CENTRE FOR SAFER SOCIETY

Brent

DOMESTIC ABUSE RELATED DEATH REVIEW EXECUTIVE SUMMARY

SANDRA
APRIL 2020

INDEPENDENT CHAIR: **DANIELLE SHARP**
REVIEW COMPLETED: **JANUARY 2025**

Preface

(written by the Chair based on information gathered from the people who knew Sandra)

Sandra, a woman whose presence brought warmth, joy, and creativity into the lives of those around her. To her family, friends, colleagues, and the children she worked with, she was a light, always smiling, always laughing, and always giving.

As a teaching assistant, Sandra was dedicated beyond measure, treating each child as if they were her own. For over a decade, she was a constant and beloved presence at her school, so much so that colleagues described her as "part of the furniture." She was a brilliant artist, finding solace in her creativity and sharing her gift with the children she supported, running an after-school art club with passion and care. Her petite frame, standing just under five feet, belied the strength of her spirit. She was described as a “tough cookie,” strong-willed and determined, though she sometimes battled with self-confidence. She had a deep love for Caribbean music, a passion that reflected her vibrant energy, and an ability to find joy in the simple moments, from chatting with her friends to starting her mornings with a packet of cheese and onion crisps.

Sandra’s loss is felt deeply and profoundly by all who knew her. She was a daughter, a friend, a colleague and a source of laughter and love. Though she is no longer here, her spirit remains in the echoes of children’s laughter, in the brushstrokes of a painting, in the rhythms of the music she loved. The Chair and review panel hope this review reflects her resilience, and the immeasurable impact she had on those lucky enough to have known her.

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Section 1: Introduction

1.1 Context

1.1.1 About Domestic Abuse Related Death Review's

Domestic Abuse Related Death (DARD) reviews[1], are a statutory requirement in the UK established under the Domestic Violence, Crime and Victims Act (2004). These reviews are conducted when a person aged 16 or over dies as a result of violence, abuse, or neglect by someone they were intimately connected with, such as a partner, family member, or household member. This review considers the death of Sandra, a 36-year-old woman who was killed by her husband, who she was separated from at the time, at her home address. The Chair and panel would like to express their sincere condolences to Sandra's family and friends for their devastating loss.

The review will consider agencies contact/involvement with Sandra and her husband Stefan from 2019, which is when they got married, to the date of the homicide in April 2020.

1.1.2 Defining domestic abuse

In simple terms, domestic abuse is any harmful or controlling behaviour by one person towards another in a close relationship. The Domestic Abuse Act (2021)[2] created the first statutory definition of domestic abuse which defines it as:

"Behaviour of a person ('A') towards another person ('B') is 'domestic abuse' if—(a) A and B are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive."

This definition encompasses a wide range of behaviours, including physical or sexual abuse, threats of violence, controlling behaviours, economic manipulation, and psychological or emotional harm. Furthermore, it highlights that these behaviours occur within relationships where individuals have a personal connection, such as partners, spouses, family members, or individuals sharing parental responsibilities.

1.1.3 Purpose of this review

The key purpose for undertaking a Domestic Abuse Related Death (DARD) review is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

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[1] Previously known as Domestic Homicide Reviews (DHRs).

[2] The Domestic Abuse Act represents a significant milestone in addressing and combatting the pervasive issue of domestic abuse within society. Enacted with the aim of providing clarity, protection, and support to victims, the legislation sets forth comprehensive measures to define, prevent, and address domestic abuse in all its forms.

The purpose of a DARD review is multi-faceted including:

- To establish lessons to be learned regarding how local professionals and organisations work individually and together to safeguard victims.
- To clearly identify these lessons, determine how and within what timescales they will be acted upon, and specify the expected changes.
- To apply these lessons to service responses, informing national and local policies and procedures as appropriate.
- To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach that ensures domestic abuse is identified and responded to effectively at the earliest opportunity.
- To contribute to a better understanding of the nature of domestic violence and abuse.
- To highlight good practice.

This review has been commissioned by the Safer Brent Partnership (the name of the local Community Safety Partnership[3]).

