Executive Summary:

Domestic Homicide Review into the Death of Rihanna

Date of death February 2016

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COMMISSIONED BY THE SOUTH WARWICKSHIRE COMMUNITY SAFETY PARTNERSHIP

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1. The Review process

1.1 In February 2016, a call to Warwickshire Police led to the discovery of Rihanna's body at a flat in Stratford Upon Avon. An investigation by Warwickshire Police led to the arrest and charge of Perpetrator 1 aged twenty-two years old and her flatmate Perpetrator 2 aged twenty years old for her murder.

1.2. In January 2017, Perpetrator 1 and Perpetrator 2 were found guilty of Rihanna's murder and were both sentenced to serve 26 years in prison by Warwick Crown Court.

1.3. The initial investigation identified that domestic violence may well have played a significant part in this 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).

1.4 The pseudonyms used in this review for the victim is Rihanna, this was chosen by her brother and his long-term partner. The perpetrators are referred to by the numbers 1 and 2 at the request of the victim's family. The victim Rihanna identified as female, White British with no known disabilities. Rihanna had been brought up in the Jehovah's Witness faith. Rihanna was for part of her childhood educated at home. All these factors limited Rihanna's contact with her peers as she grew up and it could be argued as her brother has stated left her naïve and less 'worldly' and so more vulnerable to the predations of others.

1.5 The Perpetrators identified as White British with no known disabilities. Perpetrator 1 was identified as male at birth and since an early age she has identified herself as female. To ensure the Panel appropriately understood the experience of transgender people, expert advice was sought, and representatives from Gendered Intelligence co-opted on the Panel. They prepared a useful factsheet on transgender experience and resources which has been shared by Panel members within their organisations and is attached in Appendix 1. This was shared with the DHR Team at the Home Office as a useful resource for other Reviews.

1. 6 The agencies that potentially had contact with Rihanna or the perpetrators prior to her death were contacted and asked to confirm whether they had any involvement with them and if so to secure their records of this contact. The Panel then requested 23 Independent Management Reviews from these agencies. These are -

1. South Warwickshire Clinical Commissioning Group on GP contact
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 2

8. Warwickshire County Council Children's Social Care - Perpetrator 1
9. Warwickshire County Council Adult Social Care
10. Solihull & Warwickshire National Probation Service now known as The 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.

2. Agencies represented on the Panel and those that provided information for the review

2.1 DHR 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

2.2 Independence of Panel members and Independent Management Review authors

All Panel members and Independent Management Review authors had not been in direct contact with Rihanna or the perpetrators or supervised staff who had any direct involvement with them.

2.3 Independence of the Chair and author of the Domestic Homicide Review

Jan Pickles was appointed as Chair of the DHR and author of this report in July 2016. Jan a qualified and registered social worker with forty 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. Her current roles are as an Independent Board member on a Welsh NHS Trust and a member of the National Independent Safeguarding Board for Wales. She 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.

3. The Terms of Reference of the Domestic Homicide Review

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

- Ensure the voice of Rihanna is at the centre of the review process.
- 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 for Rihanna her home educated status.
- Establish the facts that led to her death in February 2016, 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.
- 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 Rihanna's death in February 2016.
- Understand the context in which professionals made decisions and undertook actions considering their culture, training, supervision, and leadership arrangements.
- Establish if there were any equality issues that contributed to Rihanna's death:
- 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.

4 The Summary Chronology.

Rihanna's story has been difficult to piece together, her many moves and the numerous agencies she had contact with make it hard for the reader to follow. Therefore briefly, Rihanna left home in 2012 aged 16 years old, moving to stay with her sister. It was here she alleged she was raped and this rape, although never reported, caused her great distress and it was the opinion of the Panel that her distress is a significant thread through the last years of her life.

