings (these are general and not drawn specifically from your IMRs.)

Changing the language from	To
'She keeps changing her accounts to services so we don't know what actually happened	There is a risk of coercive control due to the variety of accounts given by the victim/survivor to agencies
There is no evidence to corroborate her account	There is insufficient evidence against the perpetrator for further action to be taken
These are just allegations	The victim/survivor has disclosed abuse
The onus is on the victim/survivor to engage with us	Does anyone have any suggestions on how to safely engage with the victim/survivor?
She let him in, despite there being bail conditions in place	The perpetrator broke his bail conditions by attending the address
The victim/survivor failed to engage	Our agency was unable to engage with the victim/survivor
The victim/survivor is continuing to have contact with the perpetrator despite the risks	There is a risk due to the perpetrator continuing to have contact with the victim/survivor
She has placed herself at serious risk of abuse because of her substance use	The victim/survivor has substance use issues which increases her vulnerability

Learning Point

A change in language amongst all practitioners will positively alter mindset and will make a huge difference to the way engagement with and support for vulnerable women with complex needs is considered and delivered

6.1.3 **LACK OF ENGAGEMENT**

6.1.3.1 On several occasions, Star is described as 'not engaging' with services. It is really important that, given Star's life experience (and that of other women), this is framed in the correct way. It is not that Star refused or failed to engage but rather that agencies were unable to find a way to *enable* her to engage.

6.1.3.2 It is important that we remember that the long term and repeated trauma that Star faced will have impacted on her trust of officials and agencies, this lack of trust will have been sustained over a long period of time and will have contributed to her expectations and hopes of agencies.

6.1.3.3 It is noted that, at no point, was Star referred to a service that was a specialist at supporting women from BME groups, in this case Turkish women. It is too easy to think that a service has been offered but it may not be in a way that is culturally relevant to that woman or in an environment where she feels that she, and her culture, are accepted and understood.

Whilst this review has been ongoing, a scoping exercise of the specialist services in the area is undertaken and this has been shared across the partnerships locally.

6.1.4 **DESERVING OR UNDESERVING?**

6.1.4.1 The review sought to explore if there is a sense of some people being 'undeserving' of support. One of the questions the review panel has sought to answer is whether Star was seen as what mysogonist old attitudes may have described as a 'drug using sex worker and as someone who had made her own 'choices' to act in that way. We want to challenge such attitudes and language. We have considered whether this impacted on the support she received and whether women are penalised more harshly than men in similar situations or are marginalised when they discuss their experiences or express coping behaviours and their strategies to survive adversity. Bose (2020)[109] said that, when we tell girls that they mature faster than boys we are indirectly teaching them that the onus to be the 'bigger person' sits with them and will always be with them. It excuses the behaviours of men and places the responsibility onto women to behave better.

6.1.4.2 There is a danger that agencies view strategies used to survive adversity as being synonymous to 'unwise decisions' without consideration to the impact of trauma, substance misuse and coercion and control informing those strategies. This is all too often overlooked, and women are treated based on their actions rather than on the reasons for their actions.

6.1.4.3 One view may be that, whilst practitioners would not *consciously* make this distinction there is a danger that it is made unknowingly. This may be because one of the barriers to accessing support is a client's apparent willingness to engage with the support being offered. There is a sense that if support is offered and is not accepted by a client, there is a pressure to 'move on' and offer the support to someone else.

6.1.4.4 Another possibility is that it is not so much that they had a label of 'undeserving' but that they had a label of 'not willing to engage'. Services are not flexible and responsive to the needs of service users so there might be a sense of 'we tried this before and it did not work' and this needs to be balanced against the possibility that someone may be now in a position to engage and, if not this time, maybe next time.

6.1.4.5 The review acknowledges that systems are so overworked that there may a tendency if a client is not willing to engage then services are moved to someone who will.

6.1.4.6 There is a danger that if people don't 'get better' that we consider them undeserving of services. As services are under pressure, professionals may look for reasons *not* to support them and a lack of understanding of trauma informed care can exacerbate this.

6.1.4.7 Another possibility is that legislation can force people into a box of 'deserving' or 'undeserving' but the box has a more 'professional' name such as eligible/ineligible for services. For example, housing legislation uses such terms as 'intentionally homeless' and 'no local connection' which feed this idea of being undeserving. This requires a change at a national level.

6.1.5 **UNCONSCIOUS BIAS**

6.1.5.1 Firstly, what is meant by unconscious bias. Imperial College London[110] has described it as a term that describes the associations we hold, outside of our conscious awareness and

[109] Published on Qrius in January 2020 https://qrius.com/girls-mature-faster-than-boys-a-phrase-that-needs-to-retire-with-2019/
[110] https://www.imperial.ac.uk/equality/resources/unconscious-bias/#:~:text=What%20is%20unconscious%20bias%3F,making%20quick%20judgments%20and%20assessments.

control. Unconscious bias affects everyone. It is triggered when by our brain automatically making quick judgements and assessments. It is influenced by our background, personal experience, societal stereotypes, and cultural context. Unconscious bias can have a significant influence on our attitudes and behaviours, especially towards other people.

6.1.5.2 There are different forms of unconscious bias, and we can begin to see how these may have played into the way that Star was dealt with by services:

- *Affinity or similarity bias* is the tendency to favour people who are like us in some way
- Once we have decided or form an opinion, we tend to look for or value further information that confirms this. This is called *confirmation bias*. We may end up interpreting things in a certain way or ignoring other information that contradicts our confirmation bias.
- *The halo effect* occurs when one perceived feature or trait makes us view everything about a person in a positive way, giving them a 'halo'. However, we may not know that much about the person and the halo can lead us to ignore other aspects. The *horn effect* is the opposite – when we focus particularly on one negative feature.

