Overview Report:

Domestic Homicide Review into the Death of Rihanna in February 2016

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COMMISSIONED BY THE SOUTH WARWICKSHIRE COMMUNITY SAFETY PARTNERSHIP

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Foreword by the Chair of the Review

This report outlines the findings and future learning recommendations following the Domestic Homicide Review into the death of Rihanna who was killed in February 2016

The panel wishes to send condolences to the family of Rihanna and to thank them for their generosity of spirit and hugely valuable input into this report.

Rihanna's brother and sister-in-law describe her as *"a bubbly girl who was wonderful with children".* They are devastated by her death and have found it impossible to explain to their daughter who adored her Aunt.

Rihanna's father described Rihanna as *"She was a girly girl who liked doing girly things like going shopping. Rihanna liked family times and looking after her nephews and nieces. Rihanna would organise dinner parties, well they were just family dinners really, but she liked to call them dinner parties. This was the sort of thing Rihanna did I can't describe it, but it was just so Rihanna. If you met Rihanna, you would like her. That was the sort of person she was".*

Without doubt Rihanna is sorely missed every day by those who knew and loved her.

JAN PICKLES OBE

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1.The circumstances that led to this review

This report of a domestic homicide review examines agency responses and support provided to Rihanna, a twenty-year-old female, who lived in Warwickshire prior to her death in February 2016.

In addition to agency involvement the review will also examine past events through information provided by Rihanna's family and a friend, to identify relevant background information. The Report will focus particularly on whether and what support was accessed within the community and if there were any barriers to accessing available support. By this review of need and support provided and taken up the review will seek to suggest ways in which services could be improved to help avoid such tragedies in the future.

The Review Panel feels that it is important at the beginning of this review to stress that this review is about Rihanna and her lived experience. The name Rihanna is a pseudonym chosen by her family. Rihanna was a young woman, who at the time of her death was unemployed. Her family state that she had previously worked in her local pub and was warmly regarded by her employers and colleagues there.

The review will also consider the level and quality of contact and involvement local agencies had with both Rihanna and Perpetrators 1 and 2 (as Rihanna's family wish to describe them). The initial scope of the review was from 1st January 2012 to her death in February 2016. On the 20th of September 2018, the South Warwickshire Community Safety Partnership extended the period in scope to include Rihanna's last year in education as that was felt to be relevant in understanding the circumstances of her death. The key purpose for undertaking a DHR is to enable lessons to be learned from homicides in which a person is killed as a result of domestic violence and abuse. For these lessons to be learned as effectively as possible, it is crucial that the DHR describes the background to the event, the circumstances leading up to it and the role played by the key figures and services involved, to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1 Timescales

The review was opened in June 2016 and concluded in March 2019. The review required 25 Individual Management Reports as it was agreed all of the three young people involved histories were of relevance to the Review. The panel met on 12 occasions from June 2016 to March 2019, the initial meeting in June 2016 was followed by the Crown Court in Warwick adjourning the trial against the perpetrators until January 2017. To avoid prejudicing the outcome of the trial this Review was adjourned until after its completion, and therefore the panel did not meet again until the end of January 2017 after the Court delivered its verdict and sentence was passed. This delayed the Domestic Homicide Review. It meant that the family was not offered an opportunity to speak with the Chair or Panel until after the sentence. The DHR was further delayed by late presentation of significant information from an organisation that was the last agency to engage with Rihanna. This led to a significant change in the conclusions reached by The Panel. The organisation in question had believed that as the information had been already disclosed by them to the Police, it was known to The Panel. However, that information was held along with other unused material related to the case by the Police and was not disclosed. The agency had been invited but did not attend to an Independent Management Review (IME) to brief agencies in terms of their responsibilities for the DHR. As they did not attend the briefing, they remained unaware of their role and responsibilities in providing information for the Review.

The DHR was then presented to the Community Safety Partnership in September 2019, and it was at then point decided to extend the Terms of Reference further to include the period when Rihanna was Home Educated having been removed from school due to her parent's religious beliefs, leading to a further delay.

1.2 Confidentiality

The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. In order to protect the identity of the victim, her brother and his partner chose the name Rihanna as the pseudonym to be used in this review. They did not wish the perpetrators to be given names just numbers and therefore they are referred to as Perpetrator 1 and 2.
At the time of her death Rihanna was a 20-year-old her family described her ethnicity as White British.

1.3 Terms of Reference

The complete Terms of Reference are in Appendix 2 of this report.

Whilst respecting Rihanna and her family the review sought to do the following:

- Consider the period of four years prior to the death of Rihanna subject to any information emerging that may prompt extending the review to cover earlier incidents or events. This period was amended to five years

by the Community Safety Partnership on the 20th of September 2019 to include the period when Rihanna was home educated.

- Consider the way in which information was exchanged between agencies.
- Request Individual Management Reviews from each of the agencies defined in Section 9 of the Act and to invite responses from any other relevant agencies or individuals identified through the review process.
- Seek the involvement of the family and relevant friends and the perpetrators to provide a robust analysis of the events.
- Take account of the Coroner's Inquest, criminal proceedings, and other relevant enquiries.
- Seek specialist advice on the transgender experience of one of the perpetrators and use this to inform the panel and the report.
- Produce a report that summarises the chronology of the events, details the actions of the agencies involved with analysis and comment, and makes recommendations for safeguarding individuals where Domestic Abuse is a feature.
- To aim to produce a draft report by the end of February 2018. The final draft will be shared with family members prior to being presented to the commissioning authority, South Warwickshire Community Safety Partnership. The final draft will be sent to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

The review aims not to identify the individuals involved and to that end the family were asked to provide pseudonyms.

1.4 Methodology

The purpose of this Domestic Homicide Review overview report is to ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case. To achieve this the report will seek to establish what lessons can be learnt from the case in terms of how well local professionals and organisations worked individually and together to safeguard and support the victims of Domestic Abuse including their dependent children.

Secondly to identify clearly what those lessons are, both within and between agencies, how and within what timescales those lessons will be acted on and what is expected to change as a result.

Finally, to seek to apply these lessons to how services respond in future, including changes to policies and procedures as appropriate in order to prevent future domestic homicides and improve service responses for all Domestic Abuse victims and their children through improved intra and inter-agency working.

The initial Police investigation identified that domestic violence may well have played a significant part in Rihanna's death. For that reason and in accordance with the

statutory Guidance relating to Section 9 of the Domestic Violence, Crime and Victims Act (2004), South Warwickshire Community Safety Partnership commissioned a Domestic Homicide Review (DHR). on 4th May 2016. The decision to hold a DHR was taken as it was felt that the criteria had been met in that Rihanna and Perpetrator 1 were housemates. (It later emerged that Rihanna had been in a brief relationship with Perpetrator 2 as a child.) Perpetrators 1 and 2 were believed to be in a current relationship.

This Overview Report has been completed with reference to the comprehensive Individual Management Reviews (IMR's) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. The Independent Management Reports have been signed off by a responsible officer in each organisation. The agencies' Independent Management Reports were integrated into an overarching chronology of events that led to the death of Rihanna.

The sheer volume of data available to the panel was significant with 23 Individual Management Review's requested by the panel. The Multi Agency Risk Assessment Conference (MARAC) was unable to supply an Individual Management Review due to no one agency having the lead and therefore the panel took it upon itself to avoid any further delay and reviewed all original documentation relating to this case. To effectively manage this volume and the complexity of the lives of the victim and the two perpetrators meant that each Individual Management Review was individually presented, and the author questioned in open session by The Panel. The aim of the questioning was to establish further clarification in terms of what happened and how this impacted on the dynamic between the three young adults and the events that lead to Rihanna's death.

All recommendations made in the Individual Management Reviews were accepted and this Overview Report will identify further actions for the agencies to undertake singly or jointly.

1.5 Involvement of Family and friends

Interview with Rihanna's father

In February 2017, the Chair and author visited Rihanna's father at his home, and he shared his memories of Rihanna as a child and young woman, and his thoughts on the events that led to her death. During this interview, Rihanna was described a loving and much-loved daughter who was missed by them every day. They, as a family struggle with their grief but were determined to contribute to this review in the hope of preventing this from happening to another family. They did not wish to discuss events during the scope of the review or receive support from Victims Support or the Advocacy After Fatal Domestic Abuse (AAFDA) service or have sight of the final draft of this Review.

The following is a summary of the Reviewer's Interview with Rihanna's brother and his partner.

Rihanna's brother and partner were offered support from Victims Support and……. AAFDA which they initially declined but were re-referred to in the summer of 2019 following an unrelated incident which triggered issues for them related to Rihanna's homicide.

In May 2017, the Chair and author met with Rihanna's brother and his partner who had been very close to Rihanna during the period under review. They had involved her in their family life but had felt her move away from them in the month before her death under the influence they felt of Perpetrator 2. Rihanna had been a central figure in their children's lives and was especially missed by them. Their pain at her loss was palpable. They believe Rihanna's naivety contributed to her death and that was in part due to her having been brought up as a Jehovah's Witness. They believe this meant that she was not 'worldly' and so was easier for others to influence and control. They described her as a loving caring person but with very low self-esteem. They described services failing her and gave as an example one of the many addresses she was placed in as a teenager. This was somewhere near Redditch, a significant distance away from her hometown, an area she did not know and a property where she was not allowed to remain during the daytime. From there she had to get several buses each day to travel to where she needed to be. This they feel increased her vulnerability and isolation and further reduced the little feeling of self-worth Rihanna had. The Chair and author again met the with them to review the final draft in 2019 and then again after the first Covid-19 lockdown in August 2020 and continued to be in contact until March 2021 because of related ongoing issues.

Interview with Rihanna's friend

In July 2017, the Chair and author spoke at length with a close friend of Rihanna who wished to remain anonymous and declined ongoing support from Victim Support. She described Rihanna as "easily influenced and a really kind person". She stated other friends were alarmed when Rihanna moved in with Perpetrator 1 as she was seen by the wider group as a controlling person. She did not refer to Perpetrator 2. Throughout this review it has proved difficult to get a sense of Perpetrator 2 and the nature of his relationship with Rihanna, as he did not feature in discussions, with neither Rihanna's family nor her friend and he refused a request by the author to be interviewed in Prison.

1.6 Involvement of the Perpetrators

Following the sentencing of Perpetrator 1 and Perpetrator 2 the Chair and author wrote to them both in their respective prisons and requested their involvement in the review. The Chair and author had requested that these letters were hand delivered by the Probation staff in the prisons so that any questions they had about the review process could be fully addressed. Initially Perpetrator 2 agreed to meet and then on the morning of the visit refused to leave his cell. Perpetrator 1 was more forthcoming,

and the Chair and author conducted a two-hour interview with her at HMP East Park in March 2017.

1.7 Contributors to the Review

The Panel received Individual Management Reviews from the following agencies:

1. South Warwickshire Clinical Commissioning Group
2. Warwickshire Police
3. Warwickshire and West Mercia Community Rehabilitation Company
4. Coventry and Warwickshire Partnership Trust- Mental Health
5. Refuge
6. Warwickshire County Council Children's Social Care – Rihanna
7. Warwickshire County Council Children's Social Care – Perpetrator 1
8. Warwickshire County Council Children's Social Care - Perpetrator 2
9. Warwickshire County Council Adult Social Care
10. Solihull & Warwickshire National Probation Service now known as HM Prisons and Probation Service
11. Warwick District Council Housing
12. Stratford on Avon District Council Housing
13. Orbit Housing Association
14. Stonham Housing Association
15. Bromford Housing Association
16. Stratford College
17. Warwickshire College
18. Citizens Advice Bureau
19. Compass
20. West Midlands Ambulance Service
21. Sexual Assault Referral Centre
22. Safeline
23. Victims Support

As a guiding principle, the panel sought to involve the family of the victim as early in the process as possible, taking account of who the family wished to have involved as lead members and to identify other people they thought relevant to the review process. The next of kin for the family was identified as Rihanna's father. He gave permission to view Rihanna's medical records as part of the review.

1.8 Review Panel Members

Agency	Name	Role
Independent Chair and author	Jan Pickles	Chair and author
South Warwickshire CCG	Tracy Redgate	Lead Nurse Safeguarding Adults,

Gendered Intelligence	Lee Gale and Dr. Jay Stewart	Advisers to the Panel
Warwickshire Police	Detective Chief Inspector Steve Tonks	Representing Warwickshire & West Mercia Police
Warwickshire and West Mercia CRC	Andrew Bourne	Head of Service,
Stratford District Council	Nick Cadd	Housing Manager,
Stratford District Council	Karin Stanley	Governance & Community Safety Manager. South Warwickshire CSP lead officer
CWPT	Chris Evans	Designated Lead for Safeguarding Children & Adults,
Refuge	Claire Cooper.	Senior Operations Manager
Warwickshire County Council Children's Social Care	Jenny Butlin-Moran	Principal Social Worker, Service Manager, Practice Improvement & Quality Assurance, WCC.
Warwickshire County Council	Sue Ingram	Violence Against Women and Girls Development Manager
Warwickshire County Council Adult Social Care	Mark Donnelly	Operations Manager
Solihull & Warwickshire HM Prisons and Probation Service	Kirsty Baker	Deputy Head of Coventry NPS

Warwickshire County Council	Holly Collins/Stavroula Sidiropoulou	Domestic Homicide Review Officer and notetakers

The Review co-opted 'Gendered Intelligence' on to the panel to provide specialist knowledge, understanding and skills on transgender issues. They provided The Panel with a factsheet they had specifically produced for the review which was especially useful and has been shared with Home Office Domestic Homicide Team. (See Appendix 3).