Rihanna presented to Children's Services as homeless in September 2012, she was given a tenancy by Stonham in March 2013 but was not mature enough to cope with the conditions of the tenancy and inevitably lost the tenancy whilst still a child in August 2013. A month prior to that although unstable in herself, having been referred for counselling for drug and alcohol issues in June 2013 and facing an imminent eviction her case was closed by Children's Services. She became 18 years old in September

2014. 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 the other, Perpetrator 2 whom she had known since childhood, both growing up in the same neighbourhood. It is reported Rihanna as a child had a brief relationship with him. Perpetrator 1 and Perpetrator 2 were in a relationship but had briefly separated in October 2015 because of Perpetrator 2's domestic abuse and subsequent bail conditions. The Panel believe 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. Rihanna spent Christmas 2015 with her family and then returned to the flat living there until her murder in the flat in February 2016. All three young people had presented as homeless as young people and were to some extent vulnerable, troubled, and alienated from their families.

4.1 This DHR has been an extensive review with 23 Individual Management Reviews and two helpful Reports requested by the Panel, this demonstrates the range and volume 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 people that killed Rihanna were known to her, were her friends and in many ways, believed they had much in common. As we shall see all three were local to the area, were alienated from part or all their families and mainstream society and 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 throughout their lives.

4.2 Rihanna was described as a warm and loving young woman who cared deeply for her brother's two young children. However, her family life had not equipped Rihanna in the view of the Panel, with the ability or resources she needed in order to cope with living on her own as she set out to do in May 2012. In part this was due to her growing up within a family that held strict religious views and that sought to shelter her from an outside world that did not share their values and as part of this, we understand she was removed from mainstream school and Home Educated. Rihanna described to her Counsellor that as she was home schooled during her teenage years, she felt isolated from her peers and found it harder to make friends. Children's Services were not aware of her home schooling. The quality of Rihanna's education is unknown as it was never inspected. Her brother described it as having 'no structure' and that it contributed to her naivety and made her more vulnerable to controlling and coercive relationships.

4.3. Rihanna's father describes Rihanna as a loving and lively child who become increasingly rebellious in her teenage years; overtly rejecting her parent's faith and world. He believes it was these factors that caused her to leave the family home. Rihanna in Counselling described a 'strained relationship' with her parents due to

differences over their faith. These differences she described led to a meeting in which she was told she was at risk of being ‘de-fellowshipped;’ a punishment that would further isolate her from the community and risk her being abandoned by her family of birth. However, we also know that Rihanna herself in an interview with a member of staff from the Warwickshire Psychological Services Team in 2013 described violence within the home as the reason for her deciding to leave home. Whatever the real cause for her leaving home and seeking to live independently when she did leave, she was a young person with additional vulnerabilities due to her sheltered upbringing and restricted contact with peers. We know that despite her difficulties with her family Rihanna did choose to return for Christmas 2015 to her family home.

4.4 From leaving the family home Rihanna lived in 23 different addresses. Initially Rihanna moved in with her sister for a short while. Her sister had left home in a similar fashion to Rihanna and was herself struggling to cope, resulting in an environment in which Rihanna did not feel cared for or safe. She later alleged that she was raped by her sister’s friend whilst there, increasing her vulnerability. She at no point felt able or supported to report this alleged rape to the Police. In hindsight, the Panel’s view was this experience marked her for the rest of her short life. It is from this point that we see a steady deterioration in her emotional well-being and capacity to cope as her own difficulties increased, such as homelessness, financial difficulties, self-harming, and emotional distress.

4.5 It is the Panel’s belief that Rihanna, who first sought the help of local services in September 2012 whilst still a child, was never able to establish the foundations for a safe and fulfilling life. Also, that similarly the statutory and voluntary services that worked with her were not able to engage with her in any meaningful way. She was correctly referred to local drug and alcohol service Compass in April 2013 due to significant substance misuse of a wide range of substances and was discharged after three months contact at her request due to the progress, she told the project worker she had made. We know now that this was not true and that she had continued to have problems with her anxiety and self-medicated with alcohol and drugs until her death. Around the same time Compass closed her case in July 2013, Children’s Services also closed her case even though it was known that she was still a child who was at risk of eviction from her property with no stable accommodation to move into. It is significant that a Housing Association encouraged Rihanna to voluntarily end her tenancy with them without ensuring that she (whilst still a minor) had had access to professional legal advice before doing so. As a result, in August 2013 she was again homeless. Children’s Services were aware of her situation but did not review their decision to close her case.

