LONDON BOROUGH OF REDBRIDGE

COMMUNITY SAFTY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

ANNA KIPRAS AGED 31

UNLAWFULLY KILLED IN AUGUST 2019 IN REDBRIDGE

BY AMANDEEP SINGH AGED 43 WHO DIED BY SUICIDE

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

14 NOVEMBER 2022 (V11)
30 DECEMBER 2023 (V12)

Domestic Violence Homicide Review Panel – LB Redbridge CSP

Anna Kipras unlawfully killed by Amandeep Singh in Redbridge and both found dead in August 2019

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INTRODUCTION

1. In late August 2019, police were called to rented ground floor flat in Redbridge, where Anna Kipras[1], aged 31, was found fatally stabbed. Also discovered was the body of Amandeep Singh, aged 43, from another address in Redbridge, who had apparently died from self-inflicted stab wounds, there being no evidence of third party involvement. They had been in an intimate relationship that had ended and a Restraining Order was in place to protect Ms Kipras from contact with Mr Singh. Inquests into the deaths concluded in November 2021 that Anna Kipras had been unlawfully killed (meaning: either by murder or manslaughter) and Amandeep Singh died by suicide.

2. This report of a domestic homicide review examines agency responses and support given to Ms Kipras and Mr Singh prior to their deaths. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence. 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 to reduce the risk of such tragedies happening in the future.

4. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with the 'voice' of Anna Kipras at the heart of the process. Her family had returned her to Lithuania for burial and there was no chance to meet them. However, the police provided a Lithuanian translation of the Home Office information leaflet for families that was sent to them with the offer of the Panel's heartfelt condolences upon their loss. Amandeep Singh's family have also endured loss and the Chair has offered the deepest sympathy of the Panel.

TIMESCALES

5. On the discovery of the deaths, the Chair of the Redbridge Community Safety Partnership (CSP) required safeguarding partners to recover and retain all records of contact with both deceased. The review began with the appointment of the Chair in September 2019. The first Panel meeting was held in November when draft Terms of Reference (ToR) were discussed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Anna Kipras and Amandeep Singh to be returned by early January 2020. The next meeting on the 20th reviewed the chronologies. Due to an impending Inquest (at that point set for April) the commissioning Individual Management Reviews (IMR) was pended for consideration of disclosure issues.

[1] Not her real name and randomly chosen. All other names (apart from Panel members) are pseudonyms and other potentially identifying information herein has been anonymised prior to publication.

6. A third meeting set for April 2020 was then cancelled due the Covid-19 pandemic and the process placed on hold. In discussion with the Chair, the Coroner directed that the DHR should be completed and a report provided to the Inquest in January 2021. An IMR template was issued for return by 31 May 2020, later extended due to Covid-19 pressures on health services to September. A third draft of an overview based on the reports received was reviewed and debated by the Panel in a virtual meeting via Teams in December and a fourth version agreed by another meeting on 11 January 2021.

7. A fifth interim version was provided to the Coroner and a sixth version including some subsequent information from the National Probation Service was provided in February 2021. The Coroner set two virtual Inquest hearings, 23-24 November 2021 for Anna and the 25th for Amandeep, with conclusions for both on the 26th. Following that, a seventh version was produced for review by the Panel and presentation to the CSP in February 2022, however, this was postponed to May 2022. This eighth version has been prepared for final comment by the Panel and Singh family disclosure. A delay in completion of the action plan due to the implications of the fourth recommendation resulted in the final meeting and consideration of V10 in November 2022. This resulted in the final (and anonymised) V11 that was submitted to the Home Office Quality Assurance (HOQA) Panel in November 2022. The report was considered by the Panel on 8 November 2023 and a letter dated 11 December 2023 provided approval for publication, subject to 20 'Areas for final development' being completed, leading to this final V12.

CONFIDENTIALITY

8. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. IMR's are conducted by managers not connected with events. The Panel are satisfied as to their independence.

9. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased will be referred to herein as Anna or AK and Amandeep or AS as appropriate to the narrative. Family and others that feature in the review are referred by their first name as listed below and included in the glossary for reference at the end of the report:

Mohinder	Father of Amandeep
Tulsi	Mother of Amandeep
Ishika	Sister of Amandeep
Emily	Former partner of Amandeep
Becky	Twin sister of Emily.

10. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

11. Following discussion of a draft in the first Panel meeting, the ToR were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. A third version was issued on 24 January 2020. This sets out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and may be seen in full in appendix 2. The main lines of Inquiry are:
    1. Scope of review agreed from January 2014 to date of deaths with any earlier event of significance to be included
    2. Manage the interface with parallel inquiries such as the criminal investigation and, in this case, the Coroner's Inquest into the deaths
    3. Identify relevant equality and diversity considerations, including Adult Safeguarding issues
    4. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it
    5. Take account of previous lessons learned in LB Redbridge
    6. Identify how people in the LB Redbridge gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

METHODOLOGY

12. This review was commissioned under s9 Domestic Violence, Crime and Victims Act 2004 and followed the Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).

13. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - Standing Together MOPAC Study of London DHRs October 2019
    - Redbridge Council website and related services

14. In addition, three historical DHR reports in LB Redbridge were reviewed for any parallel lessons or repeat lessons to be learned and none were identified.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

15. Following appointment, the Chair established that Anna's family had returned her to Lithuania for burial. The police kindly provided a Lithuanian version of the Home Office information leaflet for families and this was sent to Anna's family with the invitation to speak via an interpreter and that advocacy services are also available. It is understood that they have decided not to participate in the review. They were not able to travel due to Covid-19 restrictions but were offered and declined a video link to the Inquest and be supported by an interpreter. Efforts will be made for them to receive a copy of this report[2].

16. In April, the Chair wrote to a female friend of Anna enclosing the Home Office information leaflet for friends inviting a telephone conversation in the first instance due to Covid restrictions. That request has not been responded to but, with permission, a summary of her witness statement has been made available. A work colleague has also assisted in that way.

17. Amandeep's family were also provided with the Home Office information leaflet for families and in December 2020 Amandeep's sister, Ishika, participated in a telephone interview with the Chair and provided very helpful insights into what was happening in his life. She and his mother were also Interested Persons at the Inquest and had disclosure of the sixth version of this report. Subsequently, the Chair discussed the updates to the seventh version with Ishika and sought her assistance with Singh family pseudonyms for the anonymous version.

CONTRIBUTORS TO THE REVIEW

18. This review report is an anthology of information and facts from the organisations represented on the Panel, some of which were potential support agencies for Anna Kipras and Amandeep Singh:

    Barking and Dagenham, Havering and Redbridge (BDHR) Clinical Commissioning Group (CCG) (provided chronology)
    Barking, Havering and Redbridge University NHS Trust (BHRUT) (provided IMR)
    North East London Foundation NHS Trust (NELFT) (provided IMR)
    Barts Health NHS Trust (provided chronology)
    London Ambulance Service (LAS) (provided chronology)
    London Borough of Redbridge (LBR) Children's Social Care (CSC)
    London Borough of Redbridge Adult Social Care (ASC)
    Victim Support London (provided chronology)
    Metropolitan Police Service (MPS) (provided IMR)
    London Community Rehabilitation Company (LCRC) (provided IMR)
    Refuge (provided specialist DA advice, including in Eastern European culture).

[2] To be arranged by the CSP

THE REVIEW PANEL MEMBERS

19. *Table 1 – Review Panel Members*

Name	Agency/Role
Valerie Scanlon	LB Redbridge Senior Community Safety Officer
Eve McGrath	Designated Nurse for Adult Safeguarding Barking & Dagenham, Havering and Redbridge CCGs
Stephen Hynes	Designated Nurse Adult Safeguarding (Redbridge) Barking & Dagenham, Havering and Redbridge CCGs
Catherine Warboys	LB Redbridge Head of Child protection, Early Intervention, MASH, EDT and Families Together
Daniella Capasso	Named Midwife, Safeguarding & Lead Midwife for CDR & Harmful Practices/Interim Dementia Lead Barking, Havering and Redbridge University NHS Trust
Bob Edwards	Integrated Care Director LBR/North East London Foundation NHS Trust
Sue Tatch	NELFT Redbridge Access, Assessment & Brief Intervention (RAABIT) Team Manager
Andrew Meekings	Operations Manager Victim Support
Kelly Hogben	Detective Sergeant, MPS Serious Crime Review Group
Julia Dwyer	Refuge, Senior Operations Manager
Julia Kulak	Refuge, Service Manager of the Eastern European Advocacy Service
Lucy Satchell-Day	Area Manager North East London, National Probation Service
Bill Griffiths	Independent Chair and Author of report

Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

20. In November 2019 Bill Griffiths CBE BEM QPM was appointed independent Chair of the DHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel. Bill Griffiths is a former police officer who has had no operational involvement in LB Redbridge and no involvement in policing following retirement from service in 2010. Since 2013, Bill and Tony have jointly been involved in more than thirty DHRs.

PARALLEL REVIEWS

21. The Chair was assisted on the Panel by the MPS representative to be updated on the progress of criminal investigation. The crime scene examination effectively ruled out third party involvement in the deaths and the working assumption was that Amandeep killed Anna then took his own life. How a person died is a matter for the Coroner and the Chair set up liaison with the Coroner's Office and was granted 'Interested Person' status. On 26 November 2021 the East London Coroner concluded that Anna was unlawfully killed and that Amandeep died by suicide.

EQUALITY AND DIVERSITY

22. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:
Age – Anna was 31 and Amandeep was 43 at the time of the fatal incident and when they met in 2016, he lied about his age by subtracting six years and halving the age difference. Some research suggests that a substantial age difference can be seen to create a further power imbalance[3]
Disability – Amandeep had an early diagnosis of ADHD (Attention Deficiency Hyperactive Disorder) and a history of mental illness, therefore, may have been an adult with care and support needs. The Panel discussed whether he met the Care Act threshold and agreed that he did not
Gender reassignment – neither party had been, nor were known to be considering, gender reassignment
Marriage and civil partnership – their relationship had been intimate but they were not married or in a civil partnership
Pregnancy and maternity – Anna did not have children and was not pregnant

[3] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009). *Partner Exploitation and Violence in Teenage Intimate Relationships*. London: NSPCC

Race – Anna was White Eastern European and Amandeep was South Asian British. Specialist DA advisers to the Panel from Refuge have highlighted the fact that Anna was Lithuanian may have presented a cultural barrier to her accessing specialist domestic abuse services. Moreover, there is evidence that Eastern European women appear to be disproportionately killed by men, with women from Lithuania constituting one of the four most prevalent nationalities of Eastern European victims
Religion or belief – it is understood that Anna had been raised as a Catholic and Amandeep as a Hindu but there is no information either were practising religion or belief
Sex – Anna was female and Amandeep is male. Records show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner[4]
Sexual orientation – the sexual orientation for each is believed to have been heterosexual

23. The Panel have discussed whether there is evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report. There is nothing obvious, but stereotypical assumptions regarding Anna's Eastern European origin or Amandeep's South Asian heritage cannot be ruled out. The intersectionality of the applicable protected characteristics will be explored in the context of the report.

DISSEMINATION

24. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed in the table below.

Name	**Agency**	**Position/ Title**
Claire Symonds	LB Redbridge	Chief Executive
Cllr Khayer Chowdhury	LB Redbridge	Councillor for Community Safety; lead on domestic abuse
John Richards	LB Redbridge	Head of Community Safety
Lesley Perry	LB Redbridge	Business Manager Safeguarding Adults Board
Colin Stewart	LB Redbridge	Education
Paul Morris	LB Redbridge	Communication
Gladys Xavier	LB Redbridge	Director of Public Health
Gary Etheridge	North East London Foundation NHS Trust	Director of Nursing, Safeguarding and Harm Free Care
Stephen Hynes	Barking & Dagenham, Havering and Redbridge CCGs	Designated Safeguarding Adults Lead
Angela Middleton	NHS England	Patient Safety Projects Manager (London Region)
Stewart Bell	Metropolitan Police	East Area BOCU Commander

[4] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk

Kelly Hogben	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Andrew Meekings	Victim Support London	Independent Sexual Abuse Advocate
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Sir Mark Rowley	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

BACKGROUND INFORMATION (THE FACTS)

25. Anna was born in Lithuania in 1988. She had an older step-brother from her mother's previous relationship[5]. Anna travelled to London for work from about 2008. In October 2014, she gained employment with an international translation and interpreter service based in the City of London. It is important not to assume that proficiency in the English language implies understanding of the British criminal justice system or the support that was available to EU citizens resident in the UK in the event of domestic abuse.

26. There is much more information available about Amandeep which is important to set out in order to understand what happened to Anna and the lessons to be learned. There is a risk, however, that his becomes the 'louder voice' as a result and the Panel have been mindful to follow its commitment to 'hear' Anna's voice at the heart of this process.

27. Amandeep was born in Birmingham to South Asian parents in 1976. He has a younger sister born in 1977. The family moved to Slough in about 1988 where he attended secondary school. His sister recalls an episode when Amandeep aged 12 consumed a psychedelic type of illicit drug and it had a profound effect. He was subsequently diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), that manifest in impulsivity and risk behaviour. In 1992 when aged 16, he was diagnosed with depression. Around this time, he was introduced to alcohol and cannabis and this had an adverse impact of his academic achievements. The family then moved to Redbridge in East London where Mohinder worked as a science teacher. Amandeep concluded his education at an East Ham college without qualifications.