The panel met on 12 occasions from June 2016 to March 2019, the initial meeting in June 2016 was followed by the Crown Court adjourning the trial against the perpetrators until January 2017. To avoid prejudicing the outcome of the trial the review was adjourned until after its completion and therefore the panel did not meet again until the end of January 2017 after the verdict and sentencing.

1.9 Author of the Review

The Chair and author Jan Pickles was appointed as Chair of the DHR and author of this report in July 2016. Jan Pickles is a qualified and registered social worker with over thirty-five years' experience of working with offenders and victims of Domestic Abuse and Sexual Violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of Domestic Abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She was an Independent Board member on two Welsh NHS Trusts and was a member of the National Independent Safeguarding Board for Wales for eight years. Jan Pickles has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and has had no previous involvement or contact with the family or any of the other parties involved in the events under review.

1.10 Parallel Reviews

The South Warwickshire Community Safety Partnership informed the coroner that this DHR was to be undertaken in March 2016. The Panel were not informed of other ongoing reviews.

1.11 Equality and Diversity

In terms of the Protected Characteristics within the Equality Act 2010 Rihanna identified herself as a White British female with no known disabilities. Rihanna had

been brought up in the Jehovah's Witness faith. This faith is patriarchal in nature which has firm views on the role of women. Rihanna was for part of her childhood educated at home. These factors limited Rihanna's contact with her contemporaries as she grew up and it could be argued as her brother has stated that it left her naïve, less 'worldly' (a Jehovah Witness term) and meant that she potentially entered the secular world with less contacts, friends and resources than other young people,. who were of course themselves at risk given their age and other factors such as gender.

At the time of Rihanna's death Perpetrator 1 was aged twenty-two years and was a flatmate of Rihanna. Perpetrator 1 had self- identified as female from an early age and had been ascribed as male at birth Perpetrator 1 described her family life as difficult. Although not stated it is intimated that her gender status had a role in that, and likely her isolation and lack of support in the years after she left home. Perpetrator 2, who it later transpired was an ex-boyfriend of Rihanna was aged twenty years of age and identified as White British Male with no known disabilities. Perpetrator 2 was assessed as having attention deficit hyperactivity disorder as a young person but could not be prescribed medication as it was contraindicated with his lifestyle and use of drugs.

To ensure the panel appropriately understood the experience of transgender people, expert advice was sought, and representatives from 'Gendered Intelligence' were co-opted onto the panel. At the Chair's request they prepared a factsheet on transgender experience and resources which has been shared by Panel Members within their organisations and is attached in Appendix 3. This was immediately shared with the DHR Team at the Home Office as a useful resource for other Reviews.

It is likely that Rhianna's gender was a factor in her death due to her having known perpetrator 2 previously as a boy-friend, and also her proposed role in becoming a surrogate mother for her two friends who went on to kill her. There is no information to suggest that her offer of surrogacy was the result of coercion, but it is noted that she was dependent on her perpetrator's goodwill in terms of providing her with shelter, so it could have been a factor - either implicit or explicitly stated.

1.12 Dissemination

In reporting the views of individuals who witnessed the actions of the services involved, the Review Panel is not endorsing those views as an accurate or as a fair assessment of the services provided. They are the views and opinions of the family and friends and should be considered with respect, in that they may offer lessons for the services involved. The draft report was shared with Rihanna's brother and his long-term partner. They described the report in its final draft as 'fair and balanced' feeling it did justice to Rihanna's memory. Her parents were offered an opportunity to review the final draft but chose not to.

Once approved by the Home Office Quality Assurance Panel, an executive summary will be made available on the Warwickshire County Council, Safer Warwickshire, and Stratford District Council websites. The public executive summary will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 2018.

A copy of the finalised review will be sent to the perpetrators in their respective Prisons.

2 Background information

In February 2016, a telephone call from Perpetrator 1 to Warwickshire Police led to the discovery of Rihanna's body at a flat in Stratford-Upon-Avon where she was living with Perpetrator 1. Rihanna had moved into Perpetrator 1's flat in the autumn of 2015 returning home to her parents over the Christmas period but then returning to that flat in early January 2016 and remained there until her death in February 2016. Rihanna's body was found by Emergency Services in the bathroom of the unlocked flat. Rihanna had died from multiple stab wounds in a brutal and sustained attack. It was described at the trial as a "sadistic" killing carried out for "perverted pleasure". An investigation by Warwickshire Police led to the arrest and charge of Perpetrator 2 aged twenty-two years old a flatmate of Rihanna and then Perpetrator 1 aged twenty years old, the partner or recent ex-partner of Perpetrator 2 for her murder. During the investigation, a 'barbie doll' was found in the property of Perpetrator 1 which had its haircut and dyed to a similar style to that of Rihanna's and had its hands and feet taped together similar to markings found on her body. At Warwick Crown Court in January 2017 Perpetrator 1 and Perpetrator 2 were found guilty of Rihanna's murder. The Judge at his summing up described them as equally culpable for her murder stating "I'm unable to say which of the defendants was a controlling force, if there was a controlling force. The evidence compels me to this being a sadistic killing". Both perpetrators received Life Sentences of thirty years with four years deducted in recognition of their youth, therefore they will each serve a minimum of 26 years in prison.

3 Chronology

3.1 Rihanna's story has been difficult to piece together, her many moves and the numerous agencies she had contact with have made it hard to create a clear narrative. Rihanna and Perpetrator 2 grew up in same small community. As 15-year-olds in 2011 they had a brief relationship over a period of a few weeks which Rihanna's family state came to an end because of the aggressive behaviour of Perpetrator 2. Rihanna then met him again in 2015 as the boyfriend of a friend whom she had recently met at the College they both attended. Rihanna and Perpetrator 1 develop a close friendship in the few months before her death, At the time of Rihanna's death the Panel believe she and Perpetrator 1 were sharing the flat in which she was killed. Perpetrator 2 was a frequent visitor to that property, though whether he was in a relationship with Perpetrator 1 at that time is not known,

3.2 Rihanna left home in 2012 aged 15 years old, moving first to stay with her sister. However, on moving to her sister's flat Rihanna was not to experience safety. She stated she was raped at her sister's home in an assault she believed was condoned by her sister in payment for a drug debt she had incurred. This inevitably caused a breakdown in her relationship with her sister and led to Rihanna becoming homeless. Rihanna did not report the rape and so was left unsupported to manage the effects of it, physically and emotionally. At some time later following a referral from her GP Rihanna alleged to the Improved Access to Psychological Services team (IAPT) of the Coventry and Warwickshire Partnership Trust (CWPT) that she had left home due to her experiencing physical violence in the home. This violence towards her was confirmed by her brother who described all children in the family experiencing such violence if they did not follow the parent's strict religious views.

3.3 Rihanna presented to Children's Services as homeless in September 2012, she was allocated a tenancy by Stonham Housing in March 2013 but failed to cope and lost the tenancy (whilst still a child) in August 2013. A month prior to losing her tenancy, and still experiencing a range of problems and having been referred to counselling for drug and alcohol issues in June 2013 her case was closed by Children's Services, despite her age and obvious needs. With the value of hindsight, it is clear that this meant that Rhianna's lack of experience of the world, a result of her strict upbringing was not addressed nor recognised as a risk factor at a crucial time for her and one of the few points at which the State had a role in her life. Rihanna was still reported to be homeless and 'sofa surfing' in May 2014. In 2015 she met Perpetrator 1, one of the perpetrators who went on to kill her, and Perpetrator 2, the other perpetrator whom she had known since childhood, both growing up in the same neighbourhood. It is reported she had had a brief relationship with Perpetrator 2 prior to this. Perpetrator 1 and Perpetrator 2 were in a relationship but had briefly separated in October 2015 because of Perpetrator 2's violent and abusive behaviour towards her. Rihanna moved in with Perpetrator 1 during this brief period of separation and continued to live there

when Perpetrator 2 returned sometime after October 2015 and remained there until her murder in the flat in February 2016.

3.5 All three had presented as homeless as young people to State Services and were vulnerable, troubled, and alienated from members of their families. Rihanna first contacted Stratford Children's Services, presenting as a homeless sixteen-year-old in September 2012. It was recorded that she had been homeless for 'a couple of weeks' prior to this contact. Children's Services supported Rihanna under a 'Child in Need Plan' in accordance with Section 17 of the Children Act 1989. She was provided between December and March 2013 with three bed and breakfast placements all of which she left without providing explanations. She eventually secured a tenancy at a 'Stonham' property in March 2013, and she described to her counsellor at college as being "really happy" with this. Unfortunately, this did not last as she soon began experiencing problems at the property, Rihanna reported being assaulted by a tenant soon after her moving there and there were later reports of damage to property caused by a guest of Rihanna's who was staying with her. Records indicate this was reported to her college counsellor and that the Police had been involved.

3.6 In April 2013, Children's Services referred Rihanna aged 17 years old for counselling and records indicate she was seen the next day by 'Compass' a Young Persons Drug and Alcohol Service. At that appointment, she disclosed poly-drug use including 'Crack', Cocaine and alcohol use, isolation, low mood, and sleeplessness for which her GP was supporting her. She had also been referred to the Children and Adolescent Mental Health Service (CAMHS) although no confirmation of this has been obtained at the time of writing. In a review meeting at Compass with Rihanna's Social Worker in June 2013 it was noted that there were problems with her behaviour (as noted above) 'which could result in her being homeless'. On a positive note, it was noted she was engaging well with Compass and had reported to them that she was no longer drinking alcohol. It was agreed she continue with counselling. However, in July 2013 Rihanna requested she end her contact with the Counsellor as she had made progress and told the Worker that Children's Services were closing her case. Children's Services were informed of this. It is recorded that Children's Services also closed her case in July 2013. The reason for their decision was not stated.

3.7 Rihanna's time at Stonham Housing came to an end when a 'Notice to Seek Possession' was issued in July 2013, (whilst Rihanna was still a child). She was encouraged to sign over her tenancy without her obtaining legal advice in August 2013. She complied as Rihanna believed avoiding an eviction on her housing record was a positive outcome. Staff appeared to be reassured that on that occasion she had a friend with her who said she could stay with her; no checks were made about the suitability of this offer. Rihanna had told staff at Stonham that she had not told Children's Services or Stratford Housing Office about her predicament. However, we know that Children's Services were aware of her eviction when her case was closed by them as Stonham had told the Social Worker in early July 2013 of the decision.

Stonham did then contact Stratford District Council Housing Office (SDCHO), asking them to review any alternative accommodation for her.

3.8 Rihanna next contacted statutory services in September 2013 when she presented as homeless to Stratford District Council Housing Office (SDCHO), having relinquished her tenancy under the threat of eviction by Stonham in August 2013 due to several breaches of tenancy rules. In September of 2013 Rihanna became 18 years old and therefore was responded to as an adult. She was found temporary accommodation in three different B&B's over a period of weeks. During the period after her presenting as homeless there were several incidents involving Rihanna which were followed up by the Police. The most significant was one in which a third party alleged a sexual assault on Rihanna's behalf. In October 2013 Rihanna found accommodation (a room in a shared house). However, problems with her application for Housing Benefit resulted in benefit being suspended in November 2013. Rihanna did not present to the SDCHO in relation to this. Rihanna's housing history after this date is not recorded but the review has managed to establish that Rihanna used a total of 23 addresses in the period after she left the family home in September 2012 until her death in February 2016.In all of these encounters with statutory services none were able or were aware of potential additional needs that Rihanna may have had as a result of the restricted contact and knowledge she had had with the world outside of that of her faith and family. This undoubtably increased her vulnerability to others who would and did seek to exploit this.

3.9 In January 2016 Rihanna attended a New Year's Eve party at her brother and his partner's home. She was described by her brother as 'drinking and behaving badly'. At this point her brother rang his parents asking them to take her home as they had guests and could no longer manage Rihanna's drunken behaviour. A few hours later, Rihanna was taken from her family home by ambulance in a very distressed state. Her behaviour in the ambulance led to her being assessed as 'Lacking Capacity', she was uncooperative and beyond control to the point the home address was flagged as a high-risk address. This represents a marked deterioration in how Rihanna had presented to services just a few months earlier.