4.6 From this point on until her death Rihanna lived in multiple types of insecure and temporary accommodation and was never from this point able to secure a safe and stable home for herself. Her emotional well-being deteriorated, she returned to the family home for a period due to her difficulties but was unable to settle. There is evidence of her vulnerability increasing over this time. Rihanna whilst at the family

home over Christmas 2015 was admitted to Hospital following a self-harming incident. The Police were involved with her on a number of occasions as both suspect and victim of crimes, a further sexual assault on Rihanna that occurred at one of the addresses she stayed at was alleged by a third party, and she began to speak of 'flash backs' from the rape she experienced at her sister's house. She returned home to her parent's home due to her poor emotional state, her brother and his partner described her as 'particularly vulnerable' in the autumn of 2015 with flash backs of her rape amongst other difficulties.

4.7 We now know that throughout 2015 Rihanna had been self-harming and was self-medicating with alcohol and was dependent on using sleeping tablets with non-prescribed drugs in order to cope. In addition, she had referred herself to a confidential specialist counselling service who described her as 'childlike' and 'wanting to be told what to do.' She presented as overwhelmed by her emotions which she managed through her coping strategies of self-harm and alcohol. There is throughout 2015 no information logged by any services connecting Rihanna with Perpetrator 1 and Perpetrator 2 who were in a relationship and living together in 2015.

4.8 Perpetrator 1 befriended and later invited Rihanna to share her accommodation in October 2015. The circumstances of their meeting are not known exactly but they may have met in college. Rihanna had grown up in the same locality as Perpetrator 1's partner, (Perpetrator 2) and she and perpetrator 2 had a brief relationship as teenagers. We understand Rihanna told her Counsellor that relationship had broken down due to Perpetrator 2's violence. Perpetrator 1 had significant needs herself. She had been made homeless in 2010 when her father who she described as an alcoholic made her leave home, experiencing like Rihanna unstable and unsatisfactory housing from then on. In addition, Perpetrator 1 had been ascribed at birth as a male and now identified as female and was 'in transition.' She had been referred to the appropriate medical services for this, but it is significant that despite her age and her expressed vulnerability due to her transgender experience of discrimination and abuse she was never offered non-medical support, such as counselling even though for much of this period she was still under 18 years old and a child.

4.9 Perpetrator 1's upbringing was marked by parental conflict and separation, substance misuse and neglect. Like Rihanna, Perpetrator 1 was known to statutory services and to the Police as both a suspect and victim of crime and incidents relating to her self-harming and acute emotional distress, in some cases relating to her Transgender identity. As with Rihanna there is the sense of a vulnerable individual being faced with crises through 2015 that were sapping her already low level of resilience. Local Services appeared unable or unwilling to respond despite Perpetrator 1 seeking help or being seen by local agencies to be in distress.

4.10 Perpetrator 1's own testimony that since being a child she 'had to be in control' and 'did not expect help from others' seems an apt summary. It is quite probable that this sense of vulnerability and low expectation of help from services led to Perpetrator

1's dependence on Perpetrator 2, who although violent, abusive and vulnerable, in his own way provided Perpetrator 1 with acceptance and a degree of protection from the threats she felt to be around her.

4.11 Perpetrator 2 like Rihanna and Perpetrator 1 had been alienated from his family and had whilst still a child been made homeless and had slept rough for a period, and similarly was unable to establish secure accommodation or help with his own deep-seated problems. The Panel believe that Perpetrator 1 and Perpetrator 2 began their relationship in August 2014. Perpetrator 2 came to the notice of state services in mid-2015 due to his deteriorating behaviour. Like Perpetrator 1 and Rihanna, this deterioration continued despite local services' involvement. It appears that the various interventions were piecemeal in response to separate events. Perpetrators 1 and 2 independently sought help from services from June 2015 in response to Perpetrator 2's deteriorating health and behaviour. Both were open and honest in discussing the nature of the concerns and Perpetrator 2 made detailed disclosures of a wish to seriously harm others. Initially Perpetrator 1 told staff she believed she could 'manage him' and that she was not in fear of him at that time.