6.1.5.3 If left unchecked unconscious bias can lead to, at best, lazy stereotypes and, at worst, judicial or discriminatory behaviours[111]. It is incredibly important that we do not dismiss this possibility by assuming that we are too professional to have unconscious bias. Research has shown that across all social groups this is not the case. We are all influenced in ways that are completely hidden from our conscious mind.[112]

6.1.5.4 This leads to the question about what individuals and agencies involved in this review should do in response. Professor Frith[113] suggests that the very act of realising that there are hidden biases can enable individuals and organisations to mentally monitor and ameliorate any hidden attitudes before they are expressed in many decision-making.

The review identifies changes that can be made:

- **Question cultural stereotypes that seem untruthful**
- **Be open to see what is new and unfamiliar and increase your knowledge of those groups**
- **It is easier to detect unconscious bias in others than in yourself so be prepared to call out bias when you see it**

6.1.5.15 The danger is however, that by focusing on unconscious bias, the responsibility moves from an organisation and institution to individuals. It is important that organisation's review their policies and see if they are discriminatory in their practice. Barbara Cohen says, 'that overcoming the results of unconscious bias requires a personalised solution for each individual, which can operate against achieving coherent organisational change'.[114]

6.1.5.16 This issue of deserving and undeserving goes much deeper than just agency's responses. It is also about how, as a society, we respond. Many of the panel members reflected a view of their clients that BME women are not seen as victims in the public's eye. This is complicated with racism and discrimination. A key question the review panel asked was 'how do we get

[111] Unconscious bias, Professor Uta Frith, The Royal Society, https://royalsociety.org/-/media/policy/Publications/2015/unconscious-bias-briefing-2015.pdf
[112] Daniel Kahneman, Thinking, Fast and Slow, Good Reads, 2011 cited in Ibid
[113] Unconscious bias, Professor Uta Frith, The Royal Society, https://royalsociety.org/-/media/policy/Publications/2015/unconscious-bias-briefing-2015.pdf
[114] The Stephen Lawrence Inquiry Report: 20 years on, Barbara Cohen, Runnymede, February 2019

the public to think of victims of Violence Against Women and Girls (VAWG) as not just being white women?'

6.1.5.17 It is unarguable that a good proportion of the public form their views, impressions, and opinions from what they read in the media. The media will publish those stories that are newsworthy and will drive traffic to their outlet. The media will use published data to formulate their stories.

6.1.5.18 Recent research[115] set out to ask the question 'how much racial disparity in trends of homicide victimisation rates in England and Wales is obscured by the failure of official statistics to report rates of death per 100,000 people at risk?' has shown a lack of transparency in the way in which homicide data is recorded by the Office for National Statistics. Whilst this research is based upon homicide victims and not specifically domestic homicide victims, it does demonstrate how the way that data is recorded will affect the perception of the reader. The ONS data, while providing the number of homicide victims, does not record this per 100,000 population.

Year	Black	Asian	White	Other
2017-2018	95	51	477	20
2018-2019	97	42	475	24

Homicide victims by ethnicity in England and Wales[116]

6.1.5.19 Understandably these figures may lead one to a view that homicide is not as big an issue for BME communities as it is for white. However, if the data is recorded per 100,000 population a different picture, and a very different narrative emerges.

Year	Black	Asian	White	Other
2017-2018	5.1	1.7	1.0	0.8
2018-2019	5.6	1.4	1.0	1.4

Homicide victimisation rate per 100,000 population by ethnicity in England and Wales[117]

6.1.5.20 Unconscious bias can influence key decisions made in the workplace and can contribute to inequality[118].

The review has been advised that a needs assessment is planned that will lead to the development of a strategy related to women who sell sex/experience sexual exploitation and multiple disadvantage. This work will include a whole systems approach to look at the elements that lead to unconscious bias and will include:

- **Reflection on learning from this DHR-** understanding trauma and how it contributes to multiple disadvantage through homelessness, domestic abuse, substance misuse and mental health.
- **Embedding a gender based and VAWG lens -** creating a systems change where women experiencing multiple disadvantage are supported as women in need of support and services rather than being judged through their needs or roles applied to then due to their gender.

[115] Racial Disparities in Homicide Victimisation Rates: How to Improve Transparency by the Office of National Statistics in England and Wales, Kumar et al, Cambridge Journal of Evidence-Based Policing, 2020
[116] Ibid
[117] Ibid
[118] https://www.imperial.ac.uk/equality/resources/unconscious-bias/#:~:text=What%20is%20unconscious%20bias%3F,making%20quick%20judgments%20and%20assessments

- **Addressing intersectionality** ensuring that all services provide training on addressing intersectionality to ensure that professional understand the barriers people may face when trying to access services and that that their practice aligns with anti-oppressive values. This area should be addressed through supervision and case file auditing.
- **Understanding and addressing multiple disadvantage -** ensuring all LBN staff will receive training and and support to address homelessness, sexual exploitation and gender based abuse.

6.2 Analysis specific to Hanna's circumstances

6.2.1 NO RECOURSE TO PUBLIC FUNDS (NRPF)

6.2.1.1 This has been a feature of immigration policy since 1971 and those with NRPF are mostly unable to apply for benefits, tax credits and housing assistance although they are eligible for some local-authority funded education and social care[119].