3.10 Rihanna was taken to the A&E Department of the Alexandra Hospital in early January 2016, initially because she had cut herself with a razor blade. A thorough assessment appears to have been undertaken some hours after her arrival (after she had slept) in which she appeared to be lucid and co-operative. At this interview she disclosed a difficulty in coping following the trauma of her rape in 2012. She stated she did not report this rape at the time to the Police and did not want to do so at that point either. She disclosed in the assessment that she was managing her emotions by taking sleeping tablets, antidepressants, and alcohol. Rihanna following assessment was felt not to be intentionally suicidal as the cuts were shallow, and she had sought help immediately. It was acknowledged that her use of alcohol increased the risks to herself, but that she had supportive parents, and that she was involved with 'Safeline' Counselling Service and had a follow appointment with them

3.11 From October 2015 to January 2016, Rihanna received counselling from 'Safeline' a helpline to which she had been referred by the 'Blue Sky Centre Sexual Assault Referral Centre' (SARC) in August 2015. During this contact she discussed the rape she alleged had occurred whilst living at her sister's home. This was the last contact any services had with Rihanna before her death. The Review Panel on receipt of Safeline's IMR had asked in July 2017 that further information about Rihanna's state of mind, especially that related to her being fearful in her current situation be shared. This detailed information was not shared until February 2018 when it was revealed that the IMR had been completed without discussions with Rihanna's Counsellor. This information showed that she had attended six counselling sessions following an assessment in October 2015 in which she had shared her concerns and fears in detail. From these records the Review Panel learnt that Rihanna as a teenager had had a brief relationship with Perpetrator 2 which she ended because of his violence. We also learnt that over the few months before her death all three were living at their flat apart from Rihanna returning to her parents' home over the Christmas period in 2015. We also know that Rihanna had expressed her fear of Perpetrator 2 to the 'Safeline' counsellor during their sessions.

3.12 From the records of her counselling sessions Rihanna described that she had moved in with Perpetrator 1 in October 2015, sometime after that Perpetrator 1 and Perpetrator 2 reconciled (they may had separated around the Court case following Perpetrator 2's assault on Perpetrator 1). Rihanna discussed with her Counsellor the possibility of being a surrogate for Perpetrator 2 and Perpetrator 1 to have a child. Rihanna described to her Counsellor her relationship with them as 'better than nothing' and that they had a future together as a group. This suggests given her fear of Perpetrator 2 and her own experience of his violence that this was probably the only option she felt available to her. At this point Rihanna's brother, his partner and Rihanna's friend describe her as becoming harder to reach; they all felt she was under Perpetrator 1's control. However, Rihanna shared with her Counsellor at 'Safeline' that she felt close to Perpetrator 1 and that it was a supportive relationship. Rihanna returned to live with Perpetrator 1 and possibly Perpetrator 2 in January 2016. Rihanna was then killed at the flat by Perpetrator 1 and Perpetrator 2 in February 2016.

3.13. Perpetrator 1 befriended Rihanna and provided her with accommodation at a point unknown in late 2015. She too was struggling with significant difficulties and needs. Like Rihanna, Perpetrator 1 was estranged from her family. It is noteworthy that neither Perpetrator 1 nor Perpetrator 2's family feature significantly in their lives or in records relating to contact with statutory services after they had left their respective homes.

3.14 Perpetrator 1 was identified as a male at birth and initially brought up as a boy, she reported that she had described herself as female for many years, and her transgender status is referred to in records as 'transitioning' or 'transgender' with some reference "to conflict with others around her sexuality". This reflects the services she used and wider society's lack of understanding of the transgender experience and confuses gender identity and sexual orientation. This review has been aided by

'Gendered Intelligence' an organisation that has provided robust and clear guidance for the review and services going forward.

3.15 Perpetrator 1 during my prison visit with her described growing up in a house in which there was commonly drug and alcohol abuse, her mother had left the family and she was left in the care of her father. She further stated that she looked after her father and "brought herself up".

3.16 The police and other statutory bodies were often involved with Perpetrator 1 either as a perpetrator or a victim. Common themes in these contacts with Perpetrator 1 are either symptoms of distress (self-harming, suicidal thinking, and emotional distress) or conflict with others as either victim or perpetrator. It is obvious that the status of her gender was significant in this, and Perpetrator 1 stated as a child she had no help offered to her from any source in terms of her gender identity. Agency records indicate that as an adult she was referred to the Gender Identity Service which was then at Charring Cross Hospital in London. An Individual Management Review in relation to Perpetrator 1 describes her being made to leave the family home in May 2010 and 'sleeping rough' in the park for two days. There is no evidence of the manner or reason for her removal from the family home being addressed with her. It does not appear either that the issue of her transgender status was discussed with her or her parents, or her being enabled to find help or support in relation to this other than the referral described above. She was however helped in terms of her housing. In August 2011, she reported to the Children Social Care Team that she was having difficulties with her neighbours due to her 'sexuality' and was advised by them to see her GP. We know from Perpetrator 1 that she was sure of her sexuality and that it was the view of others confusing her gender identity and sexual orientation that caused her stress and unhappiness. This harassment in 2011 should have been reported and dealt with as Homophobic Hate Crime, as it was only later classified as Transphobic Hate Crime,

3.17 Perpetrator 2 figures little in reports. The Panel are aware he had a young child with a previous partner from whom he was estranged. It is clear that as his mental health deteriorated and caused considerable concern that records of his behaviour and state of mind increased as his contact with services increased. As with Rihanna and Perpetrator 1, he too was alienated from his family and presented as homeless in January 2012 as a child to Stratford Children's Services.

3.18 Perpetrator 1 and Perpetrator 2 were in a relationship for part of the time relating to this review. We cannot identify when the relationship started, Perpetrator 1 stated they started seeing each other in August 2014 and were in a relationship from October of that year. We know that Perpetrator 2's behaviour became more concerning in 2015; he was aware that his mental health was deteriorating and referred himself for help to the IAPT service of the Crisis Resolution Home Treatment Team (CWPT) in June 2015. Perpetrator 2 contacted the CRHTT again in October 2015 asking for help stating he was fearful that he would harm himself and others, and that his GP had told him he was 'schizophrenic'. During his initial assessment, the next day at Perpetrator

1's flat by a Community Psychiatric Nurse (CPN) and a Mental Health Social Worker Perpetrator 2 spoke in a violent, negative and aggressive manner about what he would do to others stating that he could "slit staff's throats and cut up their bodies". He disclosed substance abuse, continuous thoughts of self-harm and suicide and made threats to "kill someone" and had dreams of" killing a partner". As the threat was not against a specific named person the professionals did not take any immediate action. When seen briefly on her own Perpetrator 1 reassured staff that she did not want a referral to a Domestic Abuse Service and told them "this is how he is, I am fine". A DASH was not completed as it was not possible to see Perpetrator 1 on her own due to a lack of time.

3.19 The CPN following this assessment completed the 'Steve Morgan Working with Risk One' (WWR1) assessment, a nationally recognised risk assessment tool which did not suggest that there was a risk to a specific person. The CPN sought advice by raising their concerns with the Forensic CPN and was advised to check with Multi-Agency Public Protection Arrangements (MAPPA) which established Perpetrator 2 was not known to MAPPA. The CPN then shared their concerns with the Warwickshire Police Harm Reduction Unit who agreed to inform the Neighbourhood Team of the concerns.

3.20 Six days later in mid-October 2015 there were two incidents on the same day in which Perpetrator 2 had threatened Perpetrator 1 at her flat. In the first incident Perpetrator 1 had locked herself in the bathroom after Perpetrator 2 had made threats towards her. He then broke down crying and Perpetrator 1 had put him to bed. Perpetrator 1 had then called the Mental Health Crisis Team and was told to ring 999 if she was in fear of her safety. Some hours later Perpetrator 2 threatened her with a knife and again she had locked herself in the small bathroom, fearing for her safety. Perpetrator 2 had hacked at the bathroom door with a knife. Following her 999 telephone call, the Police attended the property, Perpetrator 2 was distressed and asking for help but ran away stating he would kill himself. Perpetrator 2 was detained and taken to a Place of Safety, the Section136 Suite at the Caludon Centre in Walsgrave for a Mental Health Act assessment. At that assessment he was found not to be suffering from an acute mental illness, and that his presentation was due to anger that was related to him stopping using the illicit drugs he was dependent on. He was given a low dosage of 'Quetiapine' an anti- psychotic medication and was discharged some hours later.

3.21 Perpetrator 1 had reassured staff that she could 'manage' Perpetrator 2. A 'DASH' risk assessment was completed in relation to Perpetrator 1. Due to the extreme nature of the event the DASH was scored as High Risk, even though there had been no prior Domestic Abuse disclosed. The Police were unaware that he had been released from the Caludon Centre until the Domestic Abuse Risk Officer (DARO) allocated to support Perpetrator 1 contacted the Caludon centre two days later. The Police Sergeant on the night of the incident had agreed Perpetrator 2's transfer to the Caludon Centre due to concerns about his mental health and had left explicit

instructions with the Officers taking Perpetrator 2 to the Caludon Centre that if Perpetrator 2 was assessed as having capacity, he should then be taken to a Police station to face criminal proceedings. This did not happen. There is no record that the Caludon Centre was aware of this instruction. In response to this gap being identified a review of the paperwork required at this crucial handover point between Police and Health Services was undertaken. The process is now online, and the online form asks if a crime has been committed and what action has been taken? and specifically what information is required from Health Services? This process is now in place across all Health facilities where an individual could be taken for an assessment under Section 136 of the Mental Health Act.

3.22 Perpetrator 2 and Perpetrator 1 were both seen at home by the Crisis Team later that day as part of the follow-up to the assessment already undertaken in the early hours. Perpetrator 2 presented as calmer, and Perpetrator 1 explained his behaviour as “not him but his mental health”. During this visit Perpetrator 1 was not seen on her own as the CWPT Domestic Abuse (Clinical) policy recommends.

3.23 Three days after this incident CWPT received the Police Domestic Abuse notification which recorded the incident as ‘High Risk’. That same day Perpetrator 2 and Perpetrator 1 were seen at his medical review with the Consultant Psychiatrist. In that consultation, he described himself feeling angry and hearing his own voice say, “you need to cut her… you need to tie her up”. He admitted to locking Perpetrator 1 in the flat for the first two or three months of their relationship when he went to work or went out, and to having sleeping problems that meant that he regularly had only two or three hours of sleep a night. He talked of needing to have control of Perpetrator 1 even when she went to the toilet. He admitted having suicidal thoughts. He was assessed at that consultation as ‘low to medium risk’ as the threats to harm were not directed at an individual and his medication was increased. It was agreed that he be seen in two days’ time and the case was discussed at the Team meeting the next day with a plan to see Perpetrator 1 on her own when Perpetrator 2 next attended.

3.24 Two days later Perpetrator 2 was seen at an appointment in the Health Centre and Perpetrator 1 was visited at home as planned. At that visit Perpetrator 1 described her fear that Perpetrator 2 would drown her if she had a bath and disclosed a history of coercive and controlling behaviour by him to her. She stated she was frightened of him but described him as the ‘lesser of two evils’ as he protected her. Perpetrator 2 when seen on the same day stated that the Quetiapine medication he had been given was not working as he still had impulsive thoughts of self-harm and harm to others including his girlfriend. This was a credible threat as he had a history of threatening her and had ready access to her. He was seen by a CPN the next day and given medication for the week and an appointment for a review in five days. The next day Perpetrator 2 telephoned the Crisis Team asking for help, stating he needed to be locked up as he was afraid, he would kill Perpetrator 1 and potentially hurt a neighbour who he believed had been ‘nasty’ to his dog. He was abusive and threatening to the member of staff on the phone and made threats towards Perpetrator 1, a neighbour

and a dog stating he was holding a knife to a dog's throat and "wanted them to listen as the dog gurgled as he killed it".

3.25 The Crisis Mental Health Team contacted the Police whilst Perpetrator 2 was on the line to them. When the Police arrived, Perpetrator 2 had damaged property in the flat and the furniture had been used to build a barricade. Perpetrator 2 was arrested and appeared in Court the next day, pleading Not Guilty to Threats to Kill and Criminal Damage, and Guilty to Common Assault on Perpetrator 1. He was bailed with conditions not to approach Perpetrator 1 or her address other than to collect his belongings when accompanied by the Police.

3.26 The Police undertook another DASH and again Perpetrator 1 was identified as 'High Risk'. On this occasion Perpetrator 1 disclosed to the Police Officer a history of coercive control and Domestic Abuse. She alleged Perpetrator 2 had previously attempted to strangle her on three or four occasions and tied her to the bed with fairy lights. Also, that he threatened to "fist her (sexually) until she bled and then rip out her eye- balls and have sex with the sockets". He had told her he had raped people before and wanted to rape people's grandmothers and children that were not related to him. Perpetrator 1 said she felt isolated and wanted help. She again stated she was scared to take a bath for fear of him drowning her. These two DASH assessments led to the MARAC referral and a limited action plan by the MARAC. From this incident the Domestic Abuse Risk Officer (DARO) made several unsuccessful attempts to contact Perpetrator 1, who in early November was found wandering in Stratford too anxious to return to her flat. Due to her presentation and perceived risk of suicide she was taken to an Accident and Emergency Department with concerns regarding a potential overdose. As part of this assessment, she was advised to contact the IAPT, and information was shared with her GP. The Police recorded this as a 'Vulnerable Adult' incident. In Mid-November Perpetrator 1 retracted part of her statement made to Police stating she 'made up' the risk to children Perpetrator 2 posed and the attempted strangulations of her by him. She described their relationship as "an obsession for both of them "and "that neither could leave the relationship".