4.12 There were three incidents in October 2015 that indicated deterioration in Perpetrator 2's behaviour and emotions and suggested that the level of risk to himself and others had significantly increased. Perpetrator 2 was assessed by the Crisis Team after a self-referral, but Perpetrator 1 reassured staff she was not concerned for her own safety. Rihanna in Counselling between October 2015 to January 2016 shared the view that Perpetrator 2 posed no threat to her, but she was aware Perpetrator 1 feared him. The Counsellor acknowledged that Rihanna's lack of understanding of the world may have contributed to her missing warning signs that may have been available.

4.13 The second event which occurred six days later shows the increasing deterioration in Perpetrator 2's condition. Perpetrator 2 attacked Perpetrator 1 with a knife, she ran and locked herself in the bathroom, Perpetrator 2 then attacked the door with the knife attempting to get in. Perpetrator 2 then barricaded himself and Perpetrator 1 in the flat. The Police attended and Perpetrator 1 was identified by the Police Officer attending as being at 'High Risk' from Perpetrator 2 on the DASH, (Domestic Abuse Stalking & Harassment) assessment despite Perpetrator 1 still insisting she could manage and was safe with Perpetrator 2. Perpetrator 2 was taken to a 'Place of Safety' rather than custody and his behaviour was assessed as being related to drug use. He was later discharged without the Police being informed. This has been recognised as a systemic fault and procedures are now in place to prevent a similar mistake occurring again.

4.14 Following discharge Perpetrator 2 was visited and reviewed by members of the Services' Outreach Team and made disclosures of a very disturbing and extreme nature. A crisis point was reached when some days later in October 2015 Perpetrator 2 contacted the same Team asking for help as he was still concerned, he would hurt

Perpetrator 1 and a nearby neighbour. His language, threats and attitudes in that phone conversation were so extreme that the worker taking the call contacted the Police and requested their attendance at Perpetrator 2's address. Eventually he was arrested, taken from the property, assessed as not requiring any form of intervention and released. He was some days later arrested and charged with offences relating to threats and the assault of Perpetrator 1.

4.15 It was following this event that Perpetrator 1 disclosed to the Police Perpetrator 2's sexual and violent fantasies, his repeated attempts to strangle her and the level of threat and fear that she had been living under, and that she needed help from the Police and other Services. Following these disclosures, a MARAC referral was made. However, in Mid-November 2015 Perpetrator 1 was found wandering the streets of Stratford 'too afraid to go home'. Later in November 2015 Perpetrator 1 was offered a place in a refuge as a safety measure. However, Perpetrator 1 did not accept the offer.

4.16 In December 2015 Perpetrator 2 was sentenced to a Community Sentence for one of the incidents that occurred in October in which he prevented the police entering the flat and threatened Perpetrator 1. Due to perceived improvements in his behaviour and emotional well-being it was felt he no longer required any non-mandatory supervision. He had told his consultant that he was separated from Perpetrator 1 and 'feeling better'. Following sentence Perpetrator 2 was assigned to the Community Rehabilitation Company (CRC) as he was assessed as 'Medium Risk of Harm', having the potential to cause harm to Perpetrator 1 using the CRC's specialist Domestic Abuse assessment. It is clear that neither the Pre-Sentence Report author or his later Supervising Officer had access to all the information available on Perpetrator 2 held by the Police and the agencies that had recently been treating him, and that to a degree the Supervising Officer underestimated the seriousness and imminence of the threat he posed. The Supervising Officer did follow procedure and completed all the required checks and acted in line with best practice in working with Domestic Abuse perpetrators. Crucially the Offender Manager had checked with the Services earlier involved with Perpetrator 2's treatment who confirmed his discharge from treatment in December 2015. That fact may have been interpreted by the Supervising Officer as a positive sign and that he no longer posed a risk to others.

