LONDON BOROUGH OF REDBRIDGE

COMMUNITY SAFTY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

ANNA KIPRAS AGED 31

UNLAWFULLY KILLED IN AUGUST 2019 IN REDBRIDGE

BY AMANDEEP SINGH AGED 43 WHO DIED BY SUICIDE

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

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

Domestic Violence Homicide Review Panel – LB Redbridge CSP

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

EXECUTIVE SUMMARY

The Review Process

This summary outlines the process initiated by the Chair of the Redbridge Community Safety Partnership (RCSP) to commission a Domestic Homicide Review (DHR) Panel established under s9 Domestic Violence, Crime and Victims Act 2004 independently chaired by Bill Griffiths CBE BEM QPM, to review the homicide in Redbridge of Anna Kipras[1] aged 31, caused by stabbing in August 2019. This was inflicted by a former intimate partner, Amandeep Singh aged 43, who then died by suicide.

The process began with the appointment of the Chair in September 2019 and a meeting of all agencies that potentially had contact with those involved prior to the death of Anna in November 2019. Chronologies of contact were reviewed and Individual Management Reviews (IMR) commissioned. Due to Covid-19, the process proceeded with virtual meetings, six in all, that robustly discussed the findings from the IMRs and the sixth version of the Chair's overview report was provided to the Coroner in February 2021. The Inquests were held in November 2021 and further versions were provided for comment by the Panel and the Singh family disclosure. The process ended when the RCSP Board approved a final version of the overview report at a meeting in November 2022.

Contributors to the review

Agency representatives on the Panel and participating in the review were:

Valerie Scanlon	LB Redbridge Senior Community Safety Officer
Eve McGrath	Designated Nurse for Barking and Dagenham, Havering and Redbridge (BDHR) Clinical Commissioning Group (CCG)
Stephen Hynes	Designated Nurse Adult Safeguarding (Redbridge) Barking & Dagenham, Havering and Redbridge CCGs
Catherine Warboyes	London Borough of Redbridge (LBR) Children's Social Care (CSC)
Daniela Capasso	Named Midwife, Safeguarding & Lead Midwife for CDR & Harmful Practices/Interim Dementia Lead Barking, Havering and Redbridge University NHS Trust*
Bob Edwards	Integrated Care Director LBR/North East London Foundation NHS Trust
Sue Tatch	NELFT Redbridge Access, Assessment & Brief Intervention (RAABIT) Team Manager*
Lucy Satchell-Day	Area Manager North East London, National Probation Service*
Kelly Hogben	Detective Sergeant, MPS Serious Crime Review Group*
Andrew Meekings	Operations Manager, Victim Support London*
Julia Dwyer	Refuge, Senior Operations Manager
Julia Kulak	Refuge, Service Manager of the Eastern European Advocacy Service

*IMR provided by a senior independent manager and shared with Panel members.

The Chair established that Anna's family had returned her to Lithuania for burial. The police kindly provided a Lithuanian version of the Home Office information leaflet for families and this was sent to Anna's family with the invitation to speak via an interpreter and that advocacy services are also available. It is understood that they have decided not to participate in the review. They were not

[1] Not her real name and randomly chosen. All other names (apart from Panel members) are pseudonyms

able to travel due to Covid-19 restrictions but were offered and declined a video link to the Inquest and be supported by an interpreter. They will be provided with a copy of the final review report.

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

Author of the overview report

Bill Griffiths is the author of the overview report. He is a former police officer who has had no operational involvement in LB Redbridge. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010.. Since 2013, he has been involved in more than twenty DHRs, including two others commissioned by LB Redbridge. The Panel were satisfied as to the independence of the Panel members and IMR authors.

Terms of Reference (ToR) for the review

Following discussion of a draft in the first Panel meeting, the ToR were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. A third version was issued on 24 January 2020. This sets out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour. The main lines of Inquiry are:

1. Scope of review agreed from January 2014 to date of deaths with any earlier event of significance to be included
2. Manage the interface with parallel inquiries such as the criminal investigation and, in this case, the Coroner's Inquest into the deaths
3. Identify relevant equality and diversity considerations, including Adult Safeguarding issues
4. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it
5. Take account of previous lessons learned in LB Redbridge
6. Identify how people in the LB Redbridge gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleagues.

Background Information

Anna was born in Lithuania and travelled to London for work in 2008 and In October 2014, she gained employment with an international translation and interpreter service based in the City of London. It is important not to assume that proficiency in the English language implies understanding of the British criminal justice system or the support that was available to EU citizens resident in the UK in the event of domestic abuse.