3.27 At the MARAC in late November 2015, limited information was shared between the eleven agencies attending and an action plan was put in place. CWPT shared their concerns about Perpetrator 2's behaviour, but not the detail of his disclosures to them. Despite this, the Community Service Manager who attended, recognised the grave risk to Perpetrator 1's life, but this concern was not reflected in the minutes of that meeting. From this MARAC an action was identified that an Independent Domestic Violence Adviser (IDVA) contact the Police to request a safe and well check. This was then superseded by Perpetrator 1 later contacting the IDVA. In response the DARO suggested they apply for a Restraining Order and place Perpetrator 1 in a Refuge, but Perpetrator 1 did not wish to take this up. The Crisis Team then requested a safe and well check for Perpetrator 1 due to concerns for Perpetrator 1's risk of suicide and to check that Perpetrator 2 was not at the flat. The police attended but could get no answer, neighbour informed them that Perpetrator 1 often sat in the flat in darkness.

They considered forcing an entry. A few hours later Perpetrator 1 was recorded on CCTV assaulting two people whilst drunk. Later that day the same neighbour called the Police on hearing a female screaming in the flat, though Perpetrator 1 was still in custody. When the Police attended it would appear no-one was at the flat.

3.28 Because of the Domestic Abuse concerns Stonham Housing referred Perpetrator 1 to Refuge at the end of November 2015. Perpetrator 1 was offered a place by 'Refuge', a self-contained dispersed flat, she did not take this up due to her reluctance to accept a place out of area and it was felt by Refuge that she would remain at risk if she were placed in an area where she and Perpetrator 2 knew people and she could be found. Perpetrator 1 stated that although she was fearful of Perpetrator 2, she continued to care for him.

3.29 At Perpetrator 2's Trial in early December Perpetrator 1 as a victim was offered protective measures and screens had been made available to enable her to give evidence safely. However, Perpetrator 2 pleaded to an alternative charge of Malicious Communications in relation to the Threats to Kill and Guilty to Common Assault relating to Perpetrator 1 being tied up with fairy lights. Perpetrator 2's case was adjourned for sentencing with the same Bail conditions to a date just prior to Christmas. At this point, Perpetrator 1 asked for bail conditions to be varied so that Perpetrator 2 could communicate with her, but Perpetrator 2 declined this. During December Perpetrator 1 called the Police stating she believed her property in the flat was being interfered with, no evidence of this could be found.

3.30 Perpetrator 2 was discharged by a Consultant Psychiatrist at the Crisis Team following a review meeting just before his Court appearance in late December 2015. At the time Perpetrator 2 stated he was separated from Perpetrator 1 and was able to enjoy life feeling less paranoid. He presented as 'intoxicated with cannabis' which he admitted to smoking daily. He had stopped his prescribed medication and was sleeping better. Perpetrator 2 had requested medication for his attention deficit hyperactivity disorder, but this was refused due to his stated heavy cannabis use.

3.31 Perpetrator 2 was sentenced just before Christmas 2015 at Leamington Spa Magistrates Court to a 12-month Offender Rehabilitation Act sentence with a 25-day Rehabilitation Activity Requirement and a Prohibited Activity Requirement which prohibited Perpetrator 2 from contacting Perpetrator 1 or entering the road where she lived. The IDVA updated Perpetrator 1 about the Sentence and the conditions attached. Perpetrator 1 stated that she was pleased with the sentence and made no further contact with the DARO who closed the case in mid-January 2016. The Pre-sentence Report was prepared by the National Probation Service. The Probation Officer preparing that report did not know of Perpetrator 2's violent fantasies that had been disclosed to the CWPT in October 2015 and shared with the Police in mid-October and that Perpetrator 1 had disclosed to the Police in November 2015. Once sentenced the case was allocated to the Community Rehabilitation Company, the Offender Manager supervising Perpetrator 2 undertook all appropriate checks and

acted in line with best practice unaware of these disclosures made to Police and Mental Health Services.

3.32 Perpetrator 2 disclosed to his supervising officer some of the mental health issues he was facing but gave the impression to his Offender Manager that he was more involved with local Mental Health services than he was. In early January 2016, Perpetrator 2's CPN confirmed to his Offender Manager that Perpetrator 2 had been discharged by the Crisis Team. It was noted that he had been prescribed medication, but he was no longer taking this, the review could not establish if other information were shared about his previous threatening behaviour. The Offender Manager carried out a home visit and when she visited the family home Perpetrator 2's mother and father were not present. However, his grandparents were at the property for about 'five minutes'. Perpetrator 2 when asked about his involvement with the CPN stated he 'did not feel that he needed the Crisis Team at that point'.

3.33 Some eleven days later in January 2016, Perpetrator 2 was assessed by the Offender Manager using a specialist Domestic Abuse risk assessment, the 'Spousal Abuse Risk Assessment' (SARA), he was identified as being at 'medium risk of violence towards his partner and others'. The problem areas identified were relationship problems, attitudes that support spousal assault, sexual assault and use of weapons or death threats. Another home visit was undertaken, and Perpetrator 2 was referred to counselling and the 'Explorer' Programme, a Rehabilitation Activity Requirement mandated by the Court focusing on 'life skills, self-discovery, using money and time well, employment skills/living with purpose, goal setting and action planning to making positive life changes. Violent and Sexual offenders are exempt from this programme. Despite Perpetrator 2 being convicted of an offence related to Domestic Abuse he was referred to attend this programme. At this stage, his violent and sexual fantasies were only known to the Police and Mental Health Services. It is not clear why he was not referred to a Domestic Violence Perpetrator Programme as part of his sentence.

3.34 At a subsequent session with Perpetrator 2, the Offender Manager looked in depth at Perpetrator 2's understanding of Domestic Abuse. Perpetrator 2 stated that if he had stabbed the victim (Perpetrator 1) it would not have bothered him and that he feels no empathy. The Offender Manager noted that she felt this to be untrue as Perpetrator 2 was able to maintain affectionate relationships with members of his family and that he said himself that he often says things in the heat of the moment that he does not mean and says things for effect. This assessment was based on a brief observation of Perpetrator 2 with his grandparents and knowledge of his discharge by CWPT. At this point, there is no evidence that the Offender Manager had had access to the disclosure made by Perpetrator 2 to CWPT and later shared with the Police or the disclosure made by Perpetrator 1 concerning Perpetrator 2, his behaviour, and her fear of him to the Police in November 2015.

3.35 The Review could not establish when Perpetrator 2 returned to Perpetrator 1's flat in the weeks leading up to Rihanna's death.

4 Overview

4.1 This DHR has been an extensive review with 23 Individual Management Reviews requested by the panel, this demonstrates the range and number of agencies that had contact with Rihanna and the Perpetrators prior to her murder. To understand the significance of the events that led to Rihanna's death it is important to see the context in which she lived, the people and agencies that were at various times and in different ways involved with her. All had an impact and, in line with the aims of this review, help us to see the context surrounding Rihanna's tragic death. The two young people that killed Rihanna were known to her, were her friends and in many ways, believed they had much in common. All three were local to the area, were alienated from part or all their families and mainstream society. All three lived a hand to mouth existence with insecure housing, income and with significant emotional, practical, and mental health needs that made them each in their different ways, vulnerable. Overall, the three young adults had contact with a wide range of local services.

4.2 Rihanna had always appeared vulnerable. She came from a family whose parents were Jehovah's Witnesses and had brought up their five children to follow the precepts of a way of life that was acceptable to this faith. This way of life limited Rihanna's exposure to mainstream society and left her less able to manage the complexities of life away from the family and their faith. Rihanna in her teenage years was home educated for the last years of her schooling, her father stated that this was because Rihanna was unhappy at school; other family members now outside of the religion believe it was to reduce the influence of 'worldly' society and to better maintain her in the faith. Rihanna described to her counsellor that being home schooled led to her feeling isolated and having difficulty making friends. During this review, it was established that Children's Services were unaware of her home educated status. Her brother and his partner describe Rihanna as having no structured educational input during this time and believe this contributed to her naivety.

4.3 As a teenager, Rihanna's father describes her becoming increasingly rebellious at home. She eventually rejected her parent's faith and their world. Rihanna's father described her as 'difficult' and 'rebellious' as a teenager, ultimately leading to her parents asking her to leave the family home. The family violence disclosed by Rihanna was not acknowledged by her father. Rihanna described to her Counsellor a Jehovah's Witness meeting in which she was threatened with being 'de-fellowshipped' by the Jehovah's Witness community. This was a significant threat as she saw the community as her extended family and such an action would have left her isolated and abandoned. The significance of her sheltered upbringing and her ejection from the family home was that she entered the world of Stratford and the marginalised young people within that, significantly more vulnerable and isolated due to her being so sheltered for so long from 'worldly 'society by her family.

4.4 On leaving the family home Rihanna did try to live with her sister. Her sister had similarly rejected the Jehovah's Witness precepts and had had to leave as Rihanna and her brother had previously. However, her sister herself by this point was struggling to cope living on her own. Rihanna described to Safeline several years later that she was raped whilst at her sister's home. This was never reported to the police, and she left the property feeling even more vulnerable. This experience appears to have caused continuing distress throughout the rest of her life. We see a steady deterioration in Rihanna's emotional and social wellbeing as she attempted to make her way in the mainstream world of Stratford and met the practical difficulties such as securing accommodation etc and the threats to her presented by other young people who were themselves marginalised, alienated, unstable and vulnerable.

4.5 Rihanna's brother, his partner and a friend of Rihanna's have given the Panel a picture of her as compliant, easy to manipulate and control ordinarily (a view reinforced by her counsellor) but particularly vulnerable in the autumn of 2015 prior to her death in February 2016. During this period, the Review established she had returned home to her parents, and by December 2015 was having difficulties coping and reported having flashbacks to the rape at her sister's home. In December 2015 she was seen at the Alexandra Hospital Accident and Emergency Department seeking help following an episode of self-harm. Rihanna disclosed then that she was living at home with her parents who were supportive. She did not mention her relationship with Perpetrator 2 or Perpetrator 1. She stated she had worked as a waitress, the first mention of her working recorded by professionals. (The only other reference to work was by her brother who stated she had worked in a pub). At this point she described being distressed and having flashbacks from the rape and that she shared her worries with her mother. Rihanna acknowledged she had been self-harming for some months, and that to cope she was self-medicating with alcohol and only able to sleep with prescribed sleeping tablets. She shared with a Mental Health professional at A&E that she was receiving support from 'Safeline' a specialist Counselling Service and that she was not suicidal. We know from information she shared with her Counsellor that Rihanna was fearful of Perpetrator 2 at this time, and she described his behaviour previously when he was younger as violent to her.

5 Analysis

5.1 One of the striking themes of this case is that Rihanna was clearly seeking help- she requested and engaged in counselling sessions on several occasions through this period. It is also a factor that a range of agencies had contact with her in response to Rihanna's needs. In her contact with Children's Services in 2012 she disclosed that she was 'using cannabis and alcohol, felt isolated, had no support from her family and was experiencing anxiety and sleeplessness' (Stratford Children's Services record, date not recorded). These symptoms are in the Panel's view an indication of her insecure existence and inability to achieve her needs for a safe shelter and sustenance. It is significant that for a year of the time in which Rihanna was at her most vulnerable and seeking help from state services and her friends after leaving the family home she was still a child, under 18 years. She first approached Children's Services in September 2012, presenting as homeless and was last recorded as 'sofa surfing' by Stratford District Housing in May 2014. She also sought and accessed therapeutic counselling following the alleged sexual assault which had occurred whilst living with her sister and was hospitalised in January 2016 due to her parent's concerns about her mental health. Rihanna never of course secured her safe shelter as it was whilst staying with Perpetrator 1 and associated with Perpetrator 2 that she was killed by them in February 2016.

5.2 Rihanna had known Perpetrator 2 for several years as they had grown up near each other and had a brief relationship as young teenagers that ended due to Perpetrator 2's violence. It appears Rihanna met Perpetrator 1 at Stratford College in September 2015. Rihanna became more involved with Perpetrator 1 moving in with her in October 2015 this was confirmed by Rihanna's friend and by Perpetrator 1. How much she knew of Perpetrator 2 and Perpetrator 1's dangerous and violent relationship is unknown to the review, although she herself had experienced his violence during her brief relationship with Perpetrator 2. However, her Counsellor noted that she seemed "very disconnected from any emotional awareness and that she struggled to identify how she felt about anything, including potentially feeling scared or vulnerable". The Counsellor's opinion was that Rihanna was very childlike and likely to misread other people's emotions or intentions. Around this time Rihanna's brother, his partner and Rihanna's friend describe her as becoming harder to reach; they felt she was under Perpetrator 1's control. At this point no agency was aware of this.