4.17 It appears that Rihanna had moved in with Perpetrator 1 in October 2015 and sometime after October 2015 Perpetrator 1 and Perpetrator 2 were reconciled (it is not known how long in reality they had been separated). Rihanna discussed with her Counsellor the possibility of being a surrogate mother for Perpetrator 1 and Perpetrator 2 to have a child. Rihanna described to her Counsellor her relationship with them as 'better than nothing' and that as a group they had a future together. At this point 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. We know Rihanna was taken to hospital having self-harmed in October and early January 2016, neither admission was assessed as a serious attempt on her life but show her level of distress. Rihanna went home to her family for Christmas 2015 returning to live with Perpetrator 1 and

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possibly Perpetrator 2 in January 2016. Rihanna was killed at the flat she had shared with Perpetrator 1 by her and Perpetrator 2 in February 2016.

5. Key issues arising from the Review

5.1. All three young people were local to the area, were alienated from part or all their families and mainstream society and lived a hand to mouth existence with insecure housing, income and with significant emotional, practical, and mental health needs. All three were in their separate ways, vulnerable. Overall, these three young vulnerable adults had contact with a wide range of local services. Crucially these agencies did not routinely share information with each other.

5.2 Rihanna's 23 moves demonstrate her inability to find a stable and secure home despite the involvement of many housing providers and being recognised as being in need.

5.3 Rihanna presented with numerous issues; substance abuse, anxiety, and long-term insecure housing. The Panel believe however that an underlying cause was the alleged rape that Rihanna experienced at her sister's home and the ongoing symptoms she experienced following that traumatic event.

5.4 Rihanna was clearly seeking help, she requested and engaged in counselling sessions on a number of occasions through this period, but all of this was focussed on the presenting issues and not the underlying cause.

5.5 Services appear unable to respond to Perpetrator 1's emotional and practical needs as she transitioned from the gender assigned to her at birth.

5.6 The information shared at MARAC was not properly shared, recorded and acted on.

5.7 The assessments of Perpetrator 2 by services outlined in paragraphs 4.11 to 4.16 above were dependent on information provided by him and Perpetrator 1. No attempt was made to verify or obtain information from other sources

5.8 The Pre-sentence report risk assessment was incomplete and lacked key information which was available to other services previously involved with Perpetrator 1.

5.9 That there were good examples of professionals managing risk and information sharing. Such as the pro-active approach taken by the Police Community Support Officer spending time establishing rapport and gathering information with this group of hard-to-reach young people at the flat and by the Domestic Abuse Risk Officer chasing up Perpetrator 2's discharge as explored at paragraph 4.16 above

5.10 Housing organisations appeared to lack a systematic evidence-based approach in identifying and managing Domestic Abuse risk.

5.11 Clinicians within the Health Service were not provided with information by the Police as to who should be notified if Perpetrator 2 was assessed as fit to charge. Neither did those services contact the Police on their discharging Perpetrator 2 from their care.

5.12 Perpetrator 2 made repeated threats to kill to professionals and Perpetrator 1 also disclosed his threats to kill, harm and rape others. These threats were reviewed by single agencies with no multi-agency view taken.

6. Conclusions and lessons to be learned for each agency

6.1 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 been assaulted, staff at the College believe 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 advice was sought, or referral made to 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'.

6.2 Compass

The counselling sessions provided by Compass 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 the 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 at her request. The Counsellor working with Rihanna accepted Rihanna's version of events in ending contact. We know from later contacts with A&E that Rihanna at that time was self-medicating with alcohol to cope with the flashbacks relating to the rape in January 2015. 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; poly drug use including Crack cocaine, anxiety, and self-harm as well as her alcohol abuse. It is noted that Rihanna had only had a few meetings with the counselling service. That the possibility that Rihanna's request to end contact was not considered as a sign of her 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.

6.3 Children 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 help her access resources and guidance. A review meeting had taken place ten days before the closure decision 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.