1.2 Outline of the incident leading to the review

This review is being undertaken as a result of Stefan murdering Sandra. Below we provide a brief overview of the events surrounding the incident.

On the day of the homicide emergency services were called to Sandra's address following reports of a fire. Fire crews arrived to tackle the blaze and had to force entry to the front door. They went to the upper floor and into the front bedroom where they found Sandra unconscious, with significant burns, in the foetal position beside her bed.

She was taken from the house and immediately attended to by the ambulance service who subsequently took her to St Marys Hospital for treatment. Shortly after, she was pronounced dead as a result of cardiac arrest, due to smoke inhalation.

Stefan, her husband, was found on the floor in the back garden of the property. Due to his burn injuries, he remained in hospital for several weeks. Following his discharge, he was taken into police custody and charged with various offences including Murder, Arson (with intent to endanger life), Criminal Damage and Voyeurism. He was subsequently found guilty and sentenced to serve a minimum of 32 years in prison.

The review panel express their sincere condolences to Sandra's family and all who knew her. From speaking with her friends and colleagues as part of this review, we understand the devastating impact her loss has had on all of them.

1.3 The scope of the review

[3] A Community Safety Partnership (CSP) is a legally mandated, multi-agency collaboration established under the Crime and Disorder Act (1998) to enhance public safety and reduce crime within local communities.

1.3.1 The review process

The Metropolitan Police Service (MPS) informed the Safer Brent Partnership of the homicide, suspected to be the result of domestic abuse, and the Community Safety Partnership (CSP) notified the Home Office of its intention to conduct a Domestic Homicide Review (DHR) on 11th May 2020. An Independent Chair was commissioned, but on 28th May 2020, the Chair and CSP agreed to pause the review until the conclusion of the criminal justice process. Following the trial's conclusion, the first panel meeting was held on 16th September 2021, ahead of sentencing.

During this time, the police force referred itself to the Independent Office for Police Conduct (IOPC) regarding its contact with the victim prior to her death. The IOPC investigation concluded on 16th April 2021, resulting in disciplinary actions against several officers, including the dismissal of one officer. This officer appealed their dismissal in September 2022, but the hearing did not take place until March 2023. At some stage during the IOPC process, it emerged that the original DHR Chair, an ex-MPS officer, had previously line-managed the officer who was dismissed. While this was initially deemed not to impact their independence, a later review by Brent Council found it inappropriate for them to continue as Chair.

As a result, a new Chair was appointed on 12th February 2024, with a handover meeting on 1st March 2024. However, significant gaps in record-keeping and incomplete documentation, including files with lost or incorrect passwords, meant the new Chair struggled to establish a clear understanding of previous actions. For example, it remained unclear how many panel meetings had taken place since 16th September 2021. Given concerns about the review's quality and delays impacting the family, friends, and community, the new Chair faced considerable challenges in progressing the review. Instead of starting afresh, they had to piece together fragmented records, track contributors of Individual Management Reviews (IMRs), some of whom were no longer involved, and balance the urgency of completing the review with the need for a thorough and meaningful process.

The Chair and review panel would like to extend our gratitude to Norma Hoyte from PLIAS Resettlement who has continued to advocate on Sandra's behalf to ensure this review has come to a meaningful conclusion following the early challenges.

The new Chair convened a panel meeting on 2nd April 2024, and the panel subsequently met three times in total: on 2nd April 2024, 28th June 2024, and 26th November 2024.

The completed report was passed to the CSP on 10th February 2025 and approved by them on 1st April 2025. It was submitted by the CSP to the Home Office Quality Assurance Panel and signed off for publication on 25th November 2025.

1.3.2 Terms of reference

It is unclear when the original terms of reference (TOR) were drafted, but it can be presumed this was at the initial panel meeting 16th September 2021. The new Chair worked with the panel to make some amendments to the TOR in order to finalise the review to ensure all lessons could be fully identified and explored.

The scope of the review analysed agency contact with Sandra and Stefan from January 2019, which was when the couple were married, and Stefan moved to the UK. The review has considered any contextual information prior to this period.