6.2.1.2 Those with NRPF are overwhelmingly individuals who are already vulnerable such as victims of domestic abuse and modern slavery, as Hanna was. Having NRPF limits the ability of victims of domestic abuse and modern slavery to report the crime and access the support that they need to escape from the situation[120].

6.2.1.3 Hanna was a victim of human trafficking consequently her immigration status was insecure, as a result she was not eligible to access public funds through the state. This increased her vulnerability to homelessness, 'sofa surfing', sexual exploitation through prostitution and entering into relationships with men that very quickly became physically abusive and controlling.

6.2.1.4 When Hanna was in hospital following a serious assault many professionals tried to signpost her to help but were constantly advised that she had no recourse to public funds.

6.2.1.5 **Victims of domestic abuse**

6.2.1.6 Those who are victims of domestic abuse but have NRPF have some options available. If they came to the UK on a spouse or partner visa, they could apply for financial support through the Destitution Domestic Violence Concession (DDVC) and indefinite Leave to Remain under the Domestic Violence Rule (DVILR) although this does require evidence of abuse which can be difficult to collect.

6.2.1.7 This does exclude those who entered the country with other types of visas including tourist visas, student or working visas.

6.2.1.8 All those how have NRPF are entitled to support from the local authority if they have children (via section 17 of the Children Act) and are deemed eligible to support under the Care Act.

6.2.1.9 This leaves a gap for those who have NRPF but have no children, are not on a spousal visa or are not former EEA citizens.

[119] Out of the Shadows, The Centre for Social Justice, December 2021
[120] Ibid

6.2.1.10 **Victims of modern slavery**[121]

6.2.1.11 Victims of modern slavery with NRPF have the option of entering the National Referral Mechanism (NRM) which gives them access to some short-term support and protection from the Home Office. A victim does not apply directly but is referred by a designated First Responder who identifies indicators of modern slavery and, with the person's consent, submits their details to the Home Office. We know that, when Hanna went into hospital following the fall from the balcony, she was referred to the NRM.

6.2.1.12 At a minimum, support is provided for 45 days but delays in decision making result in support often being available for longer. This does not constitute general recourse to public funds or access to mainstream benefits for its duration and afterwards. At the end of the NRM process if someone is formally confirmed as a victim of modern slavery, as Hanna was, they are entitled to a 45 day 'move on period' of additional support. This can be extended by the Home Office under the Recovery Needs Assessment (RNA) process if victims have ongoing recovery needs that cannot be met by mainstream or asylum services. Victims with NRPF are not eligible for mainstream services so may need this extension. The study by The Centre for Social Justice estimated that the average length of support under the RNA was 57 days and 53% of support requests were approved in full during the first 10 months of the scheme[122].

6.2.1.13 Those who are victims of modern slavery receive no immigration status at the end of the NRM process. Some may apply for asylum and others are entitled to apply for discretionary leave to remain for 12-30 months where leave is necessary according to their personal circumstances.

6.2.1.14 Hanna had a face-to-face assessment with officers from the NRM on 31st January 2016 and on 3rd May she received her Positive Conclusive Grounds decision accepting that she had been a victim of human slavery. Unfortunately, having moved back to London to be with the perpetrator on 17th March, Hanna disengaged from the NRM support.

6.2.2 **BARRIERS TO ACCESSING SUPPORT FOR THOSE WITH NRPF**

6.2.2.1 **Immigration abuse**

6.2.2.2 The Domestic Abuse Commissioner highlights in her report[123] that perpetrators of domestic abuse can use a victim's insecure immigration status to exert further power and control.

6.2.2.3 Whilst immigration abuse sits within economic abuse and/or coercive control, immigration abuse is unique in that it is exacerbated by immigration legislation and policy. The individual's level of vulnerability is compounded by the perception or threat of immigration enforcement and the authority that these powers hold.

[121] Out of the Shadows, The Centre for Social Justice, December 2021

[122] Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-Statutory Guidance for Scotland and Northern Ireland, Version 2.5, Home Office, November 2021 [Accessed via: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1031731/modern-slavery-statutory-guidance-_ew_-non-statutory-guidance-_sni_v2.5-final.pdf] cited in Out of the Shadows, The Centre for Social Justice, December 2021

[123] Safety Before Status, Domestic Abuse Commissioner, 2021

6.2.2.4 The Domestic Abuse Commissioner asked the Angelou Centre to provide a definition of immigration abuse. They suggested, 'Immigration abuse is a form of perpetration that uses the 'insecure', 'uncertain' or 'unknown' immigration status of an individual (or their dependents) to threaten, coerce, exploit and/or subjugate them (or their dependents) as part of a pattern of control and/or abuse and violence.

Recommendation

It is recommended that CYPS and ASC work together to develop guidance on NRPF and all forms of domestic abuse and then develops messaging that makes clear that accessing specialist support is not reliant on immigration status.

6.2.2.5 **Lack of awareness among agencies of the pathways available to those with NRPF**

6.2.2.6 The Angelou Centre, commissioned by the Domestic Abuse Commissioner[124], found that, despite the Home Office's Statement of Expectations setting out that all areas should have an NRPF strategy and an agreed pathway for this group of people. It was clear that the different practitioners did not know how to overcome the barriers that having NRPF placed on them providing support to Hanna to keep her safe.

Recommendation

It is recommended that , as part of the guidance on NRPF includes information about the agreed pathways for those with NRPF.