6.4 Children's Services – Perpetrator 1

When Perpetrator 1 first became involved with Children's Services her needs were seen solely as housing related despite her difficult home circumstances and high levels of anxiety. Perpetrator 1 presented as a male and her transgender status was not known. This contact pre-dates the current protocol between Housing and Children's Services and no joint assessment was undertaken, which would not be the case today. Consequently, she was not considered to require services under the Children's Act 1989. Under Section 17 of the Children's Act 1989 a Local Authority can provide services and under Section 20 can accommodate a child. This section could have been used to provide Perpetrator 1 with support or accommodation when in August 2011, she reported to Children's Social Care her having difficulties with her neighbours recorded as due to her 'sexuality' not her transgender status. Instead, she was advised by them to see her GP. This reported behaviour was not seen as a potential Hate Crime and responded to as such. In 2011 this would have been recorded as 'Homophobic Hate Crime', currently it would be identified as 'Transphobic Hate Crime'. Although, the review acknowledges transgender status does not always mean added vulnerability, it did in her case. On the two occasions when as a child she actively asked Children's Services for help it was not provided. As to whether this impacted on Perpetrator 1's confidence in seeking help from then on, the review cannot speculate. However, when interviewed in prison Perpetrator 1 stated that "asking services for help did not work in her case".

6.5 Children's Services – Perpetrator 2

Perpetrator 2 in 2010 aged sixteen-years old was referred to Children's Services as estranged from his family and sleeping rough in a skate park. That Perpetrator 2 was allowed to leave Children's Services offices after presenting with these risk factors without further investigation is unacceptable. More effort should have been made to contact him and establish his circumstances. Perpetrator 2's parents should have also

been informed that Perpetrator 2 was sleeping rough. At that time Perpetrator 2 should have been considered a child under the Children's Act 1989 Section 20 which places a duty on Local Authorities to provide a child with somewhere to live because the child does not currently have a home, or a safe home. 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.

Both Perpetrator 1 and 2 had been known to Children's Services prior to the murder. Both presented as vulnerable both emotionally and practically. Their contact provided an opportunity for useful early interventions that was not made. It is impossible to say of course whether such interventions would have made any difference in this case. The response of Children's Services to such children should the Panel think be examined as there may be lessons in terms of early intervention, identification of additional vulnerability and diversion to specialist services that work with and advocate for vulnerable children.

6.6 Housing

During the course of the review, the Panel have identified that Rihanna had probably spent a significant amount of time 'sofa surfing' between friends and associates as well as the 23 different addresses she lived at that were identified by the review in the last four and half years of her life.

All three young people were homeless at times and Rihanna and Perpetrator 1 had presented as homeless to the Housing Department. 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 1 or Perpetrator 2. 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 (WDC) Housing 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 a '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 and there was insufficient supervision of staff to identify this failing. 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 despite other agencies being aware of the threats he had made.

6.6.1 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 Panel 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 despite a worker within the organisation having this level of concern.

6.6.2 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 in that she was sleeping in the living room and 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.

6.7 Health agencies

There was an awareness by agencies involved of the relationship between Perpetrator 1 and Perpetrator 2 but not of Rihanna's involvement with the couple. It is a concern that Perpetrator 2 never received the help that he was seeking. There were examples of good practice. Once involved, health services were easily accessed by telephone and there was evidence of prompt follow ups. Perpetrator 1 was also spoken to twice on her own and a DASH was completed which shows good practice of working with victims of Domestic Violence and Abuse. She was able to disclose for the first time that she had had to leave her College hairdressing course because of Perpetrator 2's jealousy as he believed that she could be talking to other men. However, Perpetrator 2's discharge from the specialist health facility was not communicated to the Police and was only learned about when the Domestic Abuse Risk Officer (DARO) made contact two days later.

The Panel have been informed that problems in communication between services and the Police has now been resolved and that a series of prompts on the 'Crisis Service Notes System' at the conclusion of an Assessment now asks the following three questions 1. Has a crime been committed? 2. Has it been dealt with? 3. Is any further action in communicating with the Police required? We cannot say that had this checklist been used at the time it would have led to the Police then arresting Perpetrator 2 following his discharge after assessment. Proposed changes to legislation will make this a required action in future.