The primary key lines of enquiry for the review were to:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Sandra, Stefan and the wider family (as relevant).
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

In addition to the primary lines of enquiry, there were some additional lines of enquiry specific to the review that we will aim to explore:

Exploration of protected characteristics

- To what extent did Sandra and/or Stefan's protected characteristics, such as ethnicity, cultural background, and immigration status, shape their experiences of domestic abuse? Consider whether these factors influenced Sandra's ability to recognise, report, or respond to abuse and if they affected Stefan's behaviour, attitudes, or responses.
- How did these characteristics influence their interactions with services? Were there any notable barriers or facilitators in accessing support based on these characteristics?

Dynamics within Sandra and Stefan's relationship

- How did ethnicity, cultural expectations, and immigration status shape the dynamics of Sandra and Stefan's relationship? Were there any specific relational or power dynamics rooted in these characteristics that agencies should have recognised or accounted for in their responses?
- Explore how Stefan's immigration status, particularly any insecurity surrounding his right to remain in the UK, impacted their relationship dynamics and his own access to support, if relevant. What impact did this status have on the relational power dynamics between Sandra and Stefan?

Access to and appropriateness of support services

- What services were available that specifically catered to the cultural, ethnic, and immigration-related needs of Sandra and Stefan, and were these appropriately accessed or offered? Were any additional needs or barriers identified by the agencies due to their backgrounds?
- How did Sandra's informal caregiving responsibilities and past traumatic losses (such as the death of her child, multiple miscarriages, and her mother's death) impact her ability to engage with support services and manage her mental health? To what extent did agencies identify and address any compounded vulnerability related to this trauma?

Impact of previous trauma and grief

- How did Sandra's prior traumatic experiences and ongoing grief influence her vulnerability in relation to domestic abuse, as well as her access to or willingness to engage with support services? Were there any mental health or support interventions

provided or recommended by agencies to address the impact of these losses and her caregiving burdens?
- Did the agencies involved consider Sandra's informal caregiving role for family members and the emotional and practical burdens associated with it? How did this responsibility affect her availability to seek help, her mental well-being, and her financial or social autonomy?

Analysis of agency training and cultural competency

- How well-prepared were agencies in terms of training, policies, and cultural competency to recognise and respond to the specific needs arising from Sandra and Stefan's protected characteristics and unique backgrounds? Were there gaps in agency responses or engagement with domestic abuse services specific to ethnic, cultural, or immigration concerns?
- Were any considerations given to the specific cultural, social, and trauma-informed approaches that may have been more effective in meeting Sandra and Stefan's needs?

Agency awareness of barriers to support for both individuals

- In what ways did agencies recognise and address potential barriers to support services for both Sandra and Stefan, particularly related to cultural stigma, immigration-related fear, or mistrust of authorities? How did these factors influence each individual's willingness to engage with or disclose abuse to the relevant agencies?

1.3.3 Methodology

Section 1.3.1 outlines the process of this review. This section will consider the methodology used. As noted in the previous section, there have been considerable delays in relation to this review which we have already provided an overview of. It is notable that due to changes in staff at Brent Council who commissioned the review, and gaps in information provided to the new Chair from a previous Chair, the nature of some of these delays remain unclear. Additionally, the methodology is also somewhat fragmented due to these issues.

Following the notification of the death from the MPS, the CSP and previous Chair conducted initial scoping to understand how many agencies Sandra and Stefan were known to. From the records availible it seems 42 agencies were contacted to check their systems, with 20 reporting a nil return[4]. Based on this information the Chair and panel requested and reviewed the following information:

- **Seven[5] Individual Management Review's (IMRs) and chronologies** from Victim Support, University College London Hospitals NHS Foundation Trust (UCLH), Royal Free London NHS Foundation Trust, Imperial College Healthcare Trust, Brent Children and Young People's Services, London Ambulance Service and the Integrated Care Board.

[4] A nil return indicates they had no contact with the subjects of the review.