6.2.2.7 **Accommodation**

6.2.2.8 The NRPF conditions mean that a person not eligible for local authority housing, so victims must identify as a victim of modern slavery or domestic abuse.

6.2.2.9 Accommodation is not routinely available for modern slavery victims until they receive a positive first stage 'reasonable grounds' decision under the NRM unless the person is considered destitute or eligible for asylum accommodation.

6.2.2.10 Research has highlighted concerns about significant numbers of modern slavery victims living in unsuitable asylum accommodation, often with multiple occupancy and mixed genders, which can be especially distressing for those who have been victims of sexual exploitation and those who have suffered trauma[125].

6.2.2.11 Professionals[126] have repeatedly said that victims need time and space to make an informed decision about whether to enter the NRM, but no accommodation is available for victims with NRPF to allow them time to consider their options prior to referral. If adult victims do

[124] Safety Before Status, Domestic Abuse Commissioner, 2021

[125] British Red Cross, Far From a Home: Why Asylum Accommodation Needs Reform, March 2021 [Accessed via: https://www.redcross.org.uk/far-from-a-home]; Hibiscus Initiatives, Closed Doors: Inequalities and injustices in appropriate and secure housing provision for female victims of trafficking who are seeking asylum, November 2020 [Accessed via: https://hibiscusinitiatives.org.uk/wp-content/uploads/2020/12/2020_11_24-HI_Closed-Doors_Main-Report_FINAL_DIGITAL.pdf] cited in Ibid

[126] Ibid

not wish to enter the NRM for any reason (and many will fear authorities) then they face two options – destitution or staying with their trafficker.

6.2.2.12 The Domestic Abuse Commissioner[127] has highlighted that, for victims of domestic abuse with NRPF, there is an additional layer of economic dependency on the abusive partner. As they are not eligible to access Housing Benefit that is used to fund most refuge bed spaces and other forms of safe accommodation. The provision of refuge places for women with NRPF is much lower than the demand. Women's Aid[128] found that only 4% of all refuge vacancies listed in 2019-20 could consider women who had NRPF.

6.2.3 PROTECTING VULNERABLE PEOPLE IN HOSPITAL

6.2.3.1 The review found that as the perpetrator had both physical and mental health conditions that necessitated him attending hospitals (both acute hospitals and mental health hospitals) for both outpatient and inpatient treatment. This afforded him access to many vulnerable people and we know that Hanna met him whilst in hospital after being assaulted, as did others who experienced is abusive behaviour.

6.2.3.2 As the perpetrator was a MAPPA nominal there was a requirement for agencies to be advised of his status. Good and safe practice would suggest that, as hospitals should be notified as he status as a registered sex offender and the potential risk that he posed, then these vulnerable women would be safe as hospital staff would be able to manage him in a way that limited his access to other patients. Unfortunately, the reality is not as straight forward as good and safe practice might suggest that it should be. We know that every hospital has its own standalone computer systems and, even within one hospital, there will be numerous systems that do not talk to each other.

6.2.3.3 Accepting this limitation, good and safe practice might suggest that a flag is placed on an individual's (in this case the perpetrator's) records to highlight their risk status. Unfortunately, not all hospital systems allow a flag to be placed and, in some cases, once a flag is placed it does not appear at the front of everyone's record so, a practitioner opening the record, may not see the flag as it is lost in the history.

6.2.3.4 The review has considered, if all hospital staff could know about the perpetrator's risk, how they could actively manage that on a day-to-day basis. Hanna was not on the same ward as the perpetrator and met him when going out for a cigarette. It is unreasonable to manage how she does this, so the onus is on managing the movements of the perpetrator.

The review acknowledges that it has asked questions and raised concerns without recommending any solutions. This is a national issue that is beyond the remit of this review to address or solve but it is, in the interests of the safety of the public, imperative that this issue is acknowledged and that the Government uses the appropriate channels to consider this as a matter of urgency.

Recommendation

It is recommended that the Secretary of State for Health and Social Care ensures that these issues are reviewed as a matter of urgency.

6.3 Analysis specific to Star's circumstances

[127] Safety Before Status, Domestic Abuse Commissioner, 2021

[128] Women's Aid. (2021) The Domestic Abuse Report 2021: The Annual Audit, Bristol: Women's Aid.

6.3.1 **THE MISSING PERSON ENQUIRY**

6.3.2 Star was reported missing by her family on 10th May 2018 and was ultimately found deceased on 27th April 2019. When Star was reported missing a missing person report was recorded and it was graded as medium risk. It remained medium risk throughout the enquiry. Star's family have expressed concerns about how this enquiry was undertaken and this has been subject to an investigation by the Independent Office of Police Conduct (IOPC).

6.3.3 Star's family have been particularly concerned about their perceived lack of publicity as part of the missing person enquiry and the onus that was on them to raise awareness of her missing status.

6.3.4 Whilst it is not within the remit of this review to revisit an IOPC investigation it is important to note that the remit of each report is somewhat different. The IOPC will have looked at whether there was any misconduct or immediate learning for MPS. The DHR has a broader remit – not only to consider if policy has been adhered to but also whether that policy is correct. One of the questions the review has sought to explore is whether there is unconscious bias in this policy.

6.3.5 **The risk identified and the enquiry**

6.3.6 The missing person enquiry had 441 separate actions and the IOPC identified that a great deal of work had been undertaken in this missing person enquiry. There were a number of officers who had responsibility for this enquiry and they, and their supervisors, recognised that this was a difficult and concerning disappearance.