There is much more information available about Amandeep which is important to set out in order to understand what happened to Anna and the lessons to be learned. There is a risk, however, that his becomes the 'louder voice' as a result and the Panel have been mindful to follow its commitment to 'hear' Anna's voice at the heart of this process. Amandeep was born to South Asian parents in Birmingham and the family moved, initially to Slough and then to Redbridge where Mohinder gained a position as a science teacher. Amandeep consumed drugs from an early age and was diagnosed with with Attention Deficit Hyperactivity Disorder (ADHD), that manifest in impulsivity and risk behaviour. In 1992 when aged 16, he was diagnosed with depression. He continued to use alcohol and Class A drugs. He had a variety of jobs but he did not settle into steady work, seeming more interested in attending the local snooker club. His father set him up to run an off-licence but he did not stick at it. He would always have a money-making scheme on the go and he joined many skills courses to gain qualifications.

Amandeep had a number of criminal convictions and cautions from 1998 for forgery, motoring offences, theft and possession of Class A drugs (last caution in April 2017). He had a difficult relationship with his parents, resulting in a number of police calls over the years to domestic abuse by him that included verbal altercations and minor assaults.

Amandeep commenced a lengthy on/off relationship with Emily from 2002 when she was 17 and he was 26. He was habitually in debt and had developed a gambling problem that exacerbated the problem. In 2009, police were called to a report of Amandeep stalking Emily and he was given a First Instance Harassment Warning. They subsequently had a daughter together in 2016 but he showed little interest in her and the relationship ended when he did not show up to visit her in hospital.

Amandeep and Anna met in early 2016 at a nightclub in the West End of London. He lied about his age, being six years older, but Anna told her friend that she felt happy, peaceful and safe with him. They did not live together but the relationship was intimate with Amandeep staying for two nights a week on average and he was given a spare key to her flat in the nearby Borough of Waltham Forest. They separated in 2017 when he was imprisoned for harassment of Anna and breaching a Restraining Order (RO). According to friends the relationship was then on/off, including after Anna moved to a ground floor flat in Redbridge in April 2019. The time they were seen socialising together was in June 2019.

Summary timeline of the relationship by what was known to agencies

<u>October 2016</u>

Police officers came across Amandeep and Anna arguing in the street over separating and his jealousy, also he was restraining her. Police escorted Anna home and the incident was recorded

<u>March 2017</u>

Anna called police because Amandeep was outside her home having taken an overdose of Paracetamol and threatening to kill himself. She told the officers Amandeep had assaulted her the evening before but was unsure about attending court. Amandeep was detained then became ill and was taken to hospital, treated and discharged. The incident was referred and assessed by the Multi-Agency Safeguarding Hub (MASH)

A few days later Anna called police to her workplace in the City of London. Amandeep had been constantly calling and texting her and had shared a slide show of a female who appeared to be deceased with blood around her. To gain access to her office, he pretended to be a courier with a

parcel containing gifts. When she left work, Amandeep was waiting outside her office. When she said she would call the police, he grabbed her mobile phone and ran off but a member of the public intervened and managed to persuade him to return it to Anna. Amandeep then fled the scene. The investigation led to Amandeep's arrest and him being charged with both the assault and the harassment. He admitted the offences at Court and was sentenced to a Community Order with Rehabilitation Activity and an unpaid work requirement of 150 hours with a victim surcharge of £85. He was served with a Restraining Order (RO) that specified: *Protection from Harassment until further notice*. In the terms, Amandeep was forbidden to contact Anna directly or indirectly, not to go to her place of work and not to go to her home.

April 2017

Anna reported that, seven days after the RO was imposed, Amandeep had been constantly calling her phone from a withheld number up to 25 times a day, thereby breaching the order. Sometimes he would speak, others remained silent, others he put on a female voice pretending to be a friend. Anna ascertained from a friend that Amandeep had been using a topless picture of her for his WhatsApp profile image. Arrest enquiries were not fruitful and Amandeep was circulated as 'wanted' on the Police National Computer (PNC).

Two days later, he self-presented at the local Emergency Department (ED) following an overdose and suicide ideation following the break-up with his partner. Following assessment, he was discharged home with details of the local mental health services.

Two weeks after that, Amandeep again self-presented at the ED and disclosed to the drug and alcohol nurse a long history of alcohol, cannabis and cocaine use. He was admitted for a detox on a reducing medication regime and be sectioned if he attempts to leave due to suicidal ideation. Police were informed of the admission and it was agreed staff would report when Amandeep was due to be discharged. When the day came, he had absconded from the ward, was reported missing and arrested while driving his car. He was charged, and later pleaded guilty to, the RO breach.

The review of the police investigation for the DHR identified there were shortcomings in the risk assessment for Anna and she was not referred to DA support agencies as would have been good practice. This was the last time prior to the fatal incident that Anna had been 'on the radar' of anyone in safeguarding.

June 2017

Amandeep was sentenced to 16 weeks imprisonment and to pay a Victim Surcharge of £115. Due to time spent in custody since arrested, he was released two weeks later under the supervision of an Offender Manger (OM) from the London Community Rehabilitation Company (LCRC).