Significant weight was given to Perpetrator 1's belief that she could manage Perpetrator 2 and his violence. It was known 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. However, at the

point of closure there was the belief that the case was going to be managed by MARAC and the Criminal Justice process was ongoing which included protection for the victim. Perpetrator 2 was able to return to the flat where the victim lived. Significantly there is no evidence that the impact of this on the safety of those he was returning to was considered as part of the decision-making process.

Coercive control appears not to have been considered by those involved despite Perpetrator 1's disclosure of his jealous and controlling behaviour such as making her leave College. In addition, much credence was given to Perpetrator 2's own testimony that things were better and was not verified with other agencies when the decision was made to close the case. It may be that had further information or confirmation been sought from services that knew the cases, the Police for instance who had had extensive contact with the couple, their GP, or a family member a more accurate picture may have emerged to aid decision making. The decision to close the case meant that crucial knowledge and expertise that would have helped in managing Perpetrator 2's risk was not available to the agencies still working with him.

6.8 Warwickshire Police

Rihanna's relationship with Perpetrator 2 and Perpetrator 1 was not known to the Police. She was known separately to them 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 in which she hid in the bathroom, and he 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 herself and others. 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 said that her 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 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 the health agency involved with him.

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.

6.9. Her Majesty's Prison and Probation Service.

The 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 other agencies previously 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 Probation Service attended. The National Probation Service, now Her Majesty's Prisons and Probation Service had no mechanism for storing this vital risk information, as although Perpetrator 2 had been charged, he had not yet attended Court for sentence and a Pre-Sentence Report was yet to be requested. At this time Perpetrator 1 was perceived as the potential victim. The Panel noted the Community Safety Manager of Warwickshire County Council Community Safety Team attending that MARAC stated they left that meeting 'seriously concerned' for Perpetrator 1 safety.

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 which was not checked with the two agencies that had been involved with him. Perpetrator 2 did disclose some of his issues to the Pre-Sentence Report author, but it was seen by them as an attempt by him 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 other 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 Panel believe 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.

6.10 Community Rehabilitation Company

It would appear none of the risk information available was shared with the Community Rehabilitation Company responsible for managing Perpetrator 2 and reducing his risk of reoffending and harm in the community. As his supervision commenced in January 2016 the Offender Manager spoke to the Crisis Team, which was good practice, and was told that Perpetrator 2 was now discharged from their care**.** The Offender Manager briefly saw Perpetrator 2 with a family member at Perpetrator 2's home and felt he had an appropriate relationship with them. Had the Officer had the information concerning Perpetrator 2's violent and sexually violent fantasies a different conclusion may have been made. These factors appeared to reinforce the Offender Manager's view that his risk in the community was manageable, and that he presented a potential rather than an imminent risk to others.

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 was not robust, as although referrals for him to receive services had been made, he had not commenced any of the programmes 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 the referrals made for him. The move to reduced reporting implicitly de-escalated the case, at a time when risks were increasing. It must be acknowledged that the CRC decision to reduce frequency of contact was made without the crucial information held by the Police, MARAC, and other services. Had this information been found by or provided 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 closed down the space to investigate the perpetrator's background and real likelihood of reoffending.

6.10 The 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 by the health agency 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 MARAC with other Agencies. 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.

6.11 Victim Support

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

6.12 Safeline

The Panel were disappointed to receive only limited information from Safeline the Counselling service that had the only agency contact with Rihanna in the last weeks

of her life; in the initial IMR, the request they received asked for full disclosure. This was Safeline'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 related to the trial. The DHR Panel became aware of the critical detail information they held late in our review process. The Chair and another Panel member met with Safeline in December 2018 and have received reassurance that future requests such as 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. The Panel wish to commend the Counsellor who managed in a short time to build a trusting relationship with Rihanna, providing her with an opportunity to discuss the rape and 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 to the Counsellor. 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.

6.13 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 to the predations of others. 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.

7. Recommendations from the Review

7.1 Engagement with hard-to-reach young people.

That 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.