6.3.7 The enquiry had initially been assessed as medium. There are, within the MPS Missing Persons Policy definitions of a missing person and the different risk gradings.

6.3.8 The MPS definition states that a person is 'missing' when their whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another'. Missing person reports are risk graded and the MPS definitions are:

High risk – The risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability; or have been the victim of a serious crime; or the risk posed is immediate and there are substantial grounds for believing that the public is in danger.
Medium risk – The risk posed is likely to place the subject in danger or they are a threat to themselves or others.
Low risk – There is no apparent threat of danger to either the subject of the public.

6.3.9 The rationale for grading Star's disappearance as medium was recorded in the Merlin report as,
'I have read and noted the facts within this report. Subject reported missing by her sister - she hasn't seen her for 2 months. Subject is a drug user and is believed to be a sex worker funding her drug habit. She is also a rough sleeper. Subject has depression and is also anorexic. Subject has gone missing before and has turned up safe and well. Although she has mentioned previously harming herself. Based on the facts given I confirm this is as medium risk at this stage. It appears that the subject has NFA, but previous intel suggests

that a last known address was on (another London Borough) - transfer request has been declined. HT81 to complete the following:

2. Call the subject
3. Attend mother's home address
4. Hospital checks
5. Custody checks
6. #TE

6.3.10 The risk remained as medium but there were a number of occasions when officers considered upgrading Star to a high-risk missing person. In July 2018 it was recorded that there had been significant discussion about the risk level and there had been much debate about the risk level.

Given the description of Star given in the Merlin report, the review has considered whether unconscious bias may have played a part in this risk assessment.

6.3.11 **The media generated around Star's disappearance**

6.3.12 For a family member it is not unreasonable that they would consider that a high priority in finding their loved one is to let as many people as possible know that they are missing. Star's family feel that not enough was done and that they took the lion's share of raising awareness of her disappearance. The way in which the police handled the missing person enquiry and, in particular, the use of publicity has been subject of an independent review by the Independent Office of Police Conduct (IOPC) and therefore this review has not sought to scrutinise this but has noted the findings of the IOPC investigation.

6.3.13 There were 441 tasks were generated in relation to this enquiry and MPS took the following action in relation to publicity:

29th May 2018	Publication in Big Issue
18th September 2018	Missing Poster Tweeted on Twitter
2nd November 2018	Publication in Big Issue
26th February 2019	DCC design studio contact to have posters made with MPS Logo. Awaits cost and authorisation for posters to be used on social media
2nd April 2019	100 poster production request emailed to DCC design studio
5th April 2019	Posters approved by Press Bureau and submitted for printing
13th April 2019	Posters collected
14th April 2019	Email to BTP for poster distribution.
25th April 2019	Email to Big Issue, Daily Mirror, and The Pavement for re-publication of media appeal
26th April 2019	Confirmation from BTP about poster distribution.

6.3.14 The IOPC recognised the proactive work undertaken by Star's family in regularly delivering posters and making appeals via social media. Many of the sightings that the police were able to follow up came through this activity.

The MPS released a refreshed Missing Person Policy this year (13 April 2022). The MPS response to missing is aligned to the College of Policing Authorised Professional Practice APP with the exception of the handling category *'No Apparent Risk'*. . The vast majority of UK forces (all but 2) have abandoned this category in light of its recognised limitations.

6.3.15 The 2022 policy guidance is set out across three core documents and follows a practical 'Incident Development' format. This means officers can identify where in the response their role lies and understand expectation against MPS process (Resource and Demand Teams(RaDT), Emergency Response Policing Teams(ERPT), Missing Person Unit(MPU)).

- Pre-48 hours Incident Development – This part aligns WHAT is expected with HOW we can best deliver it. Handling & Risk assessment decisions, High Risk/Identified Complex Concern pathways, all case bespoke investigative plans and continued oversight under ERPT Incident Managers and RaDT. Merlin completion standards and enhanced concerns are also covered.
- Post-48 hours Incident Development – This covers the ongoing investigation within the MPU and wider resources. Protracted investigation and review expectation are reflected here.
- Incident Closure – The appropriate recognition of vulnerability within a Prevention interview, capture and sharing of information and the appropriate handling of Merlin, PNC and publicity matters is outlined here.

6.3.16 Within the new guidance attached its details: -

- A referral to the Homicide Teams should be made in cases where there is a substantive reason to suspect life has been taken or is under threat. Utilise BCU buddy arrangement to initiate timely contact – DCI to DCI.

- The implementation and use of THRIVE+ (MPS Decision making framework)

- The Importance of Informant Contact & Engagement (It details - Family Liaison Officers (FLO) are often considered for high-risk cases. However, we must be mindful of the needs of the informant in all cases, whether or not a FLO is considered. How we approach contact and encourage engagement with the informant, particularly with family members, can have a huge value for investigations, as well as deliver appropriate and necessary care and support for those distressed by the disappearance of someone close to them.

6.3.17 The policy was publicised on the MPS intranet, operational notices and is accessible for all staff on the MPS SharePoint.

Section Seven – Lessons Identified

7.1 When a contract moves from one provider to another, it is imperative that historical client information is not lost but is retained for future reference.

7.2 Hospitals must use this case to scrutinise whether vulnerable patients, such as Hanna, are not exposed to further danger from predatory sex offenders within their hospital environment. We recognise that this is a difficult balance between the freedom of choice for a patient such as Hanna to visit other parts of the Hospital but it is clear that this perpetrator actively targeted women within hospital settings and as such it should be a wake-up call for all hospitals to ensure patients are protected.