January 2018

Amandeep's father died unexpectedly which had a major impact on the family. Anna sent a condolences message. Later that month, and thrice again in March, Amandeep was found intoxicated or taken an overdose and was having suicidal thoughts. He reported being in debt due a gambling addiction.

April 2018

Anna informed her GP of a change of address from Waltham Forest to a ground floor flat in Redbridge.

May 2018

At an appointment with his OM, Amandeep disclosed that he and Anna had resumed their relationship and thus had breached the RO. This had been for about the last two months and had become intimate again when they would spend weekends together in hotels. He claimed that Anna was content with this arrangement and she regretted the situation that had led to the RO and

his prison sentence. The OM advised Amandeep that he should report this further breach of the RO to the police and he said that he would.
The OM reported the breach to police via the 101 system but a check conducted on the PNC did not show that the RO was in force and the report was closed without reference to the OM. Nor were intelligence checks that would have identified the circumstances of the original offences and Anna's identity undertaken.
Enquiries with the Courts and Tribunals Service (CTS) show that an order that was revoked by the Magistrates was the original Community Order imposed in late March, not the RO which remained in place and was current at the time of the fatal incident. The error appears to have occurred when the Court decisions for that day were uploaded on to the PNC, which is a daily clerical task for Court staff. It has not been possible to explore the matter further. At the last meeting with the OM in May, Amandeep stated he had ceased contact with Anna.

November 2018

Amandeep was stopped by police while driving without insurance and his car was seized. A search revealed a large amount of cash that he said was partly from gambling and the rest a loan from his mother. When at the custody centre, he appeared unwell, he was assessed and referred back to the community mental health team. He was released under investigation of money laundering.

May 2019

Amandeep was assessed by a community psychiatrist and diagnosis of Post-Traumatic Stress Disorder (PTSD) and moderate depressive episode followed which was related to a sexual assault on him when he was serving imprisonment in June 2017.

August 2019

Amandeep attended a police station to be interviewed in connection with the money laundering and he was further arrested for a bank fraud whereby he was suspected of being exploited and controlled by an organised crime gang. He was further released under investigation, about three weeks before the fatal incidents.

The homicide/suicide

Evidence of WhatsApp messages between Anna and Amandeep produced at the Inquest showed that, by late August, Anna was being explicit with Amandeep that their relationship was over. The next evening, Anna was out on a pre-arranged date. Returning home on the bus, Anna noticed that Amandeep was following her in his car. She called him and he claimed he was home in bed. The homicide investigation discovered evidence that confirmed beyond doubt that Amandeep had maintained surveillance of Anna that evening.

The next day, a neighbour called police to Anna's flat because she could be seen lying prone and covered with blood in the garden with her legs over the rear door threshold. Police and paramedics attended, forced entry to the flat and found Anna but, due to stab wounds she was beyond saving. Also there was Amandeep who had fatal slash wounds to his wrist and neck. Evidence from his phone showed he had been searching the internet for the prior two weeks on subjects related to murder weapons and suicide.

After hearing all the forensic evidence available, the Coroner concluded that Amandeep had unlawfully killed Anna and then committed suicide.

Key issues identified from the review

The review has identified that Amandeep Singh heavily used alcohol and drugs and that seemed to lead to mounting debt pressures, gambling and involvement in organised crime. In turn this may have been relevant to his mental health challenges, manifest in depression and suicidal ideation/actions. Alongside, he had a history of domestic abuse - of his close family, of a former partner and mother of his child and of a former intimate partner, Anna Kipras.

The complexity of this intersection resonates strongly across the duty to safeguard that spans multi disciplines. The daily challenge for professionals in their respective silos, is to dedicate some time to view the bigger picture.

Risk assessment is a core requirement of safeguarding, but its effectiveness is predicated on 'best information'[2] that has been communicated on the basis of public safety for a coordinated response. Issues such as GDPR and patient confidentiality are important but professional judgement should be applied and the rationale recorded in the risk assessment.

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

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

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

A different outcome may have occurred if the administrative error that led to inaccuracy on the PNC had been corrected at source, however, the challenge would be how to quality assure what is a vast operation to upload daily Court decisions to the PNC. Following enquiries, it is understood that the system for adding Court findings to the PNC is complex and should be approached systemically and jointly by the MPS and the CTS to identify the remedial action required to ensure accuracy and timeliness in the recording of Restraining Orders and other relevant information on the PNC. The MPS should also ensure that any changes are agreed nationally.

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

Lessons learned and recommendations from the review

IMR authors identified a total of nine recommendations for internal consideration by their respective organisations and they are listed in the second appendix to the overview report. All had been completed by November 2022.

The strategic learning points identified from this review are:

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

These have been formed into recommendations within an action plan set out in the third appendix to the overview report.

W Griffiths CBE BEM QPM
Chair and Author of the Domestic Homicide Review
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