5.3 Rihanna first presented in need of accommodation following her leaving her sister's home in September 2012 aged sixteen years. This was the beginning of a period of unstable living arrangements, ranging from sofa surfing, tenancies in shared housing, rent arrears and threats of and then actual eviction. It is significant that through this period from September 2012 to her death in February 2016 she had had 23 addresses. Many of these addresses had been problematic- including those provided by organisations such as Stonham, in which violence, the threat of violence

or significant difficulties with either residents or visitors confronted Rihanna. Rihanna was young for her age and did not have the skills or ability to manage some of the people she met, and she struggled to maintain her tenancies. The Police, Housing providers and the Local Authority were involved in a number of these problems related to her living arrangements either directly, or in Rihanna seeking help from them.

5.4. Running through accounts of this period is the impression that Perpetrator 1 was unable to secure a stable and safe home, employment, or training. Perpetrator 1 was found accommodation many times, but all placements were either lost or relinquished for various reasons- rent arrears, feeling unsafe or frightened, benefits being stopped etc. Perpetrator 1 often accessed support services that could intervene at times successfully to help her maintain her accommodation. In 2014 and 2015 there are numerous incidents of alleged assaults and arguments with others as well as an allegation against a neighbour filming her in the bath. Perpetrator 1 in these incidents is variously a perpetrator or a victim; in April 2015, she told Victim Support that she was being harassed due to her transgender status. This was not referred as a hate crime. The overall sense one has in reviewing this period is of immediate or pending crisis, which could only affect Perpetrator 1's already fragile ability to cope. When The author visited Perpetrator 1 in prison, it was felt she had no expectations of being helped or supported by services at that time. She described herself as always having to be in control from being a young child, as no adult was there to care for her.

5.5 During this period Perpetrator 1 described their relationship as one in which she and Rihanna were "helping each other". Perpetrator 1 saw Rihanna as a protective factor in her life stating that they would talk for hours about their feelings and they both would get drunk and use drugs (illegal and some prescribed anti-depressants) to escape their reality. This view is reinforced by the counselling records.

5.6 In the counselling sessions Rihanna shared that she often felt overwhelmed by her emotions and that she would use alcohol and self-harm to cope with these feelings. In January 2016, some two weeks before her murder Rihanna was pleased with her recent progress as she thought she was successfully cutting down her alcohol and substance use. Rihanna's counsellor did not think at that time that Rihanna felt afraid or at risk of violence but acknowledged that she may, because of her naivety have missed warning signs that would have indicated such risks. We also know that Rihanna had disclosed to her Counsellor that Perpetrator 1 was afraid of Perpetrator 2's potential to be violent to her.

5.7 This review demonstrates the complexities of domestic abuse. Perpetrator 1 has presented throughout the review process as a victim of domestic abuse, and this is not disputed by the Panel. However, whilst being a victim of Domestic Abuse she also exhibited controlling and manipulative behaviour towards Rihanna as verified by her brother, his partner, and a friend.

5.8 At the outset of this review the panel were presented with a picture of three young people whose lives were closely connected. Through the 23 IMR's a different picture has emerged; that Rihanna knew both perpetrator 1 and Perpetrator 2 independently and that the three only came together shortly before her murder.

5.9 The panel recognised good practice by the Police Community Support Officer (PCSO) who undertook many of welfare checks and anti-social behaviour calls to this group. The PCSO had clearly managed to establish good rapport with this group of hard to reach and alienated young people.

5.10 The Panel wish to commend the counsellor who built in a short time a trusting relationship with Rihanna providing her with an opportunity to discuss the idea of surrogacy and her anxieties about her future. At no point even in the weeks before her death did Rihanna disclose that she felt at risk of serious harm. The Counsellor at their initial meeting immediately recognised Rihanna's vulnerability and ensured that her practice was transparent - sharing all notes with her and adopting a pre-trial therapy approach so that had she wished to report the rape her evidence was not contaminated.

6 Conclusions

6.1 The Panel found that all three of the young people in this case to be vulnerable in different ways. Rihanna had in her brother's view not been equipped to deal with the complexities of living independently in the community. This he feels left her vulnerable to manipulation in her friendship with Perpetrator 1. Perpetrator 1 had numerous traumatic experiences in her background such as being a carer as a child to a substance addicted parent and managing the complexities of her own gender identification. This relationship was, according to her friend and her brother isolating Rihanna from others by consuming all her emotional energy. They believe Rihanna was controlled by Perpetrator 2. Her intense friendship with Perpetrator 1 placed her in contact with Perpetrator 2 who was known from a young age to be aggressive and had continued to cause harm to a partner which led to his case being discussed at MARAC.

6.2 Rihanna and the two young people who caused her death came together in the five months prior to her death. During that time agencies identified Perpetrator 1 as being at risk of Domestic Abuse from Perpetrator 2. Rihanna's presence in the flat was not known to any agency involved in the assessment of this risk. Rihanna had found what she believed was a close friend in Perpetrator 1, we know that she feared Perpetrator 2 as she in the weeks leading up to her death had disclosed this to the Safeline Counsellor.

6.3 Only four of the IMRs received by the panel referred to Perpetrator 1's Transgender status. Whilst not in itself a safeguarding issue, the Panel are aware it added to Perpetrator 1's vulnerability and may have been a factor that increased risk to her. It is also a possibility that Perpetrator 1's dependence on Perpetrator 2 and her determination to stay with him no matter could have been a result of her increased vulnerability due to her transgender status and his role in protecting her from others in the community. No support was recorded as being offered to Perpetrator 1 on this issue. That agencies were not aware of her Transgender status is significant and demonstrates a need for awareness raising throughout the area. 'Gendered Intelligence' has provided a briefing for agencies with a list of available resources. (See Appendix 3).

6.4 Whilst at Stratford College in February 2013 Rihanna was identified as vulnerable and should have been referred to Children's Services because of this.

6.5 In April 2013 Rihanna made a significant disclosure of poly-drug use including Crack Cocaine and alcohol, isolation, low mood, and sleeplessness. This led to a short-term intervention, it is noted that there had only been a few meetings with the counselling service. That the possibility that Rihanna's request to end contact was not considered as ambivalence to change, a recognised state in those faced with considering change was in the Panel's view an error. Such a decision should not have been made in isolation and would have been improved if consultation had been

made with the Social Worker who had made the referral and would have been best placed to evaluate whether closing the contact was in Rihanna's best interests.

6.6 The decision in July 2013 to close Rihanna's case by Children's Services appears to have been made despite her status as a child and did not consider her housing situation, or the significant disclosures she had made to Compass about her drug use, anxiety, and self-harm.

6.7 The earlier decisions taken by Children's Services regarding the perpetrators led to a lack of assessment of their obvious needs and a lack of appropriate services offered. Perpetrator 1 should have been statutorily supported as a Young Carer and Perpetrator 2 as a homeless 16-year-old.

6.8 The review notes the failure of WDC Housing and Children's Service to work together to ensure that all three young people were accommodated safely at different points in the period under review. When Domestic Abuse was disclosed by Perpetrator 1 although WDC policies to manage Domestic Abuse were in place, it would appear the staff lacked appropriate confidence to implement them.

6.9 Bromford Housing who were then providing the WCC funded Generic Floating Support Service for Warwickshire were so concerned for Perpetrator 1's safety that a member of staff instituted her own 'drive by' checks. This was not an evidenced based approach and an opportunity to focus on Perpetrator 2 could have continued despite him failing to keep appointments. This illustrated a lack of coordination in their response to a high-risk Domestic Abuse case between staff within the same agency.

6.10 Orbit Housing were aware a vulnerable young tenant was living in fear in a darkened flat for fear of being seen by a perpetrator of Domestic Abuse yet focussed their intervention on complaints from neighbours related to the anti-social behaviour of her dog.

6.11 Perpetrator 2's release from the Caludon Centre without the police being informed, having been arrested for violent offences related to domestic abuse a few hours earlier is considered by the panel to be a key moment. The Panel spent a significant amount of time addressing this in detail. The health professionals accepted Perpetrator 2's claims that she could 'manage' Perpetrator 1's behaviour in the knowledge that he had attacked a bathroom door with a knife after pursuing Perpetrator 1 into the bathroom and that he had previously kept her a prisoner in their flat. The existence and impact of Controlling and Coercive Behaviours within the relationship does appear not to have been considered despite Perpetrator 1's disclosure of his own jealous and controlling behaviour to them. His belief that he no longer posed a risk to Perpetrator 1 appears to have been accepted at face value and was not verified with any other agency.

6.12 Perpetrator 2 had disclosed violent and sexually violent fantasies to Health professionals and the Probation Service, these were later confirmed by Perpetrator 1 to the police. It seems this vital information was not fully shared at MARAC in November 2015, at which the National Probation Service attended. When Perpetrator 2 appeared in Court in December 2015 limited information in a Short Form Pre- Sentence Report was shared with the Court and the internal Risk of Harm assessment was incomplete. It appears that the disclosure from Perpetrator 2 was discounted at this point by the National Probation Service and was not shared with the Community Rehabilitation Company who were responsible for his supervision.

6.13 Perpetrator 2 again shared concerns for his mental health with the CRC Probation Officer, but these were seen as him attempting to mitigate and explain his domestic abuse. A Community Rehabilitation Company internal decision-making process which allowed Perpetrator 2 within a month of being sentenced to move from weekly to fortnightly reporting was not robust, as although referrals for him to receive services had been made, he had not commenced any of them and there was no evidence at that point that the risks he posed to himself, and others had been reduced. The relaxation of the frequency in reporting by an offender should be linked to reductions in risk and not referrals made. The move to reduced reporting implicitly de-escalated the case, at a time when risks were actually increasing. It must be acknowledged that the CRC decision to reduce frequency of contact was made without the crucial information held by the Police, Mental Health Services and MARAC. Had this information been available to the Pre-Sentence Report writer the intensity of supervision oversight may have been different, if not the sentence. It is the Panel's view that the sentencing process, particularly the drive to sentence on the day and the use of short Format Reports limited the space to investigate the perpetrator's background and real likelihood of reoffending.

6.14 Although the alleged assault by Perpetrator 1 on Perpetrator 2 was assessed as High Risk and led to a referral to MARAC, there were no actions identified at the MARAC to manage Perpetrator 2's risk in the community other than his existing bail conditions, nor reference to Perpetrator 2's forthcoming Court appearance which was then known by the Police. There was no reference to Perpetrator 1's isolation, additional vulnerabilities, and lack of personal support networks.

6.15 As stated, the South Warwickshire CSP extended the period under review in 2019 following discussions about the impact on Rihanna of Home Education. Elective Home Education can raise significant safeguarding issues and features in Local Child Safeguarding Practice Reviews and the previously undertaken Serious

Case Reviews[1]. In Rihanna's case we understand from her brother that she did not receive a structured education at home but was in effect left to her own devices.

[1] Parkes, Joanne (2019) Home education safety fears. Children and Young People Now.

7 Lessons to be learnt.

This review has attempted to understand the lives of all three young people the victim and the perpetrators to extract the most learning.

7.1 Stratford College

Whilst at Stratford College in February 2013 Rihanna sought help from the College Counsellor whilst still a child and some months off her eighteenth birthday. Records state that she was experiencing anxiety and panic attacks and not living at home but in 'social housing'. Her vulnerability was further exacerbated as she had recently been physically assaulted, staff at the College believed by another female student. Although the College knew of Rihanna's vulnerabilities and the strain and pressure she was having to cope with on her own, no contact or referral was made with Children's Services. The review has been reassured that this would not now be the case and that safeguarding procedures are now robust and joined up in that the Counsellor is now part of the Safeguarding Team within the College and recording by the Counsellor/s is to the standard that the British Association of Counsellors requires. The Panel note the Ofsted Inspection in March 2015 of the College assessed Safeguarding as 'Good' and that the inspection identified that the Governors were provided annually with an analysis of how effective support was for vulnerable students, which the Inspectors described as 'effective'.

7.2 Compass

The counselling sessions provided by Compass from April 2013 appear to have been helpful to Rihanna. At her initial appointment, she disclosed poly- drug use including Crack Cocaine and alcohol, isolation, low mood, and sleeplessness. The initial liaison between Rihanna's Social Worker and Compass staff was good practice. The sessions were ended at Rihanna's request as she felt satisfied, she had resolved her substance misuse. The Counsellor agreed to end work with Rihanna after three months of contact. The Counsellor working with Rihanna accepted Rihanna's version of events in ending contact. We know from later contacts with A&E that Rihanna was self-medicating with alcohol to cope with the flashbacks relating to her rape in January 2012. Therefore, had a more professionally curious approach been taken at the meeting in which Rihanna requested closing her case the decision could have been evaluated more thoroughly. Rihanna's presenting problems had been significant for a 17-year-old child, Poly drug use including Crack Cocaine, anxiety and self-harm as well as her alcohol abuse.