[5] Information from the previous Chair noted this was following further research, by the commissioning authority of the remaining agencies, only seven agencies had relevant information requiring an IMR although the precise rationale remains unclear. In the interest of due diligence, the second Chair reviewed all of the information gathered to identify whether there were any remaining agencies that should supply information (e.g. were mentioned within IMRs/chronologies or through scoping documents received), and made appropriate requests which resulted in no further IMR requests, but short reports where appropriate.

- **Five reports** which were from a) Independent Office for Police Conduct (IOPC), b) the Metropolitan Police Service who provided a report containing a summary of the homicide and a discussion regarding various related subjects including current practices in public protection, training, the assessment of risk, policing resilience, updates in technology and changes to policing practices since the incident, c) London Fire Brigade confirming that their only involvement and an overview of the events of that evening, d) the fire investigation report prepared for the criminal trial and e) a report from Mind in Islington summarising their involvement.

- **Literature and document search**[6] to review statistics including the Census 2021, Brent Black Community Action Plan, and evidence as cited throughout this report.

- **Interviews with key individuals** including Sandra's employer[7], Sandra's friend[8] and Stefan[9].

- **Engagement with an Expert Panel member** who attended all panel meetings[10] to support the panel in understanding the unique experiences of Sandra as a Black Caribbean woman. The expert panel member was from PLIAS resettlement which is a local organisation in Brent with a mission to support offenders, ex-offenders, victims and people at risk of offending and victimisation thereby improving their life chances and future prospects. Through their Phoenix (P&Act) Project they provide a free confidential service to help end violence and other harmful practices against global majority[11] women and girls in North and West London[12].

1.3.4 Timescales

The review will consider agencies contact/involvement with Sandra and Stefan between 2019 and the date of the homicide. This period was selected as 2019 was the date in which the Stefan moved to the UK with the Sandra following their marriage in that same year. In addition to agency involvement the review will also examine the past to identify any relevant background, including abuse, before the homicide, whether support was accessed within the community and if there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3.5 Parallel reviews

There were no ongoing parallel reviews at the point of this review's conclusion, however there was an Inquest and IOPC review which operated in parallel with this process which we discuss below.

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[6] By the second Chair.

[7] Undertaken by the second Chair.

[8] Undertaken by the first Chair. The second Chair emailed the individual to update on the change of Chair but received no response.

[9] Undertaken by the second Chair.

[10] From when the second Chair began. It is unclear how many previous panel meetings occurred prior to this and whether they were invited to all of them. Through discussions we understand they attended several meetings including a one to one with the Chair, however no formal arrangements were in place for their expertise which was resolved with the second Chair and the Community Safety Partnership agreed to remunerate them for their time and expertise.

[11] The term Global Majority refers to individuals and communities that belong to racially and ethnically minoritised groups in Western contexts but represent the majority of the global population.

[12] https://www.pliasresettlement.co.uk/services/pact-project/

Review	Details
Inquest	North London Coroner's Service opened an investigation on 17th April 2020, which was subsequently suspended[13] by way of an adjournment on 11th May 2020. The investigation was not resumed as criminal proceedings were instituted on a charge of murder. As a result of those proceedings Stefan was found guilty.
Independent Office for Police Complaints	An IOPC investigation took place following Sandra's death. This review found a range of learning points and poor practice, with recommendations which have informed this review. The IPOC report has been used to inform this review alongside reports and meetings with the MPS Serious Crime Review Group[14] who attended all panel meetings.

1.4 Overview of people involved in the review

1.4.1 Chair and author of the overview report

Danielle Sharp was commissioned by Brent CSP as the Independent Chair and Author of the review following a competitive Request for Quote (RfQ) process. She was the second Chair of this review, as explained in section 1.3.1.

A note from the Chair

As is evident throughout this review, the process undertaken was far from ordinary. This is the first review I have had to inherit from a previous Chair, which has presented considerable challenges. In meeting with key panel members, including community and voluntary sector representatives who had been generously offering their expertise without compensation, it was clear that there was understandable frustration about the prolonged timeline. Concerns were raised not only for those who knew Sandra and the impact this extended process has had on them, but also for the broader community, who felt that Sandra's memory risked being 'forgotten' or that she was being further let down by this process.