7.3 That MPS officers should take every opportunity to seek advice from other units when conducting a Missing Person Enquiry.

7.4 That whilst some clients can be difficult for agencies to engage, every effort should be taken to exhaust all avenues before a service closes the case.

7.5 All practitioners must continually be professional curious in their engagement with all patients/clients, particularly those with complex lives and needs.

7.6 There is a need for staff to ensure that they are fully researching clients before visiting at home and Lone Working Policies should always be followed.

7.7 Throughout the 15-year period that the review covers, delay in PNC circulation for an outstanding suspect where there are known risk such as DA, Violence to Females and known RSO appears to be a common theme.

7.8 GPs were not notified of safeguarding concerns when the perpetrator was in hospital.

7.9 The level of dangerousness and the true risk that the perpetrator posed was not identified across all agencies.

7.10 Data protection legislation had unintended consequences in that agencies are concerned about breaching data protection rules at the expense of protecting vulnerable people.

7.11 The term 'trauma informed' is used without there being any sense of a shared understanding of what is meant by the term.

7.12 A change in language amongst all practitioners will positively alter mindset and will make a huge difference to the way engagement with and support for vulnerable women with complex needs is considered and delivered.

7.13 The term 'not engaging' was used on multiple occasions to refer to Star when what was actually meant was that agencies had not found a way to engage with her.

7.14 There is a need for local agencies to be honest about the potential for unconscious bias and to address this in a realistic way.

Section Eight - Recommendations

8.1 **BARTS HEALTH NHS TRUST**

8.1.1 It is recommended that the Hospital Trust (and others across London) reviews its hospital security against this case to ensure that it is aware of dangerous patients, particularly registered sex offenders, who may be within their environ and does all it can to prevent the targeting the targeting vulnerable patients in their care.

8.1.2 It is recommended that GP letters should contain information regarding any safeguarding risks identified in hospital as well as the discharge arrangements.

8.2 **COLLEGE OF POLICING AND HMPPS**

8.2.1 It is recommended that the College of Policing and HMPPS work together to provide comprehensive guidance into the management of manipulative individuals who do not have a long list of offences thereby excluding them from current systems such as MAPPA.

8.3 **COMMUNITY SAFETY PARTNERSHIP**

8.3.1 It is recommended that this DHR is shared with Safeguarding Children's Board who consider if the support provided to women in the borough whose children is taken into care is sufficient and meets their needs.

8.4 **EAST LONDON NHS FOUNDATION TRUST – NEWHAM ADULT MENTAL HEALTH DIRECTORATE**

8.4.1 It is recommended that teams across the Directorate are briefed on the process for requesting police records check for arrests and convictions where there are concerns around a service user's offending/arrest history and it is proportionate and necessary for the Police to share this information.

8.4.2 It is recommended that Teams across the Directorate understand the Forensic Outreach Service process for requesting a forensic Psychiatric assessment and that there is a local process for ensuring the assessment is conducted and documented.

8.5 **LONDON BOROUGH OF NEWHAM**

8.5.1 It is recommended that CYPS and ASC work together to develop guidance on NRPF and all forms of domestic abuse and then develops messaging that makes clear that accessing specialist support is not reliant on immigration status.

8.5.2 It is recommended that, as part of the guidance on NRPF, information is included about the agreed pathways for those that have NRPF.

8.5.3 It is recommended that all agencies in Newham contribute to the development of the strategy for women who sell sex/experience sexual exploitation and multiple disadvantage.

8.6 **MARAC STEERING GROUP**

8.6.1 It is recommended that the MARAC Steering Group ensures that the protocol is updated to ensure that multiple part actions are recorded and monitored for completion separately.

8.6.2 It is recommended that the MARAC Steering Group monitors the introduction of this change in order that the CSP can be assured that it is being implemented consistently.

8.6.3 It is recommended that further training is provided to referring agencies which highlights the importance of clear, concise information around the current risks being provided and separated from historic, background information.

8.7 **METROPOLITAN POLICE SERVICE**

8.7.1 It is recommended that all NE BCU SLT remind staff of the MPS Missing Person Policy around Homicide consultation, and that risk grading is not a barrier for seeking advice from colleagues in other MPS Units.

8.7.2 It is recommended that NE BCU SLT dip-sample the outstanding suspects within the Public Protection and those on ViSOR to ensure circulation guidance is being followed for wanted offenders.

8.7.3 It is recommended that NE BCU SLT conduct a dip sample of CADs relating to Public Protection crimes where scheduled appointment have been booked to ensure the correct action is being taken by officers in completing CRIS reports where appropriate. Any identified deficiencies should be incorporated into BCU training.

8.7.4 It is recommended that NE BCU SLT dip-sample that NE BCU SLT dip-sample the outstanding suspects within the Public Protection and those on ViSOR to ensure circulation guidance is being followed for wanted offenders.

8.7.5 <u>MPS Continuous Policing Improvement Command (CPIC)</u>
It is recommended that CPIC review the current domestic abuse policy to ensure guidance is available to staff about the actions to take when a domestic abuse victim is not engaging in contact with an investigation.

8.7.6 It is recommended that upon guidance from NPCC and College of Policing in relation to Serial Domestic Abusers and Stalkers being tracked, monitored and managed under MAPPA and ViSOR being received, consideration for a Warning Marker on PNC is given to reflect such status. Consideration should be given to learning from this review which highlights the potential for such to have improved the Police response to incidents.