7.3 Children's Services Rihanna

The decision to close Rihanna's case in July 2013 by Children's Services (whilst still a child) meant that Rihanna had lost from this point an advocate on her behalf that could have helped her access resources and guidance. A review meeting had taken place ten days previously in which the imminent risk of Rihanna becoming homeless was discussed with her. In the context of this the reasons for closing the case are not

clear. Rihanna had been allocated a Social Worker as a 'Child in Need' due to her homelessness and was about to be again made homeless. As a child, she was still vulnerable and given her impending homelessness, family background and experiences since leaving the family home increasingly so.

7.4 Children's Services – Perpetrator 1

When Perpetrator 1 first came to the attention of Children's Services her needs were seen solely as housing related despite her poor home circumstances and her own difficulties. These additional vulnerabilities were never identified nor assessed. Consequently, she was not considered to require services under the Children's Act 1989. Under this legislation the Local Authority can provide services under section 17 or can accommodate a child under section 20. As a result of this omission Perpetrator 1 did not receive additional support which may have helped her sustain her tenancy.

7.5 Children's Services – Perpetrator 2

Children's Services failed to respond to the needs of Perpetrator 2 in 2010 when they became aware of his situation as a 16-year-old in need of help due his loss of accommodation and other needs. More effort should have been made to contact him and establish his circumstances. There appears to have been no effort made to contact his family to attempt to resolve this. At that time Perpetrator 2 should have been considered as a child under the Children Act 1989 and consideration should have been given to undertaking an assessment of his needs The Review understands that appropriate training is now provided to all staff since the re-launch of the joint protocols between Housing and Children's Services

7.6 Housing Services

During the review, we have identified that Rihanna had probably spent a significant amount of time 'sofa surfing' between friends and associates with up to 23 different addresses in the last four and half years of her life.

All three young people were homeless at various times and Rihanna and Perpetrator 1 had both presented as homeless, yet only Rihanna had received an assessment under The Joint Protocol in accordance with statutory guidance. However, the provision of accommodation under section 20 of the Children Act 1989 was not considered for either Perpetrator 2 or Perpetrator 1. They were not offered an assessment of their needs and therefore no consideration was given to the provision of accommodation.

The IMR from Warwick District Council Housing (WDC) states that Perpetrator 1 had disclosed that whilst she was living in their property, she was fearful of Perpetrator 2's associates and that he had kept her prisoner in her flat. This information was not shared with other agencies nor followed up. Although policies to manage Domestic Abuse were in place, it would appear the staff lacked appropriate confidence to

implement them. In October 2015, following Perpetrator 2's assault on Perpetrator 1 WDC Housing did contact the Police but were not aware of the level of risk he posed.

7.6.1 Bromford Housing

Bromford Housing who were then providing the WCC funded Generic Floating Support Service for Warwickshire were so concerned for Perpetrator 1's safety that a member of staff instituted her own 'drive by' checks. This approach is not evidence based and the Review believes futile as we now know that Perpetrator 1 was so fearful of being seen from the adjacent lane by Perpetrator 2 (his Bail conditions did not prevent him from using the lane even though it ran alongside her flat) that she was drawing the curtains and sitting in the dark to avoid him knowing she was at home. Support was then withdrawn from Perpetrator 1 by Bromford Housing for failure to attend appointments for support despite a worker within the organisation having this level of concern.

7.6.2 Orbit Housing

Orbit Housing were notified by one of Perpetrator 1's neighbours that a dog was in her flat and that it was causing a 'noise nuisance'. Orbit Housing visited Perpetrator 1. The Panel believe at that time the signs would have been available to them that she was struggling to cope emotionally and practically. She was young, sleeping in the living room, rather than her bedroom, on medication and she was known by them to have been a victim of Domestic Abuse. They were, The Panel believe more focussed on responding to the complaint made against her, than to identifying the signs of potential vulnerability in their young tenant

7.7 Mental Health Services

Mental Health Services had been involved several times with both perpetrator 1 and 2. Crucially however they were unaware that Rihanna was also integrally involved and was living with them and was also at risk due to her proximity. Medication that may have stabilised Perpetrator 1 was not able to be used due to his lifestyle, this meant that the risks presented by him were not being reduced. Health Services involved did act promptly and were accessible using telephone triage, home visits and responding to emergencies and contacting the Police when circumstances escalated. Good practice was followed in interviewing perpetrator 1's partner separately to assess concerns for her safety and completing a DASH. Crucially however The Health Service involved did not inform the Police of Perpetrator 1's discharge from their care after the Police had released him to them.

The Panel have been informed that new practices have been introduced when the Police remand a person into the care of the Health Authority because of mental health concerns. These additional questions now have to be answered: 1. Has a crime been committed? 2.Has it been dealt with? 3. Is any further action in communicating with the Police required by Mental Health?

Significant weight was given to Perpetrator 1's belief that she could manage Perpetrator 2 and his violence by the services involved. The Service involved knew that he had attacked a bathroom door with a knife after pursuing Perpetrator 1 into the bathroom and that he had previously kept her a prisoner in their flat. False imprisonment and use of weapons are known significant Domestic Abuse risk factors. A known victim vouching for a perpetrator was given far too much weight in the decision to discharge Perpetrator 2 from their care. In addition, Health Services placed too much faith in the ability of the Criminal Justice System to manage perpetrator 1's risks.

The existence and impact of Controlling and Coercive Behaviours within the relationship does not appear to have been considered despite Perpetrator 1's disclosure of his jealous and controlling behaviour. In addition, much credence was given to Perpetrator 2's own testimony that things were better. This belief was not verified with other agencies when the decision was made to close the case. It may be that had such views been checked with another source -the Police for instance who had had extensive contact with the couple, their GP or family member, a more accurate picture may have emerged to aid their decision making. The argument for improved information sharing and opacity is compellingly made by the failure of it in this case.

7.8 Warwickshire Police

Rihanna's relationship with Perpetrator 2 and Perpetrator 1 was not known to the Police. She had come to their attention in 2013 as a victim of crime and they knew of her previous history of self-harming, drug overdose and cannabis use. Additionally, she presented as a perpetrator of anti-social behaviour and then as a victim of an alleged sexual offence.

Perpetrator 1 was known to the Police both as a perpetrator and victim of assaults, all dealt with by Community Resolutions or cautions. They had also responded to concerns prompted by self-harming, drug overdoses and emotional distress.

Following the assault on Perpetrator 1 by Perpetrator 2 in October 2015 where she had hidden in the bathroom and he had attacked the door with a knife and damaged property in the flat, a DASH was undertaken with Perpetrator 1. Perpetrator 1 made significant disclosures about Perpetrator 2's threats to her and others including their dog. She stated that he had told her "he wishes to rape people's Grandma's and children that are not related to him". At this point Perpetrator 1's main concern was for Perpetrator 2's mental health and she stated that otherwise they had a happy relationship. The DASH identified Perpetrator 1 as 'High Risk', she was assigned a Domestic Abuse Risk Officer (DARO) and a robust Risk Management Plan was put in place. A Domestic Abuse incident notification identifying Perpetrator 1 as being at High Risk from Perpetrator 2 was shared with CWPT.

7.9 National Probation Service

The National Probation Service Pre- Sentence Report author responsible for advising the Court on sentencing appears unaware at the time of writing of Perpetrator 2's extensive violent and sexually violent fantasies. Perpetrator 2 had disclosed violent and sexually violent fantasies to those involved with him and these were later confirmed by Perpetrator 1 to the Police. It seems this vital information was not fully shared at MARAC in November 2015, which the National Probation Service representative attended. The National Probation Service had no mechanism for storing this vital risk information as although Perpetrator 2 had been charged with this offence he was not yet subject a Pre-Sentence Report request

The Pre-Sentence Report author completed a 'Short Format Report' on the day Perpetrator 2 was sentenced. The report was incomplete in that the Risk of Serious Harm screening was not completed. The report contained contradictory information concerning his mental health; information was not checked with Children's Services or Mental Health Services. Perpetrator 2 did disclose some of his mental health issues to the Pre-Sentence Report author, but it was seen by them as an attempt to mitigate and minimise the Domestic Abuse. The significance of Perpetrator 2's disclosure was not recognised by the report author who also had none of the limited risk information that was shared at MARAC due to the NPS being unable to hold information on offenders not yet referred for PSRs nor having access to the critical information held by the Police or Mental Health Services. It would appear no checks were made with local Domestic Abuse services as is established good practice. This may be a structural issue due to a Short Format PSR being used in this case. The report also highlighted a lack of understanding of safeguarding principles as Perpetrator 2 having a child was seen as a protective factor by the report author. The Panel were of the opinion that had the Pre-Sentence Report author been able to triangulate the information with the relevant agencies then the sentence may not have been different, but the supervision may have passed to the National Probation Service instead of the Community Rehabilitation Company, offering a higher level of scrutiny. The PSR process failed to reveal key information to the Court concerning Perpetrator 2. That failure may in part have been due to the quick turnaround required pf the NPS to deliver PSR's to Court within a time frame that is too tight. This failure was compounded by the supervision of the CRC which failed to collect this vital information, and a premature haste to reduce the level of contact

7.10 Community Rehabilitation Company

It would appear none of the information concerning Perpetrator 2's risk known to local services was shared with the Community Rehabilitation Company responsible for managing and reducing his risk of harm in the community. As his supervision commenced the Offender Manager spoke to the allocated CPN and was told that Perpetrator 2 had been discharged from CWPT's care. The Offender Manager briefly saw Perpetrator 2 with a family member at his home and felt he had an appropriate relationship with them, a judgement at odds with Perpetrator 2's description of his

mental health issues. The impression gained at the home visit appeared to reinforce the Offender Manager's view that his risk in the community was manageable, and a potential rather than an imminent risk. This view then led to Perpetrator 2 level supervision being reduced as referrals were made to fulfil the conditions of the Order. It is significant and a point to address that this decision was not outcome based- i.e., because of a reduction in risk, and is presumably a continuing practice.

7.11 MARAC

As stated, the Review failed to receive an Independent Management Review from the MARAC and so requested all paperwork be made available to the Panel. We note from this paperwork that Perpetrator 1 and Perpetrator 2 were discussed at the MARAC in November 2015, eleven agencies attended, and information was shared and stored by all agencies other than The Health Service and the National Probation Service. The Violence Against Women and Girls Strategy Development Manager who attended that MARAC has stated that on leaving the meeting they and others had significant concerns for Perpetrator 1's safety and the safety of her Grandmother who provided her with some support. Perpetrator 1's disclosure of Perpetrator 2's extreme violent and sexually violent fantasies consisting of threats to others including old people, children and a dog was not shared by the Police or Mental Health services. There were no actions identified at the MARAC to manage Perpetrator 2's risk in the community other than his existing Bail Conditions, nor reference to Perpetrator 2's forthcoming Court appearance which was then known by the Police. There was no reference to Perpetrator 1's isolation and lack of personal support networks. An IDVA had been allocated who went on to liaise with the DARO regarding a safe and well check.

7.12 Victim Support

Perpetrator 1 in these incidents is both a perpetrator and a victim; in April 2015, she told Victim Support she was being harassed due to her transgender status. This at the time would have met the criteria for Hate crime and should have been dealt with accordingly.

7.13 Safeline

The Panel were disappointed to receive only limited information from Safeline in the initial IMR, the request they received asked for full disclosure. This was the agency's first experience of a DHR and the completion of an IMR, they had been invited as with other IMR authors to a two-hour briefing session delivered by the chair and author and been given the relevant information about the purpose of a DHR and the importance of the IMR. However, on learning from the media of Rihanna's death they had contacted the Police and the Counsellor had been interviewed by the Investigating Officer. They wrongly assumed that all this information would be shared with the DHR panel. However, this detailed information was part of the 935 other documents in unused material. The DHR panel became aware of the critical information they held late in the review process. The Chair and another Panel member met with Safeline in

December 2018 and have received reassurance that future requests such this will be responded to promptly and fully. In January 2019 confirmation was received that Safeline had undertaken IMR training.

It is also a learning point for the members of the DHR panel that small organisations such as Safeline may have vital information but due to their resources may not be as knowledgeable of the DHR process, nor as available as statutory bodies in attendance. Chairs of DHR's may need to speak directly to small organisations to ensure they understand the rationale and process of these reviews. This Panel and future panels should have adopted and must adopt in future a more persistent and flexible approach that would have insisted and secured this information earlier in the process.

7.14 Home Education

Prior to her officially leaving school at 16 years old Rihanna was educated at home. This was according to her brother to encourage her to remain within the Jehovah's Witness faith. This experience, her brother feels contributed to Rihanna's limited ability to assess risk and manage friendships. The DHR panel agreed that Rihanna's lack of social skills in assessing controlling and coercive relationships contributed to her vulnerability. Currently children who are removed from a school roll for whatever reason are not followed up by any agency and can be invisible to any assessment of welfare or educational need.