28. Ishika describes her brother as: *Super bright and very good looking. He was innately quiet and shy, but with family and close friends he was funny and chatty*. He had a variety of

[5] It was hoped to gather details of Anna's earlier life and interests in a conversation with her family at the Inquest but they did not attend

jobs, for example, he trained as a bus driver but he failed his probation and was not successful in a subsequent attempt to gain an HGV licence. He did not settle into steady work, seeming more interested in attending the local snooker club. His father set him up to run an off-licence but he did not stick at it. He would always have a money-making scheme on the go and he joined many skills courses to gain qualifications.

29. Amandeep was in a relationship with Emily from 2002 when she was 17 and he was 26, an age difference of nine years. It was an 'on/off relationship' for many years. They had a daughter together in 2016 that was a planned pregnancy because Emily thought it would encourage Amandeep to be more committed, but he showed little interest in the child and the relationship ended when he did not show up to visit the daughter who was in hospital.

30. Amandeep was habitually in debt and did not attend to the problem, for example, he would not pay a £30 parking ticket and by the time the bailiffs called, the amount to pay would be closer to £1,000. He had also developed a gambling habit that led to borrowing and, during his relationship with Emily, he started dealing Class A drugs to pay for his debts. He would then be in debt to 'loan sharks' due to these financial difficulties. Consequently, he became heavily dependent on the generosity of his father, Mohinder. Subsequent reported difficulties in Amandeep's relationship with his father appeared money-related.

31. Amandeep and Anna met in early 2016 at a nightclub in the West End of London. Her friend was surprised by how quickly the relationship started and he started to show her too much attention in the form of constant calls and messages. Despite discovering from his driving licence that Amandeep had lied about his age, saying he was 33 when he was actually aged 39, Anna highlighted to her friend that she felt happy, peaceful and safe with him. They did not live together but the relationship was intimate with Amandeep staying for two nights a week on average and he was given a spare key to her flat in the nearby Borough of Waltham Forest. At some point Amandeep travelled with Anna to Lithuania to meet her parents and it is understood from comments to the police Family Liaison Officer they believed he was a: "Decent and honourable man".

32. After about a year, Anna told her friend she had had enough of Amandeep's lies. They separated in March 2017 when he was imprisoned for harassment of Anna and breaching a Restraining Order (RO) that provided: *Protection from harassment until further notice*. It is not known exactly when they got back together but the friend said that Amandeep could be very persuasive, behaving like a 'lost puppy' to gain her affection. He also acted with largesse in the form of extravagant gifts of flowers and champagne.

33. A friend who was also a work colleague recalls that, in the summer of August 2018 when she was with Anna in a bar in the City of London area, Amandeep just appeared making it out to be a coincidence. The friend has reflected that it was more than likely he had followed Anna. He then started to accompany her to events again. Anna said that it was just as a friend. Around this time, the friend noted that Amandeep had developed a habit of falling asleep when out socialising even when the music was loud. His movements were slow and he would even fall asleep in the middle of a conversation as if he was on medication or something.

34. The last time the friend saw Amandeep with Anna was in June 2019 when she visited Anna's flat[6] and she said that Amandeep was going to a party that night but then he appeared and he never left. As usual he was: V*ery weird and slow and fell asleep again*. The friend asked Anna why they do not move in together and she disclosed that she was trying to finally get out of this relationship by slowly pushing him away. Anna wanted to break up with Amandeep but did not know how to.

35. Anna added that the same thing was happening as before, that he was too attached to her, too jealous and that he cannot go anywhere without her. When the friend said that Amandeep was definitely not normal as a healthy person would not act like that, Anna responded that she was not really scared of him because she was sure that he would not do anything bad to her. It is understood that they did finally separate about three weeks before the deaths. In text messages two days before the homicide, Anna made it clear to Amandeep that their relationship was over.

Timeline of what was known to agencies

36. There is very little known to agencies with respect to Anna who had been living in the UK for a relatively short time and who mainly came to notice through the abuse she was subjected to by Amandeep. On the other hand, Amandeep was well known to health and the police. Consequently, there will be a far greater volume of events in the timeline that involve him alone. In order to understand the lessons to be learned in this review, it is felt necessary and appropriate to the learning to fully set out what is known to have happened in agency engagement with Amandeep, with the caveat that Anna's 'voice' should be heard in this context.

37. Amandeep had a number of criminal convictions and cautions from 1998 for forgery, motoring offences, theft and possession of Class A drugs (last caution in April 2017). There were other contacts with police of relevance to this review as follows. Some of the criminal matters will be referred to if connected to events. The underlining of dates below is to assist the reader with the passage of time and also when in the year each contact was first reported. In line with the ToR, relevant events prior to 2014 are those highlighted by IMR authors.

2003

38. In March, police were called by Mohinder following an argument over food when Amandeep had slapped him. Amandeep was not spoken to but his father had no injury and indicated he wanted no further action. This preceded the 2004 policy on recording non-crime domestic incidents and no formal record was made.

[6] Anna had moved to a Victorian house in Redbridge converted into four self-contained flats with hers on the ground floor

2005

39. In September, Amandeep's mother, Tulsi, called police because he had locked Mohinder in the bedroom over an argument when Amandeep had asked for £300 cash that his father would not give him. Amandeep was spoken to about his behaviour but, in the absence of injury or complaint, there was no Domestic Abuse (DA) record but a note placed on the intelligence system.

2007

40. In January, police were contacted by the London Ambulance Service (LAS) regarding a report of an assault. Mohinder made it clear he had not called police and did not want any action against his son. He went on to describe an argument in which Amandeep had demanded that a property that his father owns be put in his name. Amandeep became angry, slapped his father's face, then punched him in the stomach and back causing pain. The LAS conveyed Mohinder to King Georges Hospital (KGH). Amandeep was arrested and taken into custody where he admitted to losing his temper and assaulting his father. He accepted a criminal caution for common assault.

2008

41. In June, Amandeep had another argument with Mohinder, this time over money his father was lending him to start his own business, and he had punched him in the face causing two bruised eyes that had been treated at KGH five days earlier. Amandeep was not present and the officers commenced an area search. Within a short time they were called by a concerned member of the public who had seen a man forcibly drag another into a house. This was the home address and it was Amandeep assaulting Mohinder. He was arrested but this time provided no comment to questions. He was charged with two counts of common assault. Mohinder attended the police station and pleaded for Amandeep to be released, explaining that: "he gets agitated when he loses his temper". DA services were offered but declined. A supervisor noted that Amandeep's father: *Seems to be in fear [of Amandeep].* The charges were eventually heard at the Magistrates Court in August and Amandeep was acquitted.

2009

42. In early July, Amandeep's partner's sister, Becky, called police to complain that Amandeep had arrived at the address wanting to speak to his ex-partner, Emily, about their separation. Becky made it clear that her sister did not want to see him and he had then stood outside the address waiting for Emily to come out. He was not to be seen when police arrived and a non-crime domestic violence (NCDV) report was made on the Crime Report Information System (CRIS) with a DV (Domestic Violence) 'flag' and assigned to the CSU (Community Support Unit (CSU) for investigation. The officer assessed the risk as 'standard'[7].

[7] On a scale of Standard, Medium and High

43. Intelligence checks revealed Amandeep's history of DA towards his father. The investigator contacted Amandeep who confirmed he had attended Emily's address to try and reconcile the relationship. He was advised to respect Emily's desire for space and wait for her to contact him. Messages were left with the sisters to contact the investigating officer but not picked up so a letter with an update and contact details for DV support agencies provided.

44. Two weeks later, Becky did contact the investigating officer to update that Emily had been in the relationship with Amandeep for 10 years and they had split. Becky said that Amandeep had not been violent or made threats but had been seen at the address and had called Emily's mobile 30-50 times. Becky had answered once or twice and could verify it was him. Amandeep had the keys to the address and the officer advised that Emily should have them returned or speak to the housing provider to have the locks changed.

45. The officer made another NCDV report on CRIS noting that: *No crime was alleged or intimated in this report and that the incident does not represent any escalation and/or threat of violence*. The IMR author has commented that this was incorrect as there was a clear course of conduct of stalking/harassment and this was the second such report. A harassment warning or an arrest for stalking should have been considered.

46. Five days after that in early August, Emily called police because a man had been seen loitering outside her address looking into cars. Officers arrived promptly and found Amandeep loitering who said he was waiting for his girlfriend to bring some belongings to him. Emily joined them and confirmed that he had been calling her to arrange the return of his belongings. After he left the scene, Emily confirmed that she had ended the relationship in late July and matters had gradually got worse since then, including by Amandeep attending her place of work, however, she did not want to pursue the matter further or attend court as it would aggravate matters. She was not concerned he would cause any physical harm towards her or her sister. Nonetheless, the officers generated an 'arrest enquiry' on the CAD (Computer Aided Dispatch – the police database of all emergency calls) and provided Emily with the reference number and police help line which was good practice. They also provided a tear-out advice form from their report book listing DV Support Agency contacts.

47. When contacted later by the CSU investigator, Emily confirmed her position expressed above. The possibility of a First Instance Harassment Warning (FIHW) was discussed with her and she was content for this to be the course of action. Target Hardening crime prevention advice was provided and it was recommended that she consider seeking an injunction. In addition, the officer provided safeguarding advice, such as to change her mobile phone number, not to answer the door unless she knew who it was and to call 999 quoting the CAD reference if Amandeep should return. A DV referral form was submitted to Newham Action Against Domestic Violence[8]. Amandeep was contacted and issued with the FIHW and the intelligence system noted.

[8] An East London charity supporting women and children subjected to domestic abuse

2010

48. In late December, police were called to Amandeep's parents' address over a verbal argument over Amandeep asking for money. An intelligence check showed that Amandeep was wanted on warrant for non-appearance at Court with respect to an offence of 'no insurance' He was detained on the warrant. A NCDV CRIS was completed with the risk assessed as 'standard'.

2011

49. In mid-April, police were called to another disturbance, again over Amandeep asking his father for money. He was not present when they attended and Mohinder made no allegations. After they left the scene they were called back to another disturbance, this time with aggressively raised voices. They were given 'words of advice' to desist.

50. Early in May, a neighbour called police to a loud disturbance. On arrival Amandeep was absent and Mohinder was waiting outside. He explained there had been another argument over him asking for money. When told he would not be given any, he became angry and picked up a table lamp and mashed it against the wall. Tulsi took his side saying that her husband should give Amandeep money and was just as much to blame for the arguments. Mohinder did not wish to take the matter further, however, he asked for advice on how he could evict his son which they declined as a civil matter. Amandeep was not spoken to and a NCDV CRIS was recorded with 'standard' risk assessment. The IMR author has commented that this should have been recorded as a crime of criminal damage. The officers could also have signposted advice on the eviction question.

51. In early July, Amandeep was stopped by Essex Police when driving his sister Ishika's car. He admitted he did not have her permission and a check showed that he was actually disqualified from driving (from the no insurance conviction). He was transferred to Romford in the MPS and the Crown Prosecution Service (CPS) authorised charges before the Magistrates Court. In mid-September, Amandeep was issued with a Community Order, an unpaid work requirement and driving disqualification for a further three months.

2014

52. Early in November, Mohinder called police to report that bailiffs were at his home with a warrant regarding monies owed by Amandeep. He said that Amandeep no longer lived at home. The initial response by the Metropolitan Control and Command (MetCC) operator was that if the parents can prove that their son no longer lived with them, the bailiffs could be redirected to the correct address. A supervisor upgraded the call from 'Referred' to 'Significant' and a sergeant from the Emergency Response Police Team (ERPT) requested intelligence checks. Amandeep was shown as resident at the address and his mobile was contacted but he did not pick up the calls, apparently because his phone did not allow contact from withheld numbers. The CAD was recorded as a 'civil dispute' and closed.

53. A few days later in November a CAD was created for police to attend Amandeep's address to conduct an arrest enquiry on a warrant issued by Barkingside Magistrates Court in

October for a breach of the Community Order from the driving offence in July. It was assigned to the local Neighbourhood Policing Team and Amandeep was brought before Magistrates and given a residence requirement of seven days.

2015

54. In late October an emergency call to police from a female stating that her son was causing problems was abandoned before she could disclose the location. A subscriber check revealed the location as Amandeep's home address and police attended. Tulsi alleged that Amandeep had visited and asked for money which she declined and he left. She said there was no need for police involvement. Nonetheless, the officers recorded a NCDV on CRIS and, based on intelligence checks, assessed the risk 'standard'. The report was assigned to the CSU where a supervisor gave consideration to referral to the local Multi-Agency Risk Assessment Conference (MARAC)[9] on the basis of the number of reports and the 'professional judgement' criterion. It was deemed not suitable as: *there do not appear to be indicators of a risk of serious harm*' and no further action was taken.

2016

55. In mid-October Police stopped Anna and Amandeep in the street after witnessing them arguing and seeing Amandeep hold Anna's arm. They spoke to them separately, which was good practice. Each stated that they met on that day and had been arguing about separating. Anna informed the officer that she became upset and had got out of Amandeep's car. He then followed her to talk her into getting back into the car so he could take her home. Anna had no injuries on her arm. It was agreed that Amandeep would go to his home in his car and police took Anna home.