7.2 Commissioners of General Practice

These are Warwickshire North NHS and South Warwickshire CCG, Coventry, and Rugby Warwickshire CCG.

- Rihanna's case was discussed at a multiagency meeting hosted at her GP's 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 enable information sharing about young and vulnerable adults to ensure that agencies working with them have the best information available to them to help them to respond.
- That the proposed notification system of Domestic Abuse incidents from the Police to primary care practices be 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.

7.3 Housing – District and Borough Council Housing Departments

- All Housing staff (Local Housing Authority and other providers operating in Warwickshire) 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 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 Social Work aspect 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 such as, 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 the young people appear complicated to those outside of that profession. That a flow chart on accommodation options be available for GPs and other agencies which identifies what is available to vulnerable young people in the meantime.

7.4 South Warwickshire Clinical Commissioning Group

That this Housing options flow chart be circulated to all GPs.

7.5 The Local Safeguarding Children Board.

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

7.6 Warwickshire Police.

- That Warwickshire Police explore training to enable officers and staff to gain a better understanding of Coercion and Control in cases of domestic abuse. In January 2019, the Panel was informed that Warwickshire Police have commissioned the DA Matters training from the College of Policing which addresses this.
- That Warwickshire Police ensure that staff are confident to share risk information with other agencies appropriately.
- Audit new arrangements to confirm that Police are informed by relevant services when a person is being discharged from any alternative arrangements to police custody and that if the risk cannot be managed effectively via alternative means they are taken into or returned to Police custody.

7.7 Her Majesty's Prison & Probation Service

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 other local 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 emotional well-being, the threats made by him, and fantasies of sadistic sexual violence and serious concerns expressed at MARAC were not known and not provided to the Court to aid sentencing. The Review understands this to be a systemic failing, resulting from the expected turnover and production of PSRs for Court. The Review ask that the Ministry of Justice review the use of the SSS Justice 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.

- HM Prison and Probation Service review the information sharing protocol with CWPT to ensure risk information is shared appropriately.
- HM Prisons & 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.

7.8 Community Rehabilitation Company

- The Community Rehabilitation ensure the Information Sharing Protocol 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 and not just an onward referral and be based on evidence that risk has been reduced rather than on time on supervision or completion of interventions.

- It must be acknowledged that decisions concerning Perpetrator 2's risk to self and others were taken without key information about the level and imminence of the threats posed by Perpetrator 2 which were known to MARAC, the Police, and other services. Had this information been shared with or known by the Report writer at PSR stage in Court, the supervision arrangements made for him may have been different.

7.9 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

7.10 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 during supervision and when earlier being assessed. All appear to have–downplayed the significance of such threats stating them to be 'relatively common.' This approach the Panel believe leaves single organisations and personnel in a difficult position, holding potentially key information and having with

imperfect information to establish the significance and credibility 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 and local MASH to explore a process for the multi-agency management of threats to kill and harm self and others.

7.11 Health Services

- That Health Services that provide mental health care review existing policies on joint working cases with other Agencies and provide assurance of this to the CSP. Review protocols with the Police in respect of information sharing in respect of service users who are assessed as not requiring detainment following arrest. That the current Domestic Abuse policy be audited to ensure that alleged victims are seen on their own and that their belief that they can manage risk is explored.
- 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 that 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

7.12 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, and therefore also to Rhianna with whom she shared accommodation. It is also a possibility that Perpetrator 1's dependence on Perpetrator 2 and her determination to stay with him no matter what could have been a result of her increased vulnerability due to her Transgender status and his role in protecting her from others. Other than a referral from her GP no support was recorded as being offered to Perpetrator 1 on this issue at any stage in her life. 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 material 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.

7.13 That Compass prior to closing cases undertake a case discussion with referrers and other relevant parties.

- 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 therapists

7.14 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 may have been identified and the risks he posed understood and managed better.

7.15 Safeline review their internal processes in light of this DHR.

That 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.

7.16 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 with a Domestic Homicide Review or similar is included in the agreement.

7.17 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 Children's 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 services.
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.