In an effort to address some of these concerns, I have carefully reviewed the information received to date, conducted additional inquiries, and worked to enhance the quality of the existing submissions. While there are still some gaps in documenting the process, I am confident we have drawn out meaningful lessons. Above all, I hope that this review serves to honour Sandra's experiences, amplifies her voice, and ensures that her story brings about real understanding and change.

Danielle has undertaken the Home Office funded Advocacy After Fatal Domestic Abuse (AAFDA) Domestic Homicide Review training in June 2024, and prior to this had received Domestic Homicide Review Chair's training from Standing Together Against Domestic Abuse

[13] not resumed.

[14] This is a specialised unit within the MPS that conducts in-depth reviews of serious and complex crimes, such as homicides and high-profile violent offences. This group aims to ensure thorough investigations, identify lessons learned, and improve future responses by analysing the factors contributing to serious crimes and assessing the effectiveness of investigative practices and multi-agency cooperation.

(STADA)[15]. She has been the Chair and Author of twelve DHRs (inclusive of this one and others ongoing) and has been involved in over 40 reviews through varying capacities including as a commissioner of reviews through her roles at various local authorities including Enfield, Haringey, Hertfordshire and Hillingdon.

Danielle has over twelve years' experience working in the domestic abuse sector. In addition to her roles within Local Government (in which she led on domestic abuse and Violence Against Women and Girls strategy and commissioning), she has also worked with the national charity SafeLives as the Head of the Knowledge Hub. Through the latter role she worked to generate and disseminate best practice in relation to domestic abuse responses across the UK. This included managing programmes such as the Home Office funded One Front Door pilot, the Multi-Agency Risk Assessment Conference (MARAC) quality assurance programme and the Leading Lights service accreditation programme. Danielle is currently an independent interpersonal violence consultant supporting public sector and charities across the UK to strengthen responses to violence, abuse an exploitation through strategy, evaluation and research. She has a BSc in Psychology from the University of West London and has been a Trustee for several domestic abuse focussed charities including AVA and Women's Aid in Luton.

Statement of independence

Danielle is not directly associated with any of the agencies involved in the review and has never had any direct association with them (e.g. through current or previous employment). She is not, and has never been, a member of the Brent CSP.

1.4.3 The review panel and agencies contributing to the review

The review panel[16] comprised of agencies from within the London borough of Brent as this was where the victim lived. We understand that agencies were contacted as soon as possible after the review was established, to inform them of the need to secure their records.

The panel met at least four times[17] throughout the review period. The panel included a mixture of statutory and voluntary sector agencies, as well as domestic abuse specialist services. All panel members were independent, having no direct engagement with Sandra or Stefan, including any line management responsibility of individuals that did. The below table provides an overview of the panel including their role and the organisation they represented:

Name	Role	Organisation	Role within the review
Danielle Sharp	Director	Davis and associates	Independent Chair and Author

[15] Danielle is an Associate Chair for Standing Together Against Domestic Abuse (STADA) as well as Chairing independently through Davis and Associates.

[16] The review panel in a Domestic Abuse Related Death (DARD) review is a group of professionals from different agencies and sectors who come together to oversee the review process. Their role is to provide expert input, scrutinise the information provided by each agency, and ensure that the review is thorough, impartial, and focused on identifying lessons learned to improve future responses to domestic abuse. The panel works collaboratively to produce recommendations that can help prevent future tragedies.

[17] We note that this as 'at least' rather that definite as we have information regarding the initial panel meeting, and the three panel meetings convened with the new Chair. Whilst we know that there were some wider panel meetings with the previous Chair, we do not have information on how many happened.