56. This is the first recorded police contact with Anna and the first incident report recorded between her and Amandeep as in a relationship. At the time, she was living in Waltham Forest[10]. A NCDV CRIS record was made with the DV flag added. The officers correctly conducted five-year intelligence checks and completed a 'DASH' (Domestic Abuse, Stalking and Harassment and 'Honour Based Violence') risk assessment. In the assessment, Anna answered 'No' or 'Never' to all of the questions except the following:

    Have you separated/tried to separate from them? A: *No, we were talking about separating*
    Do they try to control everything you do or are they excessively jealous? A: *Jealous, not threatening*.

57. The risk was assessed as 'standard' and the report referred to the CSU. Anna was offered a referral to the National Centre for Domestic Violence which she declined. This was not best practice as she could have been offered referrals to the local specialist domestic abuse service and the National Domestic Violence Helpline, who would both provide her

[9] MARAC – is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.
[10] Source: GP clinical notes

with more holistic support beyond just support with a non-molestation order. As mentioned at the outset, Anna's good command of English should not be taken as understanding of the criminal justice system or her ability to grasp fully what support was available. The intelligence check would have revealed Amandeep's prior domestic abuse of Emily and there was a missed opportunity to consider 'Clare's Law' and inform Anna of what was known to police. A supervisor approved closure of the report with no further action.

58. In mid-November, Amandeep was stopped in his vehicle by Traffic Police Officers following an Automatic Number Plate Recognition (ANPR) activation for having no insurance. Alcohol was detected on his breath; he failed the breath test and was arrested. At Redbridge Police Station, he confirmed he had consumed three glasses of wine earlier but his evidential breath sample was below the offence level and he was released. A Pre-Release Risk Assessment (PRRA) was conducted. He declined the offer to be seen by the duty Forensic Medical Examiner (FME) but accepted a support agency information leaflet.

2017

59. In mid-March Anna called police and reported that Amandeep was outside her address. He had told her that he had taken an overdose and would kill himself. Whilst on the phone to the operator, Anna said that Amandeep had taken 40 Nurofen tablets and was taking more. The call was graded 'I' for an immediate response and assigned to a unit. The LAS were also alerted and they arrived with the police officers.

60. Anna said she believed this display was in response to her recently telling Amandeep that she wanted a break from their relationship. Over the weekend, she had gone to stay with a friend and, whilst there, she found a spare key of his and asked him to come and get it. Due to him being *weird* in a text message wanting them to get back together, she asked him to come another day in the week.

61. The evening before she had returned home to find Amandeep outside. As she attempted to go into her flat, Amandeep started to call her names and pushed her. She entered and found her bedroom untidy with several items of clothing belonging to Amandeep visible. Amandeep admitted that he had been staying in her bed whilst she had been away. She went on to describe him as being controlling during their relationship. She added that Amandeep would call and text message her countless times. He would allow her to go out with friends but then demand to know where she was throughout the evening. He would leave his personal belongings in her room to create a reason for returning.

62. Amandeep informed the officers that he had taken 40 Paracetamol tablets and numerous amounts of Microfirmin[11]. He then became unresponsive and started to fit. He was taken to Homerton Hospital (HH) by the LAS and admitted overnight. Amandeep was later arrested for common assault and coercive and controlling behaviour and given 'street bail' to attend Leyton Custody Centre later in the month, with conditions not to have direct or indirect contact with Anna and not to attend her address.

[11] Believed to be medication to lower blood sugar in diabetics

63. The incident was recorded on CRIS as a common assault with a DA flag added and an investigation report and DASH risk assessment filed. Within the assessment, Anna expressed concern that: *he may be violent towards me or start manipulating me*. It was further noted that she and Amandeep would often argue, describing him as being: *over-dramatic when they discuss relationship problems.* She added that she was: *scared after his strange behaviour.* Intelligence checks linked the previous NCDV CRIS records. The officers assessed the risk 'Medium'. It is felt that, given the significant risk factors present - stalking, separation, suicide attempts, excessive control, jealousy and escalation - consideration should have been given to a 'High' assessment. It follows that consideration could also have been given to a referral to MARAC using the 'professional judgement criterion.

64. The next day the incident was referred to the CSU and the assigned investigator contacted Anna. She said that she was not sure if she would be willing to attend court for the incident. Advice given to Anna included having her locks changed, to tell all her housemates that Amandeep is not to attend the address and call police should Amandeep attempt to return. At this stage, consideration should have been given to referring Anna to a specialist domestic abuse agency for advice and support from an Independent Domestic Violence Advocate (IDVA).

65. The officer contacted the hospital and it was confirmed that Amandeep had been discharged. Then Amandeep did not answer calls from the investigator to his mobile phone or landline telephone. Neither had the facility to leave a message. Due to the overdose he had taken, Amandeep was assessed as a 'vulnerable adult'. This required completion of a MERLIN[12] (Missing Persons and Linked Indices) report. The ACN (Adult Coming to Notice) version was completed in respect of Amandeep. Risk is assessed by the Vulnerability Assessment Framework (VAF) and the ABCDE[13] tool whereby Amandeep's vulnerabilities were assessed and noted.

66. The ACN report was reviewed by the Multi-Agency Safeguarding Hub (MASH)[14] and an initial assessment was completed by the MASH decision maker using the London Continuum of Need (LCN) model[15] that in Amandeep's case provided a risk assessment of 'Green'. As a result, consent for referral was obtained and the report shared with Redbridge Adult Social Care (ASC) in mid-April where it was assessed and forwarded to the Redbridge Access, Assessment and Brief Intervention Team (RAABIT) for follow up. Given the low risk identified, nbo further action was taken.

67. A few days after the incident in March, Anna called police to report that Amandeep had turned up at her workplace (in the City of London Police area). She reported that, since the incident, Amandeep had been constantly calling and texting her and had shared a slide

[12]An intelligence database of children, vulnerable adults and missing persons that have come to police notice that can be shared with relevant partner agencies.
[13] Appearance-Behaviour-Communication & Capacity-Danger-Environment
[14] Co-location of key agency workers to facilitate prompt, better quality information sharing, analysis and safeguarding decision making
[15] Common agreement across all Local Authorities and safeguarding agencies using BRAG – Blue, Red, Amber, Green

show of a female who appeared to be deceased with blood around her. To gain access to her office, he pretended to be a courier with a parcel containing chocolates, sweets, slippers and pillow cases that she said were not even hers.

68. Whilst on the telephone to police, Anna informed officers that she believed Amandeep was currently trying to call her from a 'No Caller ID' number. She did eventually answer the call in order to tell Amandeep to stop calling her. However, when she left work, Amandeep was waiting outside her office. She told him to go or she would call the police. He grabbed her mobile phone and ran off but a member of the public intervened and managed to persuade him to return it to Anna.

69. When officers attended, Amandeep had left. They escorted Anna home and checked her flat for his presence. Anna informed them that she had followed the advice to change her locks and all her flat-mates were aware not to let him in. She was told to call the emergency number if she saw him in the vicinity. An arrest enquiry was created and 'Special Schemes'[16] were placed on Anna's address. The officers recorded Anna's account on Body Worn Video (BWV) that was deployed with them in its pilot evaluation stage, which was good practice.

70. Their DASH written assessment noted that Anna said that Amandeep is jealous and he instructs her that: *no guy friends can stay over.* Anna added that: *A couple of months ago, he joked that he was going to kidnap me. I believed it a joke at time. We were talking about if we were to break up*. They assessed the risk as 'Medium'. It is felt that an opportunity was missed to take this seriously and see this report as an escalation. A 'High' assessment would have brought consideration of referral to the local specialist domestic abuse service. It has been noted by the Panel that the Redbridge Violence Against Women and Girls Service accepts victims at all levels of risk, so a 'high risk' assessment would not have been a pre-requisite for a referral to the service.

71. Two days after the incident the investigator made contact with Amandeep regarding Anna's harassment report and he confirmed that he would be answering to his bail the next day, accompanied by his solicitor. He was advised not to contact Anna at which point he apologised for his behaviour saying that he was: *desperately missing Anna*.

72. In interview the next day, he was further arrested for the harassment incident and, in interview, he admitted that event and the earlier common assault the week before. On the advice of the CPS, he was charged with both offences and he was convicted towards the end of March when he admitted both charges, the earlier assault in March and the harassment that followed. He was sentenced to a Community Order with Rehabilitation Activity and an unpaid work requirement of 150 hours with a victim surcharge of £85. He was served with a Restraining Order (RO) that specified: *Protection from Harassment until further notice*. In the terms, Amandeep was forbidden to contact Anna directly or indirectly, not to go to her place of work and not to go to her home [then in Waltham Forest]. The Community Order was managed by the London Community Rehabilitation Company

[16] To alert officers when assigned to an emergency call to information that could help assess risk

(LCRC). A Senior Probation Officer allocated the case to supervising officer and updated the case management record to show that Amandeep posed a Medium risk of harm to Anna and future partners, and that he is a domestic abuse perpetrator. An experienced Probation Service Officer was assigned.

73. The police investigator contacted Anna on the eve of the Court appearance and she reported that she had not had any further contact from Amandeep and did not feel that she required the 'Special Schemes' on her address anymore. It is not recorded if Anna was advised of DA Support Agencies and Referrals that could be made, such as to an IDVA that should have been done to comply with extant policy. The IMR author has noted this omission and made an internal recommendation for local management to dip sample DA reports for quality assurance.

74. A second internal recommendation arises because the opportunity was missed to consider a referral of Anna's case to the local MARAC on the criterion of repeat offences by Amandeep. Such a referral could have led to more proactivity by safeguarding support agencies and the assignment of an IDVA.

75. In early April Anna attended Leyton Custody Centre (LCC), where Amandeep had been charged with the recent offences, and reported that since the RO seven days earlier, Amandeep had been constantly calling her phone from a withheld number up to 25 times a day, thereby breaching the order. She described that sometimes he would speak but other times he would remain silent. On occasions he had put on a female voice pretending to be a friend. Anna had received a letter at her place of work claiming to be from another person asking her to contact Amandeep. Anna ascertained from a friend that Amandeep had been using a topless picture of her for his WhatsApp profile image.

76. A CAD arrest inquiry was created and, the next day, officers attended his home. Amandeep was not there and Tulsi said she did not know where he was. The local Fugitive Team took on the arrest enquiry and spoke to Amandeep by telephone. He said he was in Birmingham and he was advised to return as soon as possible. An ACT (for action) report was recorded on the Police National Computer (PNC) that would alert an officer anywhere in the country if they had contact with Amandeep. Further enquiries were made at his home on three separate days without result and in late April, Amandeep's name was added to the PNC as 'wanted'.

77. Ishika thinks that Amandeep was actually in Northampton at this time because she recalls a business venture he was involved in that had a warehouse in that city. She remembered that it was not a success and, as a consequence, that the family fielded numerous enquiries from people he owed money to.

78. Two days after Anna's report to the LCC, Amandeep presented himself on foot and unaccompanied to the KGH Emergency Department (ED) following an overdose of medication taken at home. He reported he had an argument with someone the previous day. He was upset and feeling suicidal. He was assessed by Psychiatric Liaison nurses

and discussed social stressors including the break-up of his relationship [with Anna]. He disclosed he was drinking alcohol on a daily basis. Following assessment, he was discharged home with details of the local Improving Access to Psychological Therapies (IAPT) service and to self-refer to and Mental Health Direct (MHD) crisis line. Using the Trust safeguarding template[17] there were no safeguarding concerns.

79. In mid-April Amandeep presented himself on foot and unaccompanied to Whipps Cross University Hospital (WXUH) ED, complaining of abdominal pains and vomiting blood. He expressed feeling depressed and having suicidal thoughts and he was admitted to the Acute Assessment Unit (AAU) for observation. The next morning, Psychiatric Liaison assessed the risk as low and that he should be referred to the community drug and alcohol service and IAPT talking therapy for depression. In the afternoon, Amandeep disclosed to the drug and alcohol nurse a long history of alcohol, cannabis and cocaine use and the impression recorded was 'suicidal ideation/withdrawal symptoms'. He would be admitted for a detox on a reducing medication regime and be sectioned if he attempts to leave due to suicidal ideation. Liaison was conducted with his Probation Officer who indicated that police would be informed of the current admission.

80. Two days later Amandeep was reviewed by the Psychiatric Liaison nurse who noted that Amandeep remains low in mood with negative outlook but was requesting help. He complained of tiredness and the assessment was not completed. The next day another attempt was made but Amandeep appeared sleepy. Police at the LCC contacted the ward to enquire about his progress and it was left that hospital staff would notify them of Amandeep's discharge.

81. That afternoon, Amandeep was reviewed by the Psychiatric Liaison Consultant Psychiatrist. The impression recorded was: *Impulsive overdose in the context of an adjustment disorder with depressive reaction. Possible elements of personality traits that may need to be explored further. Had capacity to consent to plan*. The plan was to start anti-depressant medication and refer to RAABIT for follow up[18].