8 Recommendations

8.1 Coordinated approach to accessing services and engagement with young people that services find hard to reach.

The Stratford District Council Community Safety Partnership lead on a co-ordinated approach to accessing services and engagement for young people that services find hard to reach. The learning from this review is shared with hard-to-reach young people in the Stratford area to co-produce an approach which improves access to wrap around services for young people. Models of this approach already exist in other Local Authority areas.

8.2 Clinical Commissioning Groups' have delegated commissioning arrangements for primary care medical services.

These are Warwickshire North CCG, South Warwickshire CCG, Coventry & Rugby Warwickshire CCG.

- Rihanna's case was discussed at a multiagency meeting hosted at her GPs practice because of the chaotic nature of her lifestyle and frequent attendances. This was good practice and the DHR recommends this information sharing and case discussion model be rolled out across Warwickshire as standard practice.
- That there is an agreement between the Multi Agency Safeguarding Hub (MASH) and GPs to establish how intelligence can be shared about young and vulnerable adults commensurate with their risk and need to ensure that at presentation agencies have the best information available to them to help them to respond.
- The proposed notification system of Domestic Abuse incidents from the Police to primary care practices is expedited.
- An audit of effectiveness of the current 'IRIS' system be undertaken. 'IRIS' provides training on Domestic Abuse for GPs to ask about Domestic Abuse and refer to an advocate is in place across Warwickshire,

8.3 Housing – District and Borough Council Housing Departments

- All Housing staff (Local Housing Authority and other providers operating in Warwickshire) and Anti-Social Behaviour staff to undertake Domestic Abuse and multi-agency risk assessment and management training. And for the effectiveness and impact of this training to be reported to Senior Managers and audited on a regular basis. The Domestic Abuse Housing Alliance (DAHA) has been highlighted as good practice by the Department for Communities and Local Government (DCLG). The DAHA's mission is to provide housing professionals with the necessary knowledge and skills to support residents to live safely and free of abuse.
  https://www.dahalliance.org.uk/

- All three young people had presented whilst still being children to Children's Children Social Care as homeless or with housing issues. Rihanna had twenty-three addresses from leaving home to her death. The current Housing and Children's Social Care protocol addresses housing need and the support element is based on the 'Single Assessment' which looks at a Young Person's holistic needs. In this case all were vulnerable and indicated exposure in varying degrees to several risk factors- substance abuse, mental health concerns, Domestic Abuse, and sexual assault. All needed additional support to maintain housing and to avoid a cycle of repeat homelessness and had a history of failed and troubled tenancies. Therefore, District and Borough Housing Departments alongside Warwickshire County Council should undertake a review of the Warwickshire Protocol for Assessing and Managing the Housing Needs of Young People to support young people with chaotic lives maintain their accommodation.
- That all Commissioners of housing provision ensure that for the 16-24 age group any eviction or threat of eviction has an attached move on plan.
- The Housing options and criteria for access to housing for young people appear complicated to those outside of that profession. That a flow chart on accommodation options is made available for GPs and other agencies which identifies what resources are available to vulnerable young people in the meantime.

8.4 South Warwickshire Clinical Commissioning Group

The proposed Housing options flow chart be circulated to all GPs.

8.5 The Local Safeguarding Children's Board

Housing and Children's Social Care undertake a reassurance exercise using this review to stress test the recently reviewed Joint Protocol

8.6 Warwickshire Police.

- Warwickshire Police explore training to enable officers and staff to gain a better understanding of Coercion and Control. In January 2019, the panel was informed that Warwickshire Police have commissioned the 'DA Matters' training from the College of Policing.
- That Warwickshire Police ensure that staff are confident to share risk information with other agencies appropriately.
- That the process at the interface between the Police Force and Mental Health Services is jointly audited to ensure the new arrangements in place at the Caludon Centre are robust. This process ensures the Police are informed of a decision not to detain a patient under the terms of the Mental Health Act. This then allows the Police to make a decision regarding a person suspected of committing a criminal act.

8.7 Her Majesty's Prisons and Probation Service and Ministry of Justice

This case has brought into relief the limitations that the 'Speedy Simple and Summary Justice Model' (SSS) has for identifying and enabling report writers and Sentencers to have access to full information on sentencing. Critical information relating to Perpetrator 2 and the level of harm he posed to others was known to the Police and Mental Health Services at point of sentence. However, within the SSS Model most offenders are expected to be sentenced on the day with at best a short adjournment to enable information gathering. Perpetrator 2 was such. The Report writer had two hours to interview, collect and assess the information gathered and write the Report. Information relating to Perpetrator 2's poor mental health, threats made, and fantasies of sadistic sexual violence and serious concerns expressed at MARAC were not known and not provided to the Court to aid sentencing. We understand this to be a systemic failing, resulting from the expected turnover and production of PSRs for Court. We ask that the Ministry of Justice review the use of the SSS system as it appears from this case to have serious flaws which led to this defendant's suitability for sentence to be misjudged. Given the present system we believe a similar event likely to happen again.

- The HM Prison and Probation Service review the information sharing protocol with CWPT to ensure risk information is shared appropriately.
- HM Prison & Probation ensures checks with relevant Domestic Abuse agencies and the Police are undertaken before a PSR is completed on offences related to Domestic Abuse or on known Domestic Abuse perpetrators.
- That the right to disclose information relevant to sentencing from public bodies such as MARAC be clarified, and advice be given to Report writers and Court Legal Advisors regarding this
- HM Prison & Probation Service audit short form PSRs on Domestic Abuse cases to ensure the Risk of Serious Harm section is completed and that Domestic Abuse risk factors have been appropriately identified. The panel were given the reassurance in January 2019 that this had been undertaken.
- That Pre-Sentence Reports prepared by trainee Offender Managers, unqualified staff, and staff new to role are gate kept by an appropriately qualified or experienced member of the NPS Court Team.

8.8 Community Rehabilitation Company

- The Community Rehabilitation ensures the Information Sharing Agreement between themselves and the CWPT is robust to ensure risk information is shared appropriately.

- The Community Rehabilitation Company's internal decision-making process which allowed Perpetrator 2 within a month of being sentenced to move from weekly to fortnightly reporting is reviewed. It is the panel's view that decisions made to reduce frequency of supervision contact should be taken following meaningful multi-agency engagement not just an onward referral and be based on evidence that risk has been reduced.

- It must be acknowledged that these decisions were taken without key information about the level and imminence of the threats posed by Perpetrator 2 which were known to MARAC, the Health Service, and the Police. Had this information been shared with or known by the Report writer at PSR stage in Court, supervision arrangements may have been different.

8.9 The Home Office and those agencies involved in the MARAC in Warwickshire

- The Warwickshire MARAC process is reviewed by an external agency to ensure that key risk information is shared and stored by individual agencies in such a way that it can inform their ongoing contact with victims and perpetrators.
- The agencies involved in the Warwickshire MARAC ensure all relevant risk information is shared by all agencies be it as in this case risks to children and animals, as these are known indicators of risk and may escalate the risk to victims.
- The Warwickshire MARAC action plans are audited to ensure robust safety packages are being put in place especially around hard to reach vulnerable people and that options for offender management including disruption approaches are offered to reduce risk to potential victims.
- The Home Office review how MARAC intelligence is stored and used prior to a subject already known to Police and other Agencies being sentenced by a Criminal Court

8.10 The Home Office review the management of repeat threats to kill by MASH.

Perpetrator 1 in her statement to the Police in October 2015 outlined her version of Perpetrator 2's violence and controlling behaviour to her and his violent fantasies of wanting to hurt kill and rape vulnerable people. Perpetrator 2 made threats to kill to both his Offender Manager and when being assessed to the clinician in the Health Service. All three of these services downplayed the significance of such threats stating them to be relatively common. This approach the Panel believe leaves a single organisation in a difficult position, holding potentially key information and having with imperfect information to establish the significance of the threat within a culture which

often normalises it. If the threat was specific and the risk of harm imminent then there are processes to follow. However, if there was a reporting mechanism to a multi-agency hub such as the MASH then a 360-degree review could be undertaken with all information available to services involved giving full sight of the risks for appropriate decision and actions to be taken.

- The panel asks that the Home Office to explore a process for the multi-agency management of repeated threats to kill and harm.

8.11 CWPT Health Service

- Health Services review existing policies on joint working cases with other Agencies in the light of this case and provide assurance of this to the CSP.
- That Health Services when discharging a patient in their care following arrest on suspicion of committing an offence inform the Police as soon as possible to allow the suspect to be arrested.
- That the current Domestic Abuse policy and its application in practice be audited to ensure that alleged victims are seen on their own and that their belief that they can manage risk is tested according to evidence based practice principles
- Consultants be advised that clinical decisions which have a social impact i.e., discharging a patient who will then be living with or dependent upon others be made only after obtaining information where this is available from other agencies who will have had contact with this person i.e., the Police, Criminal Justice, and welfare agencies.
- Information sharing arrangements are put in place between the CWPT and the Community Rehabilitation Company to ensure risks such as threats to kill and other risk information is shared appropriately.

8.12 Transgender awareness training and information

Only four of the IMRs received by the panel referred to Perpetrator 1's Transgender status. Whilst not in itself a safeguarding issue, the panel are aware it added to Perpetrator 1's vulnerability and may have been a factor that increased risk to her. It is also a possibility that Perpetrator 1's dependence on Perpetrator 2 and her determination to stay with him no matter could have been a result of her increased vulnerability due to her Transgender status and his role in protecting her from others. No support was recorded as being offered to Perpetrator 1 on this issue. That agencies were not aware of her Transgender status is significant and demonstrates a need for awareness raising throughout the area. Gendered Intelligence has provided a briefing for agencies with a list of available resources.

- That the Gendered Intelligence information and resource sheet is circulated to all agencies for cascading to staff.
- That all agencies ensure staff understand the definition of Transphobic Hate Crime and know how to respond to it

8.13 Compass.

- Compass undertake a review of its case closure process with a view to triangulating any risk information they are given with other agencies involved with the individual.
- A process is put in place that other agencies known to be involved with a service user are informed of the case closure.
- That training is refreshed to ensure the concepts of client ambivalence are addressed by its staff in their therapeutic relationships.

8.14 The provision of a Perpetrator Programme

The Panel acknowledged a significant gap in Domestic Abuse services for perpetrators. Had Perpetrator 2 had an opportunity to be referred to a Perpetrator Programme in the Community his violent and sexually violent fantasies would have been identified and the risks he posed identified and managed more effectively

8.15 Safeline review their internal processes.

Safeline use the learning from this DHR, the first in which they were involved to review their internal processes and risk assessments, that they reiterate to their staff the need to record important information in their Case Management System. That 'Safeline' take responsibility for their own information as all agencies are expected to and do not rely on other agencies- the Police in this case to pass on their information. In relation to this case, the information that Rihanna was fearful of Perpetrator 2 due to his previous behaviour and that she was considering surrogacy was only known to her Counsellor at Safeline and not contained in the recording of her sessions.

8.16 Commissioners of third sector services including Police and Crime Commissioners.

This review highlighted the need for Commissioners of services from the third sector to ensure that within the commissioning or grant agreement the requirement to share information in line with current Safeguarding arrangements is robust and that information is shared with a Domestic Homicide Review or similar is included in the agreement.

8.17 Home Education

The Community Safety Panel when reviewing this DHR asked that the Terms of Reference be in Rihanna's case extended to five years before her death, in order that the review consider her increased vulnerability due to her Home Educated status. The current legislation allows parents to remove a child from school for many reasons the majority being legitimate. However, the panel agreed that Rihanna's lack of social skills in assessing controlling and coercive relationships contributed to her vulnerability.

Therefore, this recommendation is that where a child is withdrawn from school and home educated the school and other professionals should assess whether this change might give rise to care and support needs or pose a risk to the well-being or safety of the child. If this is the case a referral to social services should be made.

The Community Safety Partnership to pursue with relevant agencies:

1. If there should be a register of home educated children in a similar way to the school register.
2. If a more holistic assessment of the well-being and education of children educated at home should be undertaken at regular intervals. Such assessments would focus on ensuring that the child is thriving, their education is adequate and would help provide and plan for appropriate support service.
3. If such assessments should involve children, as appropriate for age and ability. They should also take place in the child's home as their place of education.

Appendix 1: Methodology for the overview report

On being appointed to chair this review the coroner and the relevant agencies involved were informed of the Chair and author role.

Context

Data gathering

Reports and documentation accessed.

This report is based on the Individual Management Reports commissioned from professionals who are independent from any involvement with the victim, her family, or the alleged perpetrators. The Individual Management Reports author has indicated whether there is confidence in the findings of an Individual Management Report. The Individual Management Reports have been signed off by a responsible officer in each organisation. The agencies' Individual Management Reports were integrated into an overarching chronology of events that led to death of Rihanna.

Data analysis

The sheer volume of data available to the panel was significant with 23 IMR's. This volume and the complexity of the lives of the victim and the two perpetrators meant each IMR was presented, and the author questioned in open session. The aim of the questioning was to establish some clarity on what happened when and how this impacted on the dynamic between the three people that lead to Rihanna's death.