8.8 **NORTH EAST LONDON INTEGRATED CARE BOARD**

8.8.1 It is recommended that the ICB ensures that all GP practices are clear about the contractual requirements regarding deregistering patients.

8.8.2 It is recommended that the ICB ensures that all practices are up to date with mandatory safeguarding training.

8.8.3 It is recommended that the ICB uses this case to provide a briefing to GPs, reminding them of the need to spend time understanding the patient in front of them and employing professional curiosity particularly in relation to patients who are subjected to multiple disadvantages.

8.8.4 It is recommended that, if the bid for funding of IRIS is successful, the ICB identifies long term funding for the programme. If the bid is unsuccessful, it is recommended that funding is secured to introduce IRIS to the borough.

8.9 **UK GOVERNMENT**

8.9.1 It is recommended that the Government commissions an independent review into the impact of data protection legislation on the ability of agencies to protect the public from predatory offenders.

8.9.2 It is recommended that the Secretary of State for Health and Social Care ensures that these issues are reviewed as a matter of urgency.

Section Nine – Conclusions

9.1 Anyone who reads the circumstances of this case is likely to be struck by three main elements; the desperately sad decline and vulnerability of Star as she struggled with what life threw at her, the clear vulnerability of Hanna who had been abused by so many men throughout her life, and ineffectiveness of a system that allowed this perpetrator's true risk to be unrecognised.

9.2 This review has sought to look at those elements outlined above in an effort to learn lessons to better protect others in the future.

9.3 This has been a complex and detailed review. This report is equally complex and detailed, but it is done in order to spell out the awful circumstances of this case and to do some level of justice to the memory of both women. We also recognise the abuse that this perpetrator subjected many other women to during his offending history.

5.1 We have debated Hanna and Star's vulnerability. In particular, in Star's case, the effect upon her of losing her children into the care system and the impact of the trauma and abuse experienced on her emotional well-being and subsequent substance misuse, looking at what we can learn from service involvement with her. In Hanna's case, it is clear that she was subjected to multiple levels of abuse for many years leaving her especially susceptible to a predator such as this perpetrator.

9.4 We have looked at the evidence of vulnerability within Hospital settings where this perpetrator was able to target a number of vulnerable victims.

9.5 We have also looked at this perpetrator's history of offending and behaviour. His true risk, his 'modus operandi' of targeting vulnerable women in hospital settings and his capability for extreme inter-personal violence were not truly identified. We have looked at why and what we can learn to ensure others are properly subject to better scrutiny and intervention.

9.6 We believe this review has looked at each of the specific areas of the original terms of reference, however, as with many reviews as the information evolves so do the areas for scrutiny and attention.

9.7 This review has made a number of wide-ranging recommendations and urges all those involved in safeguarding the vulnerable and intervening with likely perpetrators to learn from this review.

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the deaths of Hanna

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Newham Community Safety Partnership in response to the death of Hanna whose body was found in April 2019. The named Perpetrator has been found guilty of her murder.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the discovery of the victim's body in April 2019 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Hanna.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Identify good practice.

2.4 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.5 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.6 Contribute to a better understanding of the nature of domestic violence and abuse.

3. The review process

3.1 The review will be undertaken in accordance with the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victims died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Draw up a chronology of the involvement of all agencies involved in the life of Hanna Szucs to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.2 Produce IMRs. The scope will of these reviews will be:

- Hanna – 16th September 2014 to 11th November 2016
- The Perpetrator – relevant life events or criminal history to 19th April 2019

4.3 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Consider and analyse key practice episodes within the timeframe, including services responses to family and friends and sharing of information.

4.5 To consider if professionals had a good understanding of risk and whether risks were identified and responded to appropriately. This will include identification of any escalation of offending by the perpetrator.

4.6 The review will pay particular attention to the vulnerability of the victim. It will consider all factors affecting her vulnerability including, but not exclusively any prejudice arising from their status as non-UK residents, culture, ethnicity, financial independence, social and family isolation, their health (including mental health) and how this may have impacted on her ability to engage with services who could have supported them.

4.7 Produce a report that summarise the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families where domestic abuse is a feature as well as identifying good practice.

4.8 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the family informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the families are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Newham Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Gary Goose and Christine Graham
Independent Chair and Overview Author

Terms of Reference for the Domestic Homicide Review into the death of Star

1. Introduction

1.2 This Domestic Homicide Review (DHR) is commissioned by the Newham Community Safety Partnership in response to the death of Star whose body was found in April 2019. The perpetrator has been found guilty of her murder.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the discovery of the victim's body in April 2019 and whether there are lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Star.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Identify good practice.

2.4 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.5 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.6 Contribute to a better understanding of the nature of domestic violence and abuse.

3. The review process

3.1 The review will be undertaken in accordance with the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victims died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

1.13 Draw up a chronology of the involvement of all agencies involved in the life of Star to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

1.14 Produce IMRs. The scope will of these reviews will be:

- Star – 1st January 2016 to April 2019
- The perpetrator – relevant life events or criminal history to 19th April 2019

1.15 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

1.16 Consider and analyse key practice episodes within the timeframe , including services responses to family and friends and sharing of information.

1.17 To consider if professionals had a good understanding of risk and whether risks were identified and responded to appropriately. This will include identification of any escalation of offending by the perpetrator.

1.18 The review will pay particular attention to the vulnerability of the victim. It will consider all factors affecting her vulnerability including, but not exclusively any prejudice arising from culture, ethnicity, financial independence, social and family isolation, their health (including mental health) and how this may have impacted on her ability to engage with services who could have supported them.