82. This service is the central point of initial referral and access to Secondary Mental Health Services within the LB Redbridge for people aged 18-65 who present with moderate to severe mental health needs. The team acts as a gateway providing initial screening and assessment of referrals and short-term intervention if indicated, or signposting to other services and agencies as appropriate. Information on drug and alcohol services and the crisis line was provided. In the evening, Amandeep was seen by the alcohol liaison nurse and agreed the plan. He was prescribed medication to take away: Lorazepam 1mg for 3 days to manage anxiety. He would be discharged from the AAU the next day, and the LCC notified beforehand.

83. That day came and Amandeep was not in his bed. WXUH reported to police that he had absconded. A MERLIN missing person report was created and the risk assessed as

[17] A standard questionnaire designed to identify safeguarding risks to be assessed

[18] Multiple follow-up calls to AS made by RAABIT staff without response but may have been due to him being in custody

'Medium' due to the report of an overdose. Amandeep was arrested driving his car later that day, having been located by ANPR, and found in possession of cocaine. He had been drinking. Interviewed in the presence of a solicitor, he confirmed he knew of the RO and having Anna's number in his phone contacts and harassment by sharing the distressing slide show. He was not questioned about having the intimate image of Anna as his WhatsApp profile image and the reason for that cannot be ascertained. He made no further admissions and was charged with the RO breach and cautioned for possession of cocaine. Anna was contacted by telephone and an update message left.

84. A risk assessment of Amandeep whilst in custody, recorded that he suffered from depression, had experienced suicide ideation and had tried to commit suicide twice by overdosing. He had been living in his car. Assessed by the custody HCP (Health Care Practitioner), Amandeep was placed in a CCTV cell for observation and his interview delayed. He then complained of abdominal pain, was taken back to WXUH for examination and assessed as fit for detention. He was advised to see his GP on release.

85. Appearing in custody in mid-June, Amandeep admitted 'Harassment – Breach of Restraining Order' between the end of March and mid-April and was sentenced to 16 weeks imprisonment and to pay a Victim Surcharge of £115. This was the last time prior to the fatal incident that Anna had been 'on the radar' of anyone in safeguarding.

86. Amandeep was released from his sentence three days later, having served the majority of the eight weeks he would serve (16 weeks halved for good behaviour) whilst awaiting trial. He was then under licence supervised by an Offender Manager (OM) from the LCRC until mid-August 2017, followed by a period of Post-Sentence Supervision (PSS) until mid-August 2018. Conditions of his licence meant that the OM could have him recalled to prison in the event of a breach of the RO. With a breach in the PSS phase, a recall could only be ordered by a Court to which an OM could make an application.

87. In reviewing the police investigation, the IMR author has commented that:
    - The RO breach offence was added to the original CRIS whereas there should have been an additional CRIS generated for this separate offence
    - A DASH risk assessment and intelligence check were not conducted as they should have been in line with the extant 'DA toolkit'
    - There was no suspect strategy or risk assessment for Anna and Amandeep after it was established he was believed to be in Birmingham and again when at WXUH
    - There is no record of consideration to DA support agency referral, nor to MARAC which would have been appropriate on the basis of professional judgement
    - Leaving a voicemail to update Anna should have been followed up with a full update within one day as required in the Victim's Code of Practice (VCOP)
    - Officers correctly shared an ACN MERLIN with ASC in Redbridge

88. One evening in mid-June, Tulsi called an emergency ambulance to attend to Amandeep who was a diabetic and was intoxicated, had vomited and fainted. Amandeep was found lying in the bathroom, alert and oriented. He had been drinking since the previous night,

the last one hour before. He had collapsed when on the toilet and was saying he just wanted to sleep. He was taken unaccompanied to Queen's Hospital (QH) where he was diagnosed with vomiting after binge drinking and noted to be lethargic and dehydrated. He was discharged home following treatment and advised to see his GP for follow up. The safeguarding concern noted was: Substance misuse – alcohol. It was recorded that he became very abusive to the Doctor who was trying to examine his throat.

89. In mid-July Amandeep attended an appointment with a new supervising officer at LCRC. He reported starting a new job (detail not recorded), explaining that he used to work in his parents' business, which they had taken on after he got into financial difficulties due to gambling. He claimed he no longer gambled to that extent. In a discussion of his mental health he reported that he no longer felt suicidal as he had adjusted to the situation and trying to get his life back in order. However, by mid-August he was sent a warning letter for failing to attend an appointment.

90. Ten days later in August Amandeep reported by telephone to the non-emergency contact number that, two days earlier, his passport, wallet and driving licence had been taken from his car. The primary investigation was completed by the Telephone and Digital Investigation Unit speaking to Amandeep over the telephone and enquiries to identify CCTV opportunities were conducted. In line with extant policy, with no suspect being identified and insufficient leads to take the investigation further, the investigation was recorded on CRIS and closed.

91. Four days after that, the LAS were called to Amandeep who was dizzy with chest pain and had difficulty in breathing. He had woken up at the bottom of the stairs but could not remember falling down them. He explained that he had been involved as a passenger in a car accident a week earlier and hit his chest which might account for the pain. He was conveyed to KGH ED. He was assessed and discharged home following treatment. No safeguarding concerns were identified.

2018

92. Following a three-month gap in contact, Amandeep attended a PSS induction meeting in January. He was informed, and signified that he understood, the enforcement procedure including to abide by the RO. He said he was unemployed, not receiving benefits and wanted to get back into employment. He added that he had no substance misuse issues, was living with family in stable accommodation and is not in any debt. It is noted that there are no mental health issues to report.

93. In late January, Amandeep's father Mohinder died in hospital aged 69. His death was sudden and unexpected so it had a major impact on the family. Ishika recalls that Anna sent a condolences text message to Amandeep.

94. A week later January, Amandeep presented unaccompanied at KGH ED with chest pain, fainting and vomiting. He had called the LAS following waking up on floor with no recollection of what had happened. He did not wait for heart blood test results, then signed

refusal against medical advice and to self-discharge himself. There were no safeguarding issues identified.

95. In early March, Ishika called police saying that Amandeep was suicidal. He had taken an overdose of Ibuprofen and their mother's cholesterol tablets, He told them that he wanted to die and had just walked out of the home. Officers called Amandeep's phone and he said he went out for air and would return soon. He did so before the officers left the scene, said he felt unwell and they conveyed him, his mother and sister to KGH for a mental health assessment. The IMR author has commented that a MERLIN report was completed due to Amandeep being missing in the first instance but that the ACN section that should have been shared with ASC was not because but the correct key stroke did not happen.

96. During triage in the ED, Amandeep declined to talk to the nurse and covered his face with his hands. The account given to the police was confirmed. He was noted to be in a low mood following the death of his father in January which had got progressively worse. He had told his mother that: *he has done a lot of mistakes*. He was referred to the mental health team, a psychiatric liaison nurse and Specialist Registrar but he declined to talk. It was noted from other conversations that he had problems with the mother of his baby [presumably, Emily] and that he does not see the child; also that an ex-partner [Anna] has a restraining order against him. He said he was £12k in debt. He did respond to a follow-up call from the psychiatric liaison nurse and agreed to a referral to RAABIT which was made, however, he did not then respond to follow up calls and an opt-in letter from RAABIT staff.

97. Three days later, Tulsi called the LAS because Amandeep had taken an overdose and wanted to kill himself, possibly due to the recent death of his father. On arrival, Tulsi reported that Amandeep had left. Together, they found Amandeep collapsed at the end of the road. He initially denied, then admitted, an overdose of 28 Ibuprofen and he was conveyed to KGH ED. This patient admission was linked to the one three days earlier, that he initially denied. Amandeep left before we was clinically assessed. The safeguarding template had noted 'mental health problems'.

98. This was reported to police who located Amandeep at his home address and conducted a 'Safe and Well' debrief interview. He said that he did not wish to be treated by the hospital so decided to go home. He added that he had access to a MH Outreach Worker he could contact should he feel the need for help. He claimed he was not feeling suicidal but felt down due to the death of his father.

99. The call to police was graded correctly for the response required and Amandeep was located and the debrief interview conducted within the time parameter of him being located. The risk assessment at 'medium' highlighted the overdose. However, once again the ACN report was not shared due a fault with the MERLIN system. The IMR author has made a third internal recommendation in this regard.

100. Four days after that, the LAS were called to a report that Amandeep had taken an overdose. He was found in a foetal position on the bedroom floor, asleep but rousable. On

examination he was alert, denied pain and any suicidal thoughts. He refused consent for clinical observations so was conveyed to KGH ED. Amandeep was referred and seen by the Psychiatric Liaison nurse. He denied any suicidal ideation and was discharged home following treatment to be seen in the community by the RAABIT, however, no safeguarding concerns were identified. Again, Amandeep did not respond to follow up calls and an opt-in invitation letter.

101. Later that day, police received information from an anonymous source that Amandeep was in debt to loan sharks following a business deal. He was unable to pay the debt, had been blackmailed, threatened and beaten. The caller also reported that Amandeep had been coerced by these individuals to stab someone but no details were provided. A letter had been posted at the family home making threats if the debt was not paid. It was noted that this letter may have been produced and posted by Amandeep as a way to obtain money from his family to pay his debts. Amandeep had served a prison sentence and was unemployed. His father, who would have provided financial support to him, had recently passed away.

102. Police attended and spoke to the family and 'Special Schemes' were placed on the address. Amandeep was not present and initially declined to speak to officers. When he eventually did, he said he was fine, he was seeking help with the financial matters and was not feeling depressed or suicidal. He clearly stated that: *he does not have persons chasing him for money apart from the legitimate debts*. As a result the investigation was closed. The IMR author has identified that there was insufficient evidence to proceed further, but that Amandeep's vulnerabilities were clear, a VAF assessment should have been completed and a MERLIN report generated for sharing with ASC.

103. About a week later Amandeep attended an LCRC appointment. He discussed the loss of his father and the need to sell the family business. On the subject of the RO, Amandeep said that Anna had contacted him when his father passed away, saying that she wanted the RO removed. The OM told Amandeep that this was a matter between Anna and the Court. Amandeep also reported he was on way to hospital to visit his daughter and confirmed that the relationship with her mother was good. Amandeep was looking for employment and the OM provided Job Fair material and arranged for him to speak to an Employment Training and Education (ETE) worker as well as place his details on the ETE case management system, indicating readiness for work.

104. In the early hours one day toward the end of March, the LAS were called to Amandeep at home because he was banging his head against a wall, behaving irrationally and had possibly taken an overdose. On their arrival, Tulsi reported that he had come home drunk and very upset and banging his head saying he wanted to die. Amandeep had a history of overdoses, the last two weeks prior. He had been very depressed at the loss of his father. On examination, Amandeep was on the bedroom floor under a duvet, was coherent and denying suicidal thoughts or consumption of anything other than alcohol; he just wanted to sleep. All clinical observations were within normal parameters, save a raised blood glucose reading, and the crew assessed he had the capacity to decline help. He was left at home in the care of his mother.

105. Three days later, Tulsi called police because Amandeep was having a mental health episode, throwing things at them, being violent and banging his head. She added that he had attempted suicide on three prior occasions and again that day. The police command centre notified the ambulance service and when they called Tulsi to update her, she said that Amandeep had left. Officers attended and found that the kitchen had been trashed, with food all over the floor and the washing machine on its side, undamaged. Ishika was at home but asleep at the time and she relayed on behalf of her mother, whose first language was Punjabi with limited understanding of English, that the argument happened when Amandeep asked her for money. When Amandeep left the house he said that he was going to kill someone and then kill himself. Ishika added that Amandeep suffers with depression, had attempted suicide by overdosing a week before and she was concerned he would do this again.

106. The officers called Amandeep's phone and he returned home. He confirmed that he was OK and had been walking around a park but did not want to discuss the matter further, including the issue of his debts. Tulsi disclosed that after he asked for the money and she responded that she had none to give him, Amandeep shouted at her, pushed her and tapped her on her leg. She made a gesture indicating it was a slap. When the officers probed further, Tulsi changed her account saying that he did not touch her but she acknowledged she was frightened when he became angry and started throwing things around the kitchen. Amandeep was arrested for Common Assault which he later denied while admitting causing the disruption to the kitchen. He was released without charge.

107. The officers recorded their actions at the scene on BWV, completed an incident report and a DASH risk assessment that included the statement from Tulsi that Amandeep: *used to take cocaine and had tried to take his life a week ago*. An ACN MERLIN was shared with Redbridge ASC where the First Contact Team forwarded it to RAABIT for follow up contact which was not responded to by Amandeep. A CSU investigator assessed that Amandeep had been under pressure for debt that led to frustration and he required help. The family did not regard his actions as abusive. Amandeep was provided with advice to contact the National Debt-line. Tulsi declined the offer of referral to a DA Support Agency, saying that she did not want further involvement.

108. In mid-April Anna reported to her GP a change of address to another in Waltham Forest. She lived there until mid-November that year when she moved again[19] to the flat in Redbridge that became the scene of the fatal incident. It is not known if Amandeep was aware of these changes but it is known that he somehow traced her whereabouts by 2018 and they resumed a relationship.

109. Around that time Amandeep failed to attend a PSS appointment and he was sent a 'breach letter'. He subsequently explained in a telephone conversation that he had been

[19] Confirmed in GP chronology

unwell. The OM informed him that a decision would be made regarding the breach at the next appointment in early May.