This process shaped the review recommendations with members being asked to use their specific knowledge to identify best practice in their area of expertise. It is a generative process which encouraged us to ask the aspirational question – 'what a safe system would look like?' The issue of the Transgender status of one of the perpetrators was advised on by Gendered Intelligence ensuring that any conscious/unconscious bias was acknowledged and explored in a safe and respectful manner.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked 'restricted'. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the report in full to remain **OFFICIAL** and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel**.**

Appendix 2 Terms of Reference

Rihanna DHR

A Domestic Homicide Review (the 'Review') has been commissioned by the South Warwickshire Community Safety Partnership (the 'CSP') in response to the deaths of Rihanna in Feb 2016.

This review into the death of Rihanna has been commissioned because the incident is alleged to have involved a person or had previously been, in an intimate personal relationship and/or lived in the same household. The Review will be conducted in accordance with the Statutory Guidance for Domestic Homicide Reviews (Home Office 2011:5) which was established under the provisions of the Domestic Violence, Crime and Victims Act (2004).

To manage the Review, a Domestic Homicide Review Panel (the 'Panel') has been established from a core group of statutory members of the CSP. This includes:

Agency	Role
Independent Chair and author	Chair and author
South Warwickshire CCG	Lead Nurse Safeguarding Adults,
Warwickshire Police	Representing Warwickshire & West Mercia Police
Warwickshire and West Mercia CRC	Head of Service,
Stratford District Council	Housing Manager,
Stratford District Council	Governance & Community Safety Manager. South Warwickshire CSP lead officer.
CWPT	Designated Lead for Safeguarding Children & Adults,
Refuge	Senior Operations Manager
Warwickshire County Council Children's Social Care	Principal Social Worker, Service Manager, Practice Improvement & Quality Assurance, WCC.
Warwickshire County Council Adult Social Care	Operations Manager

Solihull & Warwickshire HM Prison & Probation Service	Deputy Head of Coventry NPS
Warwickshire County Council	Violence against Women and Girls Strategy Development Manager
Warwickshire County Council	Domestic Homicide Review Officer and notetaker

Gendered Intelligence was later co-opted on to the Review Panel in an advisory capacity.

At the meeting of held on 4th May 2016 the Panel asked Warwickshire County Council (on behalf of the South Warwickshire Community Safety Partnership) to contract an Independent Chair and Report Author ('the Independent Chair') for the purposes of the Review. On the 9th of May 2016 Jan Pickles was offered this role.

Jan Pickles is not currently employed by any of the statutory agencies involved in the Review (as identified in section 9 of the Act) and has had no previous involvement or contact with the family or any of the other parties involved in the events under review.

Purpose of the review

The purpose of the review is to:

- Ensure the voice of Rihanna is at the centre of the process

- Establish the facts that led to the incident in February 2016 which resulted in her death and to identify whether there are any lessons to be learned about the way in which professionals and agencies, both locally and across borders, worked together to safeguard the individuals involved.

- To listen to family, friends and relevant others in the community who have views on this tragedy and to ensure these views are reflected in the report.

- Establish whether the agencies or inter agency responses were appropriate leading up to at the time of the incident in February 2016.

- Establish whether the agencies have appropriate policies and procedures to respond to Domestic Abuse and to recommend any changes because of the review process.

- Identify what those lessons are, set out how they will be acted upon and explain what is expected to change as a result.

- Publish the findings in accordance with the Home Office Guidance to enable the lessons learned to be shared in the wider arena.

NB: It is NOT the purpose of a Domestic Homicide Review neither to establish how the victim died nor to identify who is culpable for their death. Those are matters for coroners and criminal courts. Equally it is not the purpose of the Review to apportion blame to agencies or individual practitioners. The purpose of the Review is to identify lessons which can be learned which may ultimately prevent others from becoming victims of domestic violence in the future.

Scope of the review

The review will whilst respecting Rihanna and her family:

- Seek to establish whether the events in February 2016 could have been predicted or prevented.

- Consider the period from 1st January 2012 onwards, however if agencies have relevant information prior to this date, they can include this within their IMR. This period was amended to five years by the Community Safety Partnership on the 20th of September 2019 to include the period when Rihanna was Home Educated.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours, friends, and relevant others to provide a robust analysis of the events.

- Take account of the Coroner's inquest, criminal proceedings, and other enquiries in terms of timing and contact with the family.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals, families, and children where Domestic Abuse is a feature.

- Aim to produce the report by the end of January 2017 subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process and the criminal prosecution, the individual management reviews being completed and the potential for identifying matters which may require further review.

Family involvement

As a principle, the Panel will seek to involve the families of both the victim as early in the process as possible and the alleged perpetrators and any significant others in the review process.

The Panel will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. The Panel will be sensitive to their

wishes, their need for support and any existing arrangements that are in place to achieve this.

Legal advice and costs

Each statutory agency will be expected to inform their legal department that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

There may be a requirement to access independent legal advice on the part of the review panel and in such circumstances, the Chair of the Panel will seek funding from the statutory partners represented on the Panel and agree from which source this advice will be sought.

At this stage it is not anticipated that the Panel will require additional resources of funding to undertake this Review. Should the scope of the Review become extended beyond the initial expectations, the Chair will raise this through the statutory members of the Panel for further guidance.

Expert witnesses and advisors

The membership of the Panel will include a Domestic Violence specialist who will provide an expert view of the findings and recommendation arising from the report. The need for other appropriate agencies or individuals to provide advice or information may be identified during the review and may be invited to attend Panel meetings at the request of the Chair.

Media and communication

The management of all media and communication matters will be undertaken by Warwickshire Council Media team on behalf of the South Warwickshire Community Safety Partnership. No steps will be taken to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention. However, a reactive press statement will be developed to respond to any enquiries which will inevitably come at the end of the trial. This will explain the basis for the Review, why and who commissioned it, the basic methodology. It will emphasise that the Panel is attempting to work closely with the family, friends, neighbours, and employers where relevant throughout the process.

An executive summary of the completed Review Report will be published on all agency's intranet websites, with an appropriate press statement available to respond to any enquires. The recommendations of the Review will also be distributed through the partner agencies websites, the Domestic Abuse Forum and applied to any together learning opportunities with partner agencies involved with responding to Domestic Abuse.

All written communication from the Panel will be sent under the CSP logo.

Reporting and the finalised report

The Independent Chair and Report Author has been appointed by the South Warwickshire Community Safety Partnership and will provide them with regular progress reports. Such reporting will take place in a variety of formats, including meetings and through electronic means.

The draft overview report will be circulated to the panel and marked 'restricted' until final comments are received the panel members will have the right to share the draft report with those participating professionals and their line managers who have a pre declared interest in the review.

It is the intention that the draft report be shared in the draft state with Rihanna's close family and again they will have the right to comment.

If a difference of opinion is expressed this will be clearly noted in the final report which is to be signed off by the South Warwickshire Community Safety Partnership and then submitted to the Home Office.

Once agreement has been given by the Home Office quality assurance panel an executive summary will be available post publication on the Warwickshire County Council website (www.safeinwarwickshire.com) all will be suitably anonymised to protect the dignity and privacy of the family and comply with the Data Protection Act 1998. This will mean reports are redacted suitably before publication.

Appendix 3 Trans Inclusion briefing

Trans Inclusion: An Introductory Briefing

This briefing, written by **Gendered Intelligence**, aims to help those involved in Domestic Homicide Review Panels and similar roles to begin developing basic
knowledge and inclusive practices around transgender people.

Gendered Intelligence is a trans-led not-for-profit organisation whose vision is of a world where people are no longer constrained by narrow perceptions and expectations of gender, and where diverse gender expressions are visible and valued.

Transgender
People who feel that the sex/gender they were assigned at birth does not match or sit easily with their sense of self may use the term 'trans' or 'transgender' to describe themselves.

Gender identity and/or expression is **different from sexuality or sexual orientation**. Gender identity is about a person's sense of self, whilst sexuality/sexual orientation is about what kind of sex a person likes, who they are attracted to, and who they want to have that sex and/or a relationship with.

People who describe themselves as transgender are a wide spectrum of people including:

- People who have had medical intervention.
- Those who may have had no medical intervention but live their lives in the 'opposite' gender to the one they were assigned at birth.
- People who cross gender boundaries, but who may not necessarily subscribe to either a male or female identity and may or may not have had medical intervention.

Some (but not all) trans people may use medical intervention to align their body and their outside appearance with their internal feelings / sense of self. Trans people who seek medical intervention are typically diagnosed with 'Gender Dysphoria' as a first step. This is described as a:

> *"Strong, persistent discomfort or distress caused by the dissonance between a person's self-identified gender and the gender they were assigned at birth."*

In recent times, more people are starting to describe themselves as 'non-binary'. This term is usually used by or about people who do not subscribe to the gender binary and who may regard themselves as neither male nor female, both male and female, or something else entirely.

The right term(s) to use to describe any individual is whatever they use to describe themselves. In general, you will have to ask to know what that is – and it's OK to ask.

Above all remember trans people are people and more than just a trans identity. It is good practice to continue to use the person's present identity even when referring to them in the past as this creates consistency as well as respecting the person's identity.

It is useful to understand the distinction between **gender assigned at birth** and **self-identified gender**. The term 'assigned gender' refers to the gender that someone was assumed to have, based on the genitals they had when they were born.

The term 'self-identified gender' refers to the gender that someone identifies as.

This form of words makes it clear that everyone has the right to state what their own gender is, and that none of us can reliably ascribe the gender of others. It also distinguishes a person's own sense of gender from the gender they were assigned at birth. The law uses the phrase '**acquired gender**' to mean the same thing.

Transitioning is a word used to mean taking the journey from your assigned sex/gender to your self-identified gender; it can refer to social, medical and/or legal changes.

Gender Reassignment is a protected characteristic in the Equality Act 2010.

> Section 7 states: *"A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."*

This protects a person from discrimination. In this Act, Gender Reassignment is a social process, rather than a medical process. You do not need to be under medical supervision, and all ages are protected.

Support in prisons

Trans people may be identified as particularly vulnerable in a prison context. There is a current focus with the Ministry of Justice following a major cross-cutting report recommending legal and practical changes: **Transgender Equality Report House of Commons, Women and Equalities Committee**, January 2016 www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf

A new version of **The Care and Management of Transgender Offenders** (PSI 17/2016) Ministry of Justice was launched in November 2016: https://www.justice.gov.uk/offenders/psis/prison-serviceinstructions-2016

Prisoners should have access to NHS healthcare alongside everyone else. The medical pathway to psychological services and gender care is via a Gender Identity Clinic. For information about pathways see: **Interim Gender Dysphoria Protocol and Service Guideline 2013/14** NHS England, 2013. This guideline lists treatments/treatment criteria for England and includes a useful process/ access flowchart (p6) www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

Other resources

Trans: A practical guide for the NHS DoH (Department of Health), 2008
Aimed at people working within the NHS to enable them to understand the basics of trans issues and how to treat trans people fairly: www.gires.org.uk/assets/DOH-Assets/pdf/doh-trans-practical-guide.pdf **Guidance for Doctors Treating Transgender Patients** General Medical Council, March 2016 http://www.gmc-uk.org/guidance/28851.asp

Gender Dysphoria Services: A Guide for General Practitioners and other Healthcare Staff NHS UK, April 2013. Explains to GPs how to work with trans people and refer them on appropriately. It contains useful information on the roles of different health professionals. https://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

Good Practice Guidelines for the Assessment & Treatment of Adults with Gender Dysphoria Royal College of Psychiatrists, October 2013
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr181.aspx

Stronger Together: Guidance for Women's Services on the Inclusion of Transgender Women LGBT Youth Scotland, Scottish Transgender Alliance, LGBT Domestic Abuse Project, 2015 http://www.scottishtrans.org/stronger_together_-_september_2015/

Gender Identity and Gender Reassignment Policy for those in our Custody Scottish Prison Service and Scottish Transgender Alliance, 2014
http://insidetime.org/download/rules_&_policies/scotland/SPS-policy-on-treatment-oftransgenderprisoners-2014.pdf

Galop An organisation that runs a national, LGBT Domestic Abuse helpline: http://www.galop.org.uk/ **Domestic Violence: A Resource for Trans People**

http://www.teni.ie/attachments/af76bb4a-2141-41cb-8c3c-99a4bda0a57b.PDF

The briefing is very much a basic starting point and Gendered Intelligence can provide a wide range of training, consultancy, and support options to help you develop your inclusion practices further:

About Gendered Intelligence

Gendered Intelligence is a Community Interest Company established in 2008.
Our mission is to increase understanding of gender diversity and to improve the lives of trans people, young trans people in particular.

We work throughout the UK (and beyond) delivering professional services across public, private and voluntary sectors, including trans awareness and inclusion training, consultancy and policy development. We provide groups, sessions and residentials for young trans and gender questioning people, mentoring for young trans people, and workshops and assemblies in schools, colleges, and universities.

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