1.19 Produce a report that summarise the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families where domestic abuse is a feature as well as identifying good practice.

1.20 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the family informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the families are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Newham Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Gary Goose and Christine Graham
Independent Chair and Overview Author

Appendix Two – Registered Sex Offender (RSO)

1 As an RSO the perpetrator was managed as a nominal under the Multi-Agency Public Protection Arrangements (MAPPA)[129] as a Category 1, Level 1 subject. The MPS Jigsaw Team were the lead agency responsible for his supervision. This categorisation does not mean that other agencies will not be involved, only that it is not considered necessary for the case to be referred to level 2 or level 3 MAPPA meetings (Category 2 nominals are Violent offenders, Category 3 are other Dangerous offenders).

2 MAPPA Risk categorisations are as defined: -

2.1 ***LOW:*** *current evidence does not indicate a likelihood of causing serious harm.*

2.2 ***MEDIUM:*** *There are identifiable indicators of serious harm. The offender has the potential to cause such harm but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.*

2.3 ***HIGH:*** *There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.*

2.4 ***VERY HIGH:*** *There is an imminent risk of serious harm. The potential event is more likely that not happened imminently and the impact would be serious.*

3 Throughout his MAPPA supervision he was consistently assessed at MEDIUM Risk. As a Level 1 MAPPA nominal, the perpetrator was subject to two mandatory home visits a year. Regular Risk Assessments and Risk Management Plans (RMPs)[130] were recorded on VISOR[131]. The MEDIUM risk was also confirmed by a more in-depth Active Risk Management System (ARMS)[132]. A table below details the perpetrator's contact by the MPS Jigsaw Team between 2016 - 2018.

4 Note: *When home visits are carried out by the Jigsaw Team, a note is made of appearance, demeanour and the general condition of the premises, but this does not extend to any form of a search.*

Date	**MAPPA Management – MPS Jigsaw Team**
10/05/2016	The perpetrator was seen at the Police Station for an office visit with the Jigsaw Team.
17/10/2016	The perpetrator was seen at the Police Station for an office visit with the Jigsaw Team.
10/11/2016	Home visit conducted by Jigsaw Team at the perpetrator's home address.
24/04/2017	Risk Management Plan completed.
17/06/2017	Home visit conducted by Jigsaw Team at the perpetrator's home address.

[129] Multi-Agency Public Protection Arrangement - is the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.
[130] Risk Management Plans (RMPs) – These are completed, following the "four pillars of supervision model" during the Level 2 or Level 3 meeting. It is a collective MAPPA responsibility for the creation of Risk Management Plans, which are led by the Lead Agency.
[131] Violent and Sex Offender Register (VISOR) - The Police, the National Probation Service ('NPS'), prison service and other agencies use a confidential national computer database to contribute, share and store critical information about MAPPA Offenders and manage their cases.
[132] Active Risk Management Sysytem (ARMS) – a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending and protective factors known to be associated with reduced offending.

29/08/2017	Risk Management Plan completed.
08/10/2017	An Active Risk Management System Assessment (‘ARMS’) completed.
14/12/2017	Home visit conducted by Jigsaw Team at the perpetrator’s home address.
19/12/2017	Risk Management Plan completed.
21/04/2018	Risk Management Plan completed.
02/07/2018	Home visit conducted by Jigsaw Team at the perpetrator’s home address.
29/08/2018	Risk Management Plan completed.
07/11/2018	Risk Management Plan completed.
11/12/2018	Home visit conducted by Jigsaw Team at the perpetrator’s home address.
12/12/2018	Home visit conducted by Jigsaw Team at the perpetrator’s home address.
13/12/2018	Home visit conducted by Jigsaw Team at the perpetrator’s home address.
31/12/2018	Home visit conducted by Jigsaw Team at the perpetrator’s home address.

Appendix Three – Previous convictions

Date	Offence	Disposal
25/09/2003	Theft	Fine & Court Costs
01/03/2004	Making a false statement or representation in order to obtain benefit or payment. Failing to surrender custody at appointed time.	Fine. Bodmin 27/11/2003.
20/06/2005	Using a vehicle while uninsured. Driving otherwise in accordance with a license.	Fine and Court Costs Disqualification from driving for 6 months. Driving license endorsed. Fine Driving license endorsed.
15/05/2007	Sexual Activity with a female child under 16, offender 18 or over. Common Assault.	Imprisonment 30 months. Extension period of license 36 months. Sex offenders notice – Life. Imprisonment 30 months concurrent.
23/07/2008	Grievous Bodily Harm (GBH). Actual Bodily Harm (ABH). Wounding.	Imprisonment 15 months consecutive. Imprisonment 18 months. Imprisonment 24 months consecutive.
28/09/2012	Theft from dwelling.	Imprisonment 14 weeks concurrent.
26/08/2015	Criminal Damage	Compensation Costs Community Order. Curfew requirement 42 days with electronic tagging.
29/09/2018	Assault a Constable. Theft from dwelling.	Imprisonment 4 weeks. Imprisonment 16 weeks. Victim Surcharge
03/09/2020	Murder x2 Preventing lawful and decent burial of a dead body x2	Imprisonment – Life Imprisonment 5 years concurrent.

Appendix Four – Ongoing professional development of Chair and Report Author

1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)

2 Christine has completed that Homicide Timeline Online Training (Five Modules) led by Professor Monckton-Smith of University of Gloucester.

3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford (September 2018)
- Attended AAFDA Annual Conference (March 2017,2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)