110. About a week after that, Ishika contacted police to report a burglary at her home. Amandeep had returned home from going to the shop and an unknown male had followed him through the front door punching Amandeep to his left ribs. The male had then entered Ishika's room and taken her laptop from a drawer. The male did not enter other rooms and did not take anything else. Ishika felt that her brother's account was *sketchy* and he was not keen for police to be called. He had declined medical help for the assault.

111. Police attended and consulted a Scenes of Crime Officer by telephone who assessed there were no forensic opportunities. Neighbour and CCTV enquiries yielded no information. A burglary was recorded on CRIS. Amandeep was later spoken to and expressed surprise that police had been called. He then disclosed that the male that came to the address was someone he did not want to name but that he had attended to collect a debt from him. He did not have the money to pay the debt so gave him his sister's laptop in lieu. He said that he had since paid the debt and recovered the laptop for return to his sister. The burglary offence classification was altered to 'theft from a dwelling'. The investigator contacted Ishika who confirmed Amandeep's account and made it clear she did not wish to take action against her brother. Amandeep was eliminated as a suspect and the report was closed with no further action.

112. At Amandeep's early <u>May</u> appointment with his OM, they discussed the failed appointment and it was agreed that it would be logged as an acceptable absence. Amandeep confirmed that the family business was being sold and he agreed to follow up his employment needs (seeking a driving job but concerned about his criminal record) with the ETE worker.

113. Amandeep then disclosed that he and Anna had resumed their relationship and thus had breached the RO. This had been for about the last two months and had become intimate again when they would spend weekends together in hotels. He claimed that Anna was content with this arrangement and she regretted the situation that had led to the RO and his prison sentence. He further claimed that Anna had felt under pressure from the police to take out the RO. [Note: Amandeep's version of events relayed to the OM is countered by Anna acting on her own initiative in April 2017 to attend the police custody centre and report continued harassment in breach of the RO, for which he received the prison sentence]. The OM advised Amandeep that he should report this further breach of the RO to the police and he said that he would. Meanwhile, the OM would be consulting a supervising officer.

114. On advice, the OM contacted the police 101 number and provided Amandeep's name and date of birth, explaining that: *One of our service users is in breach of his restraining order,* then asking for a PNC check to be done. A CAD reference number was given to the OM. The PNC check revealed that a RO was in place and Amandeep was convicted at North London Magistrates Court in mid-June but that the RO was <u>revoked</u> on the same day. Nonetheless, the CAD was referred to the Redbridge CSU requesting that an officer is

assigned to speak to the 'informant' (OM) and an appointment was made for 09:00 two days later.

115. It is believed that did not happen and the next entry on the CAD record is: *No restraining order shown on the PNC*. At 20:17 that day, the CAD was reviewed and referred back to the CSU with this request: *If there is no restraining order in place and there is no allegation from the female there is nothing to report?* At 20:36 the CAD was closed with: *No restraining order in place – no offences. 3rd party report in good faith*. Intelligence checks that would have identified the circumstances of the original offences and Anna's identity were not undertaken.

116. Enquiries with the Courts and Tribunals Service (CTS) show that the order that was revoked by the Magistrates was the original Community Order imposed in late March, not the RO which remained in place and was current at the time of the fatal incident. The error appears to have occurred when the Court decisions for that day were uploaded on to the PNC, which is a daily clerical task for Court staff. It has not been possible to explore the matter further.

117. Three days later the OM applied to the Court for a copy of the original RO and, once to hand, made a phone call to Amandeep reiterating the advice earlier given. About a week later May Amandeep's solicitor[20] contacted LCRC to say that Amandeep had been advised not to inform police about the breach but also not to have further contact with Anna. It could only be her decision to apply to the Court to have the RO removed.

118. At their final PSS meeting near the end of May, Amandeep told the OM that he had ceased contact with Anna. LCRC contact with Amandeep ended with an exit interview in mid-June when he attended with a family advocate. The final risk assessment completed within a few days included:
- Low risk of Amandeep's reoffending (based on an actuarial tool)
- Medium risk of harm to a known adult (based on professional judgement of risk factors linked to relationships, thinking and behaviour such as offending behaviour and the further contact disclosed; also protective factors such as the additional scrutiny arising from the disclosure, the report to police, settled accommodation and willingness to engage in improving mental health)
- Risk to self, acknowledged as an ongoing concern
- Future potential risk (ex-partners and any new partners)
- Any relationship breakdown not in Amandeep's control could increase risk; developing empathy and understanding others alongside conflict resolution could mitigate risk.

119. Around the same time in June Amandeep's GP referred him to RAABIT for assessment. Despite repeated attempts at contact and an opt-in letter he did not respond, he was discharged on 16 July and his GP informed.

[20] AS's solicitor was contacted but did not respond

120. In early September, IAPT talking therapies recorded that Amandeep had self-referred to their service. On 13 September this was referred on to the RAABIT and opened for screening. The RAABIT nurse eventually managed to speak to Amandeep by telephone early in October and he reported feeling depressed due to mounting debt of £15k and pressure from bailiffs. A call back to provide debt support information was not responded to and there was no message facility. An appointment letter for early December was sent to his home.

121. In early November, Anna saw her GP to report three instances of fainting in public places in the past month with one ED attendance with ongoing stresses such as long working hours and abdominal signs and symptoms. She was suffering mood swings and feeling more irritable than usual and anxious about the problem. Screening tests were conducted and she self-referred on 6 November to NEFLT for Psychological Talking Therapy. She completed an initial screening and was accepted for treatment; however when the service contacted her in February 2019, with a date to commence treatment, she declined saying she had sought help elsewhere and no longer required the service. It is noteworthy that in the initial screening questions, Anna answered that she had no history of someone being violent towards her and did not report any historic or current abuse. Nonetheless, it could be speculated that an opportunity for further professional curiosity was missed.

122. One morning in mid- November, Amandeep was stopped by police for a minor traffic matter, checks revealed that he was driving without insurance and his vehicle was seized[21]. Before inspecting the vehicle, the officers inquired if Amandeep had anything of value inside. He said he had £5k in cash from winnings at a Casino the evening before. A search commenced and an additional large sum of cash was discovered along with a parcel addressed to another person that he said he had found. He was arrested for theft and a search of his home was authorised. This resulted in the recovery of a bank card in the name of his former partner, Emily.

123. At the LCC, the Custody Sergeant completed a risk assessment and noted that Amandeep appeared unwell. His speech was slurred and he appeared vacant. He informed the officer that he was diabetic, suffered from depression and had taken an overdose last year and again earlier this year. The Sergeant recorded the concern that Amandeep was struggling with his diabetes as he was overdue his medication which he did not have in his possession. A HCP was called and arranged for medication but advised that Amandeep should sleep and would not be fit for interview.

124. An additional assessment was completed for Liaison and Diversion Services, a service commissioned and funded by the NHS for vulnerable people of all ages when they enter the criminal justice system. Amandeep was allowed a call to a Liaison and Diversion Practitioner (LDP) and he informed them that he had been already referred to NELFT RAABIT. He had been offered Talking Therapies. The LDP did not feel that Amandeep met the threshold for Mental Health Act (MHA) assessment or voluntary admission but

[21] 'Operation Reclaim' allows for police seizure of vehicles from unlicenced and uninsured drivers

requested an earlier assessment by the RAABIT (Amandeep had an appointment for 3 December).

125. The custody record shows that Amandeep had talked of a low mood, the effect of his father passing away and the experience of trauma when he was in prison. He voiced concerns at being evicted from his home along with his mother and sister. He claimed that he had won money at the Casino but minimised the suggestion that he had a gambling problem. An email was sent to Redbridge MH team, which would be followed up by a phone call, to ascertain if Amandeep could be seen before the appointment. Amandeep was given a crisis plan, telephone contact for Redbridge and information about housing.

126. Amandeep was released under investigation to return the next day. He provided a prepared statement that explained his winnings from the Casino and that the other cash was a loan from his mother, some of which was to pay off his debt. He made no comment to supplementary questions. Tulsi provided a witness statement to confirm she had lent Amandeep the money. The cash seizure aspect of investigation was transferred to a Financial Investigator and onward to the Central Specialist Crime Economic Crime Team (CSCECT). The owner of the parcel said that a replacement had been provided by the company from which it was purchased. The company had thus become the 'victim' of the theft but it proved not possible to obtain evidence to prove the theft so the report was closed with no further action. When asked about the bank card, Amandeep made no comment and that aspect was also closed without further action[22].

127. In late November, Amandeep called police to report the loss of his mobile phone. Police no longer routinely record lost property and Amandeep was correctly directed to the 'Immobilise' website to register his mobile phone as lost. Any found or recovered phones would be checked against that database. He was provided with a police reference number for the phone call that he could input to the website.

128. Early in December, Amandeep attended his pre-booked appointment and the RAABIT nurse completed an initial assessment. He reported issues with ongoing debts and poor sleep. He spoke about being arrested by police with a large amount of money and stolen goods inside his car and that the case is ongoing. He reported that he was sexually assaulted when he was in in prison in 2017 and is having flashbacks about this[23]. He presented as low in mood and admitted to fleeting suicidal thoughts but had no active plans. Risk assessment completed: low risk. There were several follow up calls to provide information on debt support without reaching him and a letter with the information was sent to his home.

129. In mid-December the nurse was contacted by a Mental Health Wellbeing worker who had been helping Amandeep for three months and sought to discuss Amandeep's mental health presentation. The nurse briefed on her role and the plan for Amandeep, which was to attend a medical review, to contact IAPT for a therapy update and be provided with debt

[22] It appears that the connection was not made to Amandeep's former partner Emily or sister Becky
[23] There is no reference to reporting such an event in his LCRC case notes

support information. An appointment was booked for February that Amandeep did not attend and an opt-in letter subsequently sent.

2019

130. An appointment was eventually made for mid-May with the RAABIT Psychiatrist. Amandeep's presenting condition was noted as: *Low mood, poor sleep with nightmares, flashbacks, social isolation. Diagnosis: Post traumatic stress disorder (PTSD) and moderate depressive episode*. His medication was increased (Mirtazapine 15mg, increasing after two weeks to 30mg) which the GP would monitor along with his health and provide repeat prescriptions, he was placed on the waiting list for Cognitive Behavioural Therapy (CBT) and given a follow-up appointment in three months, later set for early September, a date later than the fatal incident.

131. In the first week of August, on behalf of Lloyds Bank, a Fraud report was recorded because a number of unauthorised payments were made from an elderly females account and paid into three different accounts. Lloyds Bank reimbursed the customer and became the victim of the loss. One of the accounts that the money had been paid into between 25 January and 6 April was identified as Amandeep's. Three days later an arrest enquiry was conducted at Amandeep's home address. The house was undergoing a major renovation at the time and no one was present.

132. Later that morning Amandeep attended Romford Police Station. This was by appointment to be interviewed by fraud investigators in relation to the cash seizure in November 2018. He was further arrested for the Lloyds Bank allegation. A search of his home was authorised and a number of items were seized including another bank card in the name of Amandeep's ex-girlfriend Emily[24]. He was interviewed in the presence of a solicitor and answered 'no comment' to all questions. He was released under investigation and remained so until the fatal incident. Further lines of enquiry were completed, however, and it is possible to hypothesise that Amandeep was one of a number of 'money mules' under the control of an organised crime gang that exploited their accounts to transfer and 'launder' fraudulently-obtained funds.

133. When in custody, (this was about three weeks before the fatal incident), Amandeep was examined by the HCP who noted that Amandeep: *suffers with Diabetes, high cholesterol and depression. He has meds for all here in custody. He appears a little down in mood.* In the Doctor's medical opinion Amandeep was: *depressed / fed up / self-harm / in debt.* And the medical advice recorded was: *no AA [Appropriate Adult] require; having help with depression.* At about this time, Ishika recalls that Amandeep was provided with employment in construction through a family friend and he seemed to have found his ideal work, and talked of becoming a property developer.

134. The police IMR author has reviewed the three occasions when Amandeep was in police detention between April 2017 and August 2019 as a whole. There were multiple custody

[24] Again, the link was not made to Emily/Becky and the case was closed

risk assessments, three HCP reviews and one referral to a LDP variously referencing his diabetes and high cholesterol, depression, debt pressures and suicide ideation/attempts. The Custody Toolkit does cross-reference with the Vulnerable and Protect Adult toolkit but there is no specific requirement to consider the VAF or provide guidance on completion of a MERLIN ACN report to the local MASH when the person is in custody. This has led to a fourth internal recommendation to review the relevant toolkits to ensure more effective links and coordination.

135. Evidence of WhatsApp messages between Anna and Amandeep produced at the Inquest showed that, by late August, Anna was being explicit with Amandeep that their relationship was over, for example (as written):

18:59 (Amandeep to Anna) I miss u x
19:00 (AK to AS) Amandeep I don't miss you and it's time for you to get used to it
19:28 (AS to AK) … will always love u and care for u my dear xxx
19:30 (AK to AS) Please Amandeep don't be a victim of your own mistakes
19:48 (AK to AS) And don't expect me to have pity for you after what you have done in two years
19:49 (AS to AK) I'm not baby I want u to be happy my baby
19:50 (AK to AS) I will start with a simple note you have started the relationship first time based on many lies correct or not? We have ended up the whole thing in the biggest possible disaster and chaos caused by you not me
19:50 (AK to AS) After one year I have decided to talk to you and tried to give you second chance, but I have realised it was biggest mistake I have ever done in the end
19:51 (AK to AS) Because you did not change much you continued lieing to me and disrespect me
19:52 (AS to AK) Pls I'm sorry
19:52 (AS to AK) Pls don't say no more darling
19:52 (AK to AS) However as many great moments we had together I will cherish these forever, but somehow I'm sorry I can't love you ever again and this is the consequence of the fact how I was treated by you through out.

The homicide and suicide

136. One evening late in August, Anna was at the Westfield Centre in Stratford, LB Newham on a pre-arranged date. Returning home on the bus, Anna noticed that Amandeep was following her in his car. She called him and he denied the surveillance saying he was home in bed. The homicide investigation team conducted cell site analysis on Amandeep's phone and ANPR sightings of his car that confirmed his surveillance of Anna that evening.

137. At about 13:00 the next day, a neighbour called police to Anna's flat in Redbridge because she could be seen lying prone and covered with blood in the garden with her legs over the rear door threshold. Police and paramedics attended, forced entry to the flat and found Anna as described in the call. Stab wounds were evident, including a severe cut to the right side of her neck. Nearby was a bloodstained knife and her mobile telephone. She was clearly beyond saving and life was pronounced extinct at 13:12.

138. Also in the kitchen was the unconscious form of Amandeep lying on his back. He had slash wounds to his left wrist and neck and another kitchen knife lay nearby. There was an irregular heart rhythm detected and resuscitation commenced without success. His life was pronounced extinct at 13:45.

139. Post mortem examinations were later conducted. There were in excess of 40 stab wounds to Anna's body, including defence wounds on her hands. Such an attack would meet the definition of 'Overkill' in the latest Femicide Census Organisation 10-year study (2020) which cites an earlier study[25] that identified 'Overkilling' as: *the use of excessive, gratuitous violence beyond that necessary to cause the victim's death*. Over the ten-year study period there was evidence of overkilling in 55% of the femicides analysed.

140. The cause of death for Anna was: *Hypovolemic shock[26] and incised wounds to the neck and chest*. For Amandeep, it was: *Hypovolemic shock and stab wound to the neck.*

141. Forensic examination of the scene concluded that there was no evidence of forced entry or third party involvement and it cannot be established how Amandeep gained entry[27]. Having done so, the hypothesis is that Amandeep killed Anna using one knife and then took his own life with another and this was confirmed by the Coroner having heard the evidence tendered in the Inquests.

142. That morning at 11:40 Anna had sent a work-related email to a colleague. Cell site analysis on one of his telephones recovered from the scene showed that Amandeep was in the house at that time. Amandeep had a second telephone that was recovered from the boot of his car which was noted to be parked at an odd angle to the kerb. His family pointed out at the Inquest that parking in this way was Amandeep's habit.

143. Interrogation of Amandeep's telephones for internet based searches revealed that from mid-August, Amandeep conducted multiple inquiries relevant to the outcome of the fatal incident:

Best methods for killing someone by stabbing (7)
Sourcing knives (4)
Euthanasia and assisted suicide (5)
Best methods for suicide (9)

144. In addition, he searched how to: *Track my girlfriends iPhone without knowing her apple ID* and *By holding someone drowning can police tell*? He made six enquiries to source poisons such as cyanide. The most prescient search was at 00:17 on the day he killed Anna then took his own life: *If some kills there lover then commits suicide [sic]*. It is known from London-based research[28] that, for perpetrators of domestic violence, there is a strong link between suicidal behaviour and being homicidal.

[25] Mitchell, C., Anglin, A., (2009) *Intimate Partner Violence: A Health-Based Perspective*, p. 325, Oxford University Press
[26] Significant loss of blood – more that 40% in volume likely to cause loss of consciousness
[27] In an earlier WhatsApp exchange Anna had referred to "raquets" she had that belonged to Amandeep
[28] https://www.standingtogether.org.uk DHR Process and Analysis Report 2020

145. Ishika and her mother remain astonished by this violent conclusion to Anna's and Amandeep's lives. Accepting that he had often thrown things in the past and sometimes lashed out with physical contact when frustrated and distressed, he had never to their knowledge committed an assault with intent to cause injury or used a weapon. Moreover, he had a life-long aversion to knives and sharp objects such as needles used for injections, a point that was raised in questions at the Inquest.

146. Amandeep had been diagnosed with ADHD, had abused drugs and alcohol and fallen into significant debt that had led to depression and suicide ideation, some of which had led to hospitalisation and, latterly, a diagnosis of PTSD. However, during the week in which it is now known he was conducting internet searches indicative of planning the terrible end to their lives, Amandeep had appeared to his family as noticeably calm and settled, even happy.

147. Another question raised by the family was that, on the morning of the homicide, Amandeep had taken a call from a relative in India just prior to his arrival at Anna's flat and would barely have had time to travel there, thus opening the possibility of third party involvement in Anna's homicide that was then discovered by Amandeep who was either also unlawfully killed or took his own life through grief. From their perspective, this could have been connected to the debts that Amandeep had accrued. In ruling out this possibility, the Coroner alluded to the cell-site analysis of Amandeep's telephone, the absence of forced entry to the flat and the fact that all footprints found in the substantial blood staining at the scene were accounted for by comparison with officers and paramedics' footwear.

ANALYSIS

Overview

148. There is limited information available to this review about how and when Amandeep somehow persuaded Anna to enter a relationship with him again. He was known for his romantic gestures but also for his persistence to the level of manipulation and causing her to be fearful. In the weeks leading up to the fatal incident Anna told a friend that she was slowly trying to ease him out which she was finding difficult. Police involvement with her had been frequent between October 2016 with the first report of an assault by Amandeep and June 2017 when the Restraining Order imposed by the Court was breached and Amandeep imprisoned. Amandeep disclosed to an Offender Manager in May 2018 that he and Anna had resumed their relationship but then said he was no longer in contact with her. The RO was still in force when Anna was unlawfully killed in August 2019, albeit the PNC showed it had been revoked.

149. Had the PNC record that informed the police control centre decision been accurate, it is probable that the police would have followed up the concerns of Amandeep's OM arising from his self-disclosure that he had breached the RO by re-joining the relationship with Anna because they would have had reasonable grounds for arrest. The extent to which

such action would have changed the course of events is speculation but the question is raised concerning the quality assurance of PNC records that are meant to accurately reflect Court decisions, particularly in matters relating to safeguarding, sauch as Restraining Orders.

150. Relevant information on Amandeep is more plentiful, starting with an ADHD diagnosis when he was a teenager and then with early depression. In April 2017 one psychiatric liaison report identified possible elements of personality traits that may need to be explored further but that was not progressed. In his case also, there is long history of domestic abuse incidents involving his family, drunkenness and overdoses resulting in multiple visits to hospital Emergency Departments, particularly noticeable after January 2018 when his father died. There were six reports of an overdose or a binge drinking session in the following months culminating in a mental health episode and believed assault on his mother at the end of March. By November he was being supported by a Liaison and Diversion Practitioner who did not feel that Amandeep met the threshold for a MHA assessment but did refer him to the RAABIT for support. He was eventually assessed by a Psychiatrist from that team in May 2019 and diagnosed with PTSD and moderate depressive episode, placed on the waiting list for CBT and prescribed anti-depression medication.

151. Later that year, evidence emerged of Amandeep's mounting debts incurred either through gambling or drug dealing or both. He was also being pursued by court bailiffs for unpaid parking tickets and other civil debts. By August 2019, he was subject of a double investigation into unexplained cash possession joined with money laundering activity associated with an organised crime gang. His last medical assessment when in police custody about three weeks prior to the fatal incident was that he was depressed, fed-up, thinking of self-harm and in debt. He had been released under investigation pending further enquiries. By any measure, his financial situation was dire with no obvious solution. His allegation to a psychiatrist in December 2018 that he had been sexually assaulted when in prison for the RO breach and had suffered flashbacks would, if true and the PTSD diagnosis correct, have shaped his vision of being sent to prison again.

152. There is no knowing precisely what was in Amandeep's mind when he somehow gained access to Anna's flat one evening in late August 2019 but the history of internet searches on his phones in the previous week provides powerful evidence of his burgeoning intent to kill Anna and then himself. There is substantive research[29] available that relationship-based homicides are rarely spontaneous and the: 'He just snapped' explanation, which suggests an immediate proximal provocation, is not supported. Schlesinger describes 'catathymic homicides' as occurring when:

> *There is a change in thinking whereby the offender comes to believe that he can resolve his inner conflict by committing an act of extreme violence against someone to whom he feels emotionally bonded.*

[29] Schlesinger 2002, Adams 2007, Monckton Smith 2012

153. A recent study[30] of Intimate Partner Femicide (IPF) uses Foucauldian analysis to track the eight stages that were present in almost all the relationships' progression to homicide. To inform the learning for this review, evidence drawn from the narrative above will be compared to the research findings:

Stage one: Pre-relationship history of stalking or abuse by the perpetrator

When Amandeep's relationship with Emily broke up in July 2009, his persistent harassment and stalking behaviour toward her resulted in Amandeep being issued with a First Instance Harassment Warning.

Stage two: The romance developing quickly into a serious relationship

It is known that the relationship started in a West End Club and it developed rapidly into intimacy and that Amandeep was given his own key to Anna's flat.

Stage three: The relationship becoming dominated by coercive control

The main elements of coercive control[31] by Amandeep were: psychological – Anna reported that Amandeep had been over-dramatic in relationship discussions. He had 'staged' an impulsive overdose outside her flat. He had sent her pictures of a female who appeared to be deceased with blood around her. He had stalked her place of employment and she told police officers she was frightened after his strange behaviour. When they spoke of breaking up he talked of kidnapping her (saying that was a 'joke'); physical – the first encounter with police was by passing officers noticing Amandeep had Anna in a restraint. He pushed her when she found him in her bed while she had been away and was arrested for common assault. His repeated stalking behaviour was intimidating. He breached a Restraining Order imposed in March 2017 within a month of its imposition; sexual – post the separation, Amandeep was using Anna's topless image as his WhatsApp identity image which is a form of sexual abuse; financial – it is known that Amandeep was short of money, was gambling, dealing drugs and hassling his parents for cash but it is not known if that impacted on Anna's finances; emotional – Amandeep drew upon Anna's protective instincts by his dramatic displays and using his 'puppy dog' appeal to her emotions. His persistent harassment had the effect of grinding down her resistance.

Stage four: A trigger to threaten the perpetrator's control

It is confirmed in the Femicide Census research that separation leading to loss of the perpetrator's control is a time of heightened risk. This had been 'managed' in the first instance by a Restraining Order that he later breached and served a term of imprisonment. They had re-joined the relationship despite this being a further breach but, by June 2019, Anna was trying to slowly ease him out. In WhatsApp messages two days before the homicide Anna was clear that their relationship had ended

Stage five: Escalation - increase in the intensity or frequency of the partner's control tactics

Amandeep had found a way to re-engage the relationship but, when it did not sustain, the reality of a second separation challenged his desire to exert ultimate control and punishment.

Stage six: A change in thinking/decision to act

There is evidence that Amandeep was conducting multiple outcome-related internet searches over the eight days prior to the fatal incident. He carried out covert surveillance

[30] Monckton-Smith 2019

[31] See full definition in ToR appendix 1

of Anna the evening before the homicide that may have confirmed to him she was in a new relationship.

Stage seven: Planning

Amandeep had frequently spoken of, and attempted, suicide in the past by overdosing. The internet searches for poisons and knives provided him with a more straightforward option to use knives. He conducted covert surveillance the evening before.

Stage eight: Homicide

The research suggests, as is found in this review, it is not unusual for the extreme level of violence (termed 'Overkill' in the research cited above) to appear to have no direct relation to the level of violence evidenced earlier in the relationship. Amandeep's subsequent suicide points to a determination to complete his particular 'journey to homicide' by also ending his own life.

154. From the safeguarding perspective, there were some opportunities to disrupt the stages identified in the IPF study arising from contact with Anna during 2016-17 and these were developed into action that led to the imposition of a Restraining Order and also dealt appropriately with the breach that followed. Renewed contact between her and Amandeep may have occurred in the context of her sending him a condolences message when his father died in January 2018 and it is now known that a friend saw them dating again in June 2019, but none of this was known to anyone in safeguarding.

155. The first awareness of what was a further breach of the RO was Amandeep's disclosure in May 2018 to his Offender Manager. When this was checked on the PNC the record indicated that the RO had been revoked in June 2017 which did not give rise to police action because no offence was revealed. It is likely that there was an error on the recording of the sentence on PNC by a Court official because it was the Community Order that had been revoked, not the RO. Following his disclosure, Amandeep did not inform the police about the breach as the OM had advised him, possibly because he had received legal advice to the contrary.

156. Contact with Amandeep was more frequent and, while his suicidal ideation was apparent from his repeated hospital ED attendances, the talk of his burgeoning debt problem and his depression following the death of his father, there was no indication recorded that he intended Anna physical harm. At one KGH ED attendance in March 2018 he disclosed the RO regarding Anna during triage but he did not follow up that visit with the RAABIT so the opportunity for professional curiosity did not arise there and the RO is not referred to by him in other clinical notes. Nor is it recorded whether he was asked about the potential risk he posed to others or whether his issues with mental health were cross-checked with his history of violence against women and family.

157. It is felt that the inaccurate recording on PNC that the RO had been revoked led to a missed opportunity for the police to investigate the breach, take steps to speak to Anna about any further harassment and bring it to the attention of the Court for sanction. The fact that Amandeep himself believed he was in breach and that this was relayed to them by a concerned OM, could have been dealt with proactively, for example, by a basic

intelligence check and through a 'safe and well' check on Anna, rather than being closed without professional curiosity being applied.

158. As part of the IMR template, reviewers were invited to conduct analysis from the perspective of their organisation.

Metropolitan Police Service perspective

159. It is important to highlight that, over the 17 years since the first report of abuse in 2003, policies and procedures have changed to improves risk assessments and partnership working. DA toolkits provide checklists for all staff to access. A major restructuring in 2017 has formed 32 Borough commands into 12 areas. This has led to a dedicated Safeguarding Unit in each area and enhanced training for all staff. [Note: Specialist advisers have recent anecdotal experience in Redbridge of an unintended consequence in that it is more difficult for officers to identify to which services victims should be referred. This has been flagged up for with the new North East command for remedial action].

160. Since first coming to police attention for domestic abuse in 2003, Amandeep has been involved in 15 DA reports, with the majority involving his family and recorded as NCDV. Amandeep showed his propensity for harassment abuse in the relationship with Emily in 2009 when he was issued with a FIHW. In the four reports made by Anna in 2016/17 there was one note that she had declined referral to the National Centre for Domestic Violence but there were also missed opportunities to discuss with her the support available from local DA Support Agencies, an IDVA or referral to the MARAC.

161. In the reports regarding Amandeep, relationship breakdown, mental health and money are consistent themes, in particular when incidents have occurred with his father over demands for money, then his mother once father died in January 2018. Financial pressures should trigger a risk and vulnerability consideration. This was not always the case and there are occasions when Amandeep was in custody when an ACN MERLIN should have been recorded. This has also happened when Amandeep was reported missing and a system error has been identified in those cases.

162. The custody risk assessment following Amandeep's arrest for fraud three weeks prior to the fatal incident revealing the extent of his depression was a missed opportunity to generate an ACN report for the attention of Adult Social Care who may have had an open case on Amandeep[32].

North East London NHS Foundation Trust perspective

163. RAABIT received four separate referrals for Amandeep between April 2017 and June 2018 and the first three referrals were discharged without any positive engagement with him because he did not respond to attempts to contact him. This is in keeping with the

[32]AS was under RAABIT with an appointment for early September 2019

nature of the service and the standard operating policy and there is no indication that earlier engagement would have altered his presentation or the treatment offered.

164. In December 2018 the team nurse completed an initial assessment of Amandeep as 'low' and when he was eventually further assessed by the team psychiatrist in May 2019 about 14 weeks before the fatal incident, he was diagnosed with PTSD and mild depressive episode and referred back to his GP with increased anti-depression medication. Risk assessments were completed or updated by NELFT mental health services staff appropriately following appointments and there does not appear to have been any indication of increased risk identified.

Barking, Havering and Redbridge University NHS Trust perspective

165. Despite the numerous attendances related to drug and alcohol abuse, there is no mention in the documentation of a referral to Drug and Alcohol Services. It is unclear whether these conversations occurred and clearer documentation of this may have helped provide a picture of how willing Amandeep was to engage with services

166. Professional curiosity regarding having a partner at home and any issues related to domestic abuse. Guidance often leads professionals to look for the vulnerability of the victim, however, in this case, further questioning of Amandeep's current relationships may have revealed clues to identify Anna. On one clinical entry, Amandeep mentioned a previous relationship and restraining order against him from that partner. If asked, he might have divulged information regarding the current relationship.

167. Throughout the review it is noticeable that more detailed record keeping may have enhanced the learning from this event, particularly in relation to failed attempts at interaction, acceptance of support from drug and alcohol referral and whether referral to external safeguarding teams were made.

London Community Rehabilitation Company perspective

168. In terms of management of risk, the overall assessment of risk level was accurate across all periods of supervision. There were some gaps in using the full range of options available to manage risk, but these were unlikely to have altered the outcome, given the length of time elapsed since the end of supervision and the tragic killing of Anna and death of Amandeep. Nonetheless the knowledge and training gaps identified in this review have subsequently been addressed by the organisation: London CRC has recently introduced an updated version of SARA (SARA 3) and implemented training for practitioners across London. A new case management system was also introduced in 2019 which requires assessors to indicate why a SARA has not been completed. This allows for monitoring of completions and allocation of SARAs to trained staff to ensure completion.

Refuge perspective

169. Specialist DA advisers from Refuge did not have contact with either party so did not provide an IMR but they have brought their considerable expertise to review IMRs and draft

overview reports and their feedback has been incorporated in the body of the report. Some concerns are more strategic:

1. Notwithstanding her good command of English and her job as an interpreter, the fact that Anna was Lithuanian may have presented a cultural barrier to her accessing specialist domestic abuse services.
2. There is an apparent heightened risk of domestic homicide to Eastern European women that should be explored. The Femicide Census study (earlier referred to) shows that Eastern European women appear to be disproportionately killed by men, with women from Lithuania constituting one of the four most prevalent nationalities of Eastern European victims.
3. Generally there was a real lack of coordinated community response in this case, with each service working in isolation and very little evidence of agencies working together to increase the safety of the victim and manage the risk of the perpetrator.

CONCLUSIONS, GOOD PRACTICE AND LESSONS LEARNED

170. The Panel have debated how the learning from this review can improve safeguarding in Redbridge. The review has identified that Amandeep Singh heavily used alcohol and drugs and that seemed to lead to mounting debt pressures, gambling and involvement in organised crime. In turn this may have been relevant to his mental health challenges, manifest in depression and suicidal ideation/actions. Alongside, he had a history of domestic abuse - of his close family, of a former partner and mother of his child and of a former intimate partner, Anna Kipras. It is stressed that these are identifiable risk factors and do not amount to a reason or an excuse for Anna's homicide.

171. The complexity of this intersection resonates strongly across the duty to safeguard that spans multi disciplines. The daily challenge for professionals in their respective silos, while 'firefighting' the immediate problems within the pressure to succeed, is to dedicate some time to view the bigger picture, to 'join the dots' and to understand the connections so as to achieve positive outcomes as a team.

172. Risk assessment is a core requirement of safeguarding, but its effectiveness is predicated on 'best information'[33] that has been communicated on the basis of public safety for a coordinated response. Issues such as GDPR and patient confidentiality are important but professional judgement should be applied and the rationale recorded in the risk assessment. As one Panel member has remarked: "Everyone has a responsibility for professional curiosity".

173. Structures such as MASH and MARAC have rightly emerged in recent years as models of joint working and have been effective in managing risk and ensuring coordination and accountability for action. The MASH in Redbridge is known for effectively managing coordination of children's safeguarding but, so far as adult safeguarding is concerned, has been more of a post box for referrals (for example, MERLIN of March 2017 referred on to

[33] Meaning all of the information available together with a clear understanding of what needs to be ascertained

the RAABIT). Surrounding Boroughs, such as Waltham Forest, have a MASH equally focussed on their adult safeguarding coordination role.

174. There is a danger that these structures become bureaucratic and moribund processes if the dynamic nature of intersectionality is not proactively managed. It may be more productive to think and plan for the worse case, if only because it is easier and more cost effective to scale down a properly flexible and coordinated response than to have to rapidly scale up to address a systemic failure.

175. It should not be necessary to introduce new structures; rather it may be more effective as well as efficient to challenge the undoubted pressure for silo working by: Working together for the right result. The words of Lord Laming in the Victoria Climbie Inquiry[34], could help define the desired working culture for Redbridge Community Safety Partnership: To bring a healthy scepticism, an open mind and, where necessary, an investigative approach.

176. It is not known what different outcome could have been achieved had Anna been referred to the Redbridge MARAC or, indeed, to what extent Anna was aware of the support available or what barriers there were to her identifying and accessing specialist domestic abuse services. The Refuge VAWG service was running in Redbridge at the time that she could have accessed or been referred to regardless of level of assessed risk. Since 2020 Refuge have initiated a project that provides an enhanced Eastern European outreach service that provides cultural and language specific support to Eastern European women.

177. A different outcome may have occurred if the administrative error that led to inaccuracy on the PNC had been corrected at source, however, the challenge would be how to quality assure what is a vast operation to upload daily Court decisions to the PNC. It was initially felt that a feasibility study might assist to narrow the scope of the challenge, such as by the CTS introducing a supervisory check of any change to a PNC record that refers to Restraining Orders.

178. Following further enquiries, it is understood that the system for adding Court findings to the PNC is complex and should be approached systemically. Findings from a Magistrates Court are recorded on a CTS system known as ‘Libra’. This is automatically fed into the MPS ‘B7’ system and onwards updated onto the PNC. Anything that fails or is classed as a ‘trigger/exception’ will appear on the B7 Portal to be updated manually.

179. A further complication occurs when such disposals are ordered by Crown Courts, the CTS system for which is known as ‘Xhibit’. These cases all have to be manually updated to the PNC.

180. A court sentence being added to PNC consists of the relevant court, plea, date of sentence and the disposal. Disposals for PNC purposes are a set list of numeric codes and these are added along with text providing details. The disposal list may include the fact the person received an order and this will be added along with the duration but the

[34] Para 14.78 The Victoria Climbie Inquiry (2003)

disposal history page is not designed to hold the conditions. Details of orders to include conditions and expiry date are added to the operational information page of PNC.

181. Thus, an Order will be recorded on the disposal history page of PNC, however it will also need to be included on the operational information (OI) page. To be able to record the details on the OI page a reference (for example, Crimint) has to be supplied to enable the circulation to take effect. At present in the MPS, the PNCB who will add the details to PNC require the OIC/Unit dealing with the case who get notified of the order to provide a copy of the order along with a completed form PNCB18, so the details can be added to the PNC operational page.

182. This evident complexity in the system leads the Panel to conclude that a systemic review should be jointly held by the MPS and the CTS to identify the remedial action required to ensure accuracy and timeliness in the recording of Restraining Orders and other relevant information on the PNC. The MPS should also ensure that any changes are agreed nationally.

Good practice identified

183. The BHRUT IMR identified that liaison with Mental Health Services is evident throughout Amandeep's attendances to BHRUT Emergency Departments.

184. Amandeep was referred to the RAABIT service on a number of occasions and discharged due to lack of engagement. It is positive to note that this did not prejudice NELFT mental health services when making or accepting further referrals and he was engaged with the RAABIT service from October 2018 until the date of the incident. The RAABIT communication by phone and letter following up on non-attendance and providing debt support advice when he did attend was also commended in the NELFT Serious Incident Report.

185. LCRC identified that required assessments were undertaken in a timely way, and where possible new sentencing events were allocated to an officer already familiar with Amandeep. There was also evidence of good professional judgement to maintain compliance, for example in not instigating breach to allow for completion of requirements near the end of an order, and maintaining contact to encourage continued engagement after report to police. There was good use of practical support to progress employment. There was a prompt response in reporting breach of the restraining order to the police and good efforts to maintain a working relationship which appeared to have a positive impact on Amandeep's willingness to disclose personal information.

186. Refuge have pointed to good practice since July 2020 whereby they have been providing a specialist Eastern European Outreach Service in Redbridge and Barking and Dagenham with a team of staff who speak Eastern European languages and have knowledge of Eastern European cultures.

Lessons learned

187. The strategic learning points identified from this review are:
    1. The need to improve understanding across agencies of the complexity of the known intersectionality and the partnership response required and Redbridge should consider expanding its MASH processes to embrace the coordination of both children's and adult safeguarding
    2. The need to refresh and develop the understanding of professionals regarding referral to support services regardless of level of risk and referral to MARAC in repeat or high risk cases so they are better informed and more confident and responsive to professional judgement on risk
    3. The need to build upon the Refuge specialist Eastern European Outreach Service community project
    4. The need to conduct a joint review of the approach to the recording of Restraining Orders, and any changes thereto, on the Police National Computer by the Courts and Tribunals Service.

RECOMMENDATIONS

188. The MPS, NELFT BHRUT have made recommendations for system improvements within their respective organisations (consolidated with progress updates in appendix 2):

MPS

North East BCU to dip sample:

1. DA reports to ensure Support Agencies and IDVA referrals are recorded
2. DA reports to ensure compliance with current MARAC referral criteria and that rationale is being recorded
3. Adult MERLIN reports to ensure they are being generated where a 'Safe and Well' debrief has been completed, vulnerabilities identified and they are shared with Partner Agencies
4. CPIC[35] to review the custody policy toolkits and Vulnerability and Protection of Adults at Risk policy toolkits to ensure guidance is available to staff about the requirement for recording ACN MERLIN reports when vulnerability and risk is apparent

BHRUT

1. Case Study to be presented by the Trust Safeguarding Team and lessons learned shared in relation to this case regarding documentation and professional curiosity

NELFT

1. Mental health service staff in the NELFT assessment and triage services to have refresher training on the risks associated with drug and alcohol use, mental health issues and domestic violence
2. Increased information-sharing and liaison opportunities between mental health/drug and alcohol services and police/criminal justice agencies.

LCRC

1. London CRC to re-check that relevant supply chain staff have received mandated training in relation to domestic abuse and MARAC framework

[35] Subsequently renamed the Front-Line Policing Delivery Unit (FLDPU)

2. Operational Managers to confirm ongoing support and monitoring of practitioner training needs to ensure access to the right level of training at the right time.

Refuge

The enhanced Eastern European outreach service is currently a short-term project as it only has one year of funding from MHCLG.

1. It is recommended that the boroughs identify funding in order to extend the service and the cultural and language specific support provided to Eastern European women.

189. Recommendations for multi-agency or wider improvements have been discussed and agreed by the Panel following the conclusion of the joint Inquests and observations by the Coroner. The Action Plan in appendix 3 follows the four Learning Points above and is populated with progress on the following recommendations:

1. To improve understanding across agencies of the complexity of the known intersectionality and the partnership response required and to consider expanding Redbridge MASH processes to embrace the coordination of both children's and adult safeguarding
2. To refresh and develop the understanding of professionals regarding referral to support services regardless of level of risk including referral to MARAC in repeat or high risk cases so they are better informed and more confident and responsive to professional judgement on risk
3. To build upon the Refuge specialist Eastern European Outreach Service community project
4. To conduct a joint systemic review by the MPS and the CTS to identify the remedial action required to ensure accuracy and timeliness in the recording of Restraining Orders and other relevant information on the PNC. The MPS should also ensure that any changes are agreed nationally.

Author

Bill Griffiths CBE BEM QPM

14 November 2022 (V11)
30 December 2023 (V12)

Glossary

ACN	Adult Coming to Notice
ASC	Adult Social Care
BDHR	Barking and Dagenham, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University NHS Trust
CAD	Computer Aided Dispatch
CCG	Clinical Commissioning Group
CPIC	Continuous Professional Improvement Command
CSU	Community Support Unit
CTS	Courts and Tribunals Service
DA	Domestic Abuse
DV	Domestic Violence
DHR	Domestic Homicide Review
ED	Emergency Department
FLDPU	Front-Line Policing Delivery Unit
GP	General Medical Practitioner
IAPT	Improving Access to Psychological Therapies
IMR	Individual Management Review
KGH	King George's Hospital
LAS	London Ambulance Service NHS Foundation Trust
LB	London Borough
LCRC	London Community Rehabilitation Company
LBR	London Borough of Redbridge
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
NELFT	North East London NHS Foundation Trust
NHS	National Health Service
OM	Offender Manager
PNC	Police National Computer
pnn	Police National Network
PSS	Post-Sentence Supervision
RAABIT	Redbridge Access, Assessment and Brief Intervention Team
ToR	Terms of Reference
WXUH	Whipps Cross University Hospital

Name references used

Anna (31)	Victim of homicide
Amandeep (42)	Perpetrator of homicide who took his own life
Mohinder	Father of Amandeep
Tulsi	Mother of Amandeep
Ishika	Sister of Amandeep
Emily	Former partner of Amandeep
Becky	Twin sister of Emily

Domestic Violence Homicide Review Panel – LB Redbridge CSP
Anna Kipras unlawfully killed by Amandeep Singh in Redbridge and both found dead in August 2019

Appendix 1

Context for review

In late August 2019, police were called to a ground floor flat in Redbridge, where **Anna Kipras,** aged 31, was found fatally stabbed. Also discovered was the body of **Amandeep Singh**, aged 43, from another address in Redbridge, who had apparently died from self-inflicted stab wounds, there being no evidence of third party involvement. They had been in a domestic relationship. An Inquest into the deaths has been opened and will be heard in April 2020.

A Domestic Homicide Review (DHR) into the deaths has been commissioned by the London Borough of Redbridge Community Safety Partnership under s9 Domestic Violence, Crime and Victims Act 2004.

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

4. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified. [Note: agreed on 18/11/19 that period of review would be January 2014 to August 2019 - date of deaths]

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Note: agreed that a representative from NELFT should attend and specialist advice on mental health would be needed. Also agreed that the Refuge representative would provide specialist advice regarding Lithuanian culture]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: third party involvement has been ruled out so there will be no criminal trial; any misconduct issues have yet to be established; the Coroner will be holding a Inquests in April 2020]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required. [Note: AK is White Eastern European and AS is South Asian British. The Refuge representative is an Independent Domestic Violence Adviser]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings. [Note: no record at MARAC/MAPPA]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2018, if so, how it could be best managed within this review. [Note: there are no children involved. A reference in records toAS having 'a dependent' will be researched]

7. To determine whether this case meets the criteria for an Safeguarding Adult Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs'. [Note: some evidence of mental health issues for AS but insufficient to conclude need for SAR at this stage. Will be kept under review]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she was looking after, prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it. [Note: AK's family have returned to Lithuania where AK also buried. They would require a Lithuanian translation of the Home Office leaflet and can be met at the Inquest. The Chair will meet AS's family and AK's flat mate. AK worked from home]

9. To identify how the review should take account of previous lessons learned in the LB Redbridge and from relevant agencies and professionals working in other Local Authority areas. [Note: in hand with Redbridge Community Safety and the Chair]

10. To identify how people in the LB of Redbridge gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague. [Note: in hand with Redbridge Community Safety and the Chair]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Anna Kipras and Amandeep Singh, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1 January 2014 relating to Anna Kipras and Amandeep Singh. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Anna Kipras and Amandeep Singh
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of Anna Kipras and Amandeep Singh

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with Anna Kipras's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Appendix 2

Consolidated internal recommendations from agency IMR's[36]

Rec No	Agency/Source	Action taken or to be taken within agency	Outcome of action, what has been achieved and date of completion
1	Metropolitan Police Service (MPS)	It is recommended that North East Basic Command Unit (NEBCU) Senior Leadership Team (SLT) dip sample DA reports to ensure DA Support Agencies and IDVA referrals are being referred to and the contact recorded within report	Risk Management Team set-up to ensure cases like this won't be missed in future and a DCI will conduct the dip-sample of current cases. NE BCU being used as an example of good practice and will be used as a positive example. MERLIN's are dip-sampled to ensure appropriate referrals are made. Also additional training to be provided for supervisors. Completed November 2020
2		It is recommended that NEBCU SLT dip sample DA reports to ensure compliance with current MARAC referral criteria and that rationale is being recorded within report	As above In addition, Duty Officers receive a handover of all DA calls, action taken is outlined and dip-sampled to ensure nothing has been missed. Completed November 2020
3			

[36] To be updated by IMR author for BRHUT

		It is recommended that East Area (EA) BCU SLT dip sample Adult MISPER Merlin reports to ensure ACN Merlin reports are being generated where a 'Safe and Well' debrief has been completed, vulnerabilities identified and that they are shared with Partner Agencies	BCU are setting up a Continuous Improvement Team to identify such issues where the missing person report does not generate a Vulnerable Adult referral and will ensure correct procedures are followed and will review such incidents. Completed November 2020
4		It is recommended that the MPS Front-Line Policing Delivery Unit (FLPDU) review the current Custody policy toolkits and Vulnerability and Protection of Adults at Risk policy toolkits to ensure guidance is available to staff about the requirement for recording ACN Merlin reports when vulnerability and risk is apparent	BCU Commander has referred action to FLPDU to get percentage of MERLIN's for Adult missing persons where they are identified as vulnerable are translated into Adult Come to Notice MERLIN Completed November 2020
5	North East London Foundation NHS Trust (NEFLT)	Mental health service staff in the NELFT assessment and triage services (PLS, RAABIT) to have refresher training on the risks associated with drug and alcohol use, mental health issues and domestic violence	Completed January 2022 Presentation delivered by NELFT Named Professional - Safeguarding Adults This training supported NELFT staff to update their knowledge base regarding domestic violence, especially the increased risks associated with drug/alcohol abuse, the importance of professional curiosity and what to do if they have concerns.

6		Increased information-sharing and liaison opportunities between mental health/drug and alcohol services and police/criminal justice agencies	<u>Completed January 2022</u> Redbridge mental health services & substance misuse services have set up a weekly surgery facilitated by a substance misuse worker on mental health service premises, for mutual clients to be referred/assessed, and for mental health staff to have the opportunity to gain updates/information on clients who may be under substance misuse services. A liaison worker has been identified in each adult mental health team to support this initiative. In addition, there is a monthly Consultant-led dual diagnosis meeting to discuss complex clinical cases, attended by the Consultant from substance misuse services and the Associate Medical Director for Redbridge mental health services in addition to any other staff who want to discuss complex or concerning cases. Mental health service staff also attend MAPPA, MARAC, IOM & PREVENT monthly meetings with police to discuss cases of concern. Information from these panels is shared across agencies, and these also enable liaison & closer working

			relationships to be formed across services
7	Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT)	Case Study to be presented by the Trust Safeguarding Team and lessons learned shared in relation to this case regarding; • Documentation • Professional Curiosity	The team had to prioritise other case studies in the bulletin and this recommendation will be completed by November 2022
8	London Community Rehabilitation Company (LCRC)	London CRC to re-check that relevant supply chain staff have received mandated training in relation to domestic abuse and MARAC framework	Completed for LCRC July 2021 London Community Rehabilitation Company (LCRC) ceased to exist on 26th June 2021, at the point of reunification of probation provision into one national provider: the Probation Service. Prior to unification, LCRC staff completed all mandatory training, including domestic abuse training. All supply chain staff also had mandatory training delivered. Post-unification of the system, all staff in the new Probation Service, including ex supply chain staff, are required to undertake a further mandatory learning and development plan. This includes domestic abuse training and in-depth training on principles of risk management

			and use of key partnership risk management structures. Probation Delivery Units in every borough engage with and attend MARAC meetings and individual supervision of all practitioners is in place to provide oversight of risk management and good practice advice
9		Operational Managers to confirm ongoing support and monitoring of practitioner training needs to ensure access to the right level of training at the right time	<u>Completed for LCRC July 2021</u> As mentioned above, all practitioners in the new Probation Service are subject to mandatory training plans. Completion is monitored to ensure that all staff have completed their necessary training. Regular supervision is in place to support all staff in case management and identify additional individual learning that may be required to support practice development. Management information is available to support managers in focussing oversight and supervision to cases that pose risk concerns, including domestic abuse perpetrators

Appendix 3

Domestic Violence Homicide Review Panel – LB Redbridge CSP
Anna Kipras unlawfully killed in Redbridge by Amandeep Singh and both found dead in August 2019

ACTION PLAN[37]

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones Achieved in enacting recommendations	Target Date	Date of completion and outcome
Learning Point 1: The need to improve understanding across agencies of the complexity of the known intersectionality and the partnership response required and Redbridge should consider expanding its MASH processes to embrace the coordination of both children's and adult safeguarding						
1 To improve understanding across agencies of the complexity of the known intersectionality and the partnership response required and to consider expanding Redbridge MASH processes to embrace the coordination of both children's and adult safeguarding	LB Redbridge	Develop a single pathway into support services for both victims and perpetrators of domestic abuse	People-Adults and Children's social care/ Community Safety	Re- aligning internal and commissioned services to a single pathway to support	November 2022	**Ongoing**
Learning Point 2: The need to refresh and develop the understanding of professionals regarding referral to support services regardless of level of risk and referral to MARAC in repeat or high risk cases so they are better informed and more confident and responsive to professional judgement on risk						

[37] LP4 to be completed

2 To refresh and develop the understanding of professionals regarding referral to support services regardless of level of risk including referral to MARAC in repeat or high risk cases so they are better informed and more confident and responsive to professional judgement on risk	LB Redbridge Partner Agencies	Develop ongoing training for professionals and develop community champions to identify and signpost into services	Community Safety/VAWG Partnership	Increased referrals to both MARAC and commissioned services	September 2020	**Ongoing** through quarterly reviews at VAWG Partnership meetings
Learning Point 3: The need to build upon the Refuge specialist Eastern European Outreach Service community project						
3 To build upon the Refuge specialist Eastern European Outreach Service community project	LB Redbridge & LB Barking and Dagenham	Joint application by LBR/LBBD for continuation of funding	Community Safety	Continuation of service	Application to Home Office	**Completed** Home Office has approved extension of funding for the service to April 2023

Learning Point 4: The need to conduct a joint review of the approach to the recording of Restraining Orders, and any changes thereto, on the Police National Computer by the Courts and Tribunals Service						
4 To conduct a joint systemic review by the MPS and the CTS to identify the remedial action required to ensure accuracy and timeliness in the recording of Restraining Orders and other relevant information on the PNC	Metropolitan Police and Courts and Tribunals Service	1. Conduct a review of CTS process for notifying Court Orders to police 2. Conduct a review of MPS process for recording Court Orders on PNC	Courts and Tribunals Service Metropolitan Police	1. Accurate recording of Court Orders to notify police 2. Accurate and timely recording of Court Orders on Operational Information pages on PNC	March 2023 March 2023	**Ongoing**