Name	Role	Organisation	Role within the review
Jacqueline Hinds	Chair of Trustees	PLIAS	Expert panel member *(Black Caribbean experiences of domestic abuse)*
Amy Glover	Director of Services: Domestic Abuse	Advance (specialist domestic abuse service)	Expert panel member *(dynamics of domestic abuse)*
Nisha Das	Violence & Vulnerability Coordinator (Domestic Abuse & VAWG Lead)	Brent Community Safety Partnership	Panel member and CSP representative
Justin Armstrong	Review Officer - (SCRG) Specialist Crime Review Group	Metropolitan Police Service	Panel member
Rachel Nicholas	Head of Service – London Domestic Abuse Service	Victim Support[18]	Panel member and IMR
Sonya Kalyniak	Head of Safeguarding and Quality Assurance	Brent Children and Young People's Service	Panel member and IMR
Zoe Tattersall	Strategic Partnership Lead for Safeguarding Children	Brent Safeguarding Children Forum	Panel member
Natalia Croney	LAS Safeguarding Specialist for NW London and R&SA	London Ambulance Service	Panel member and IMR
Kayliegh Creamer	Strategic Partnership Lead for Safeguarding Adults Board	Brent Adult Social Care	Panel member
Stephanie Evis	Named Nurse for Safeguarding Adults	North West London Integrated Care Board (ICB)[19]	Panel member

[18] Since the new Chair took over the review there was no representation from them on the panel. This included an attempt to contact other members of the organisation. As such the panel has proposed the recommendations based on the initial information and IMR they submitted as part of the early panel with the previous Chair.

[19] Due to the limited health contact in this case, a decision at the restart panel meeting was that the ICB would be the health representative, acting as a conduit between broader health services and relevant NHS Trusts. Very brief information was received from University College London Hospitals NHS Foundation Trust (UCLH), Royal Free London NHS Foundation Trust, Imperial College Healthcare Trust, Central Northwest London (CNWL) NHS Trust which indicated they had little to no contact.

1.5 About this report

1.5.1 Confidentiality

This review has been anonymised in accordance with the 2016 statutory guidance. As such several specific dates have been omitted where required, and pseudonyms have been utilised for all individuals referred to in line with the table below:

Individual	Pseudonym	Age at time of death	Ethnicity
Victim	Sandra	36	Black British.
Perpetrator	Stefan	44	Trinidadian national.
Child of Stefan	Aaliyah	13-15 *(specific age not included to retain anonymity)*	Trinidadian national.
Mother of victim	Dorothy	Deceased	Not known.
Family friend/auntie living with the victim and perpetrator	Gloria	Unknown	Unknown

To retain anonymity, the name of the school in which Sandra worked has also been redacted to maintain confidentiality.

1.5.2 Dissemination

Following Home Office Quality Assurance (QA) this report will be published on Brent council's website, in line with the statutory duty.

In addition, and prior to publication, the report will be shared with all contributors, including panel members and IMR authors. Once publication has been agreed (post police conduct matters) it will also be shared with the school in which Sandra worked. In line with the recommendations, learning events should be facilitated to disseminate the learning across local partnerships appropriately. A copy will be sent to the Mayor's Office for Policing and crime and in line with the duty to cooperate with the Domestic Abuse Commissioner.

The responsibility for dissemination of the report and implementation of its recommendations will be owned by the CSP, with the Violence & Vulnerability Coordinator (Domestic Abuse & VAWG Lead) in Community Safety responsible for monitoring the recommendations and reporting on progress.

Section 2: The facts

This section will provide an overview of the information known relating to the individuals and the agencies involved. It will focus specifically on the factual elements of what was known, and by whom.

2.1 Background information

2.1.1 About Sandra

Sandra was a 35-year-old Black Caribbean woman. A family friend described Sandra as a happy person always smiling, with a laugh that brightened-up people's day. She was a teaching assistant and treated all children as if they were her own, with a colleague adding that she never had a day off. She had worked at the school she was employed at for around eleven or twelve years and had strong friendships with her colleagues, one of which described her as 'part of the furniture' often starting her day with a packet of cheese and onion crisps.

She loved Caribbean music and was a brilliant artist often using this as her escape. A work colleague described how she was very creative and would run an art club after school for some of the children.

She was a very petite at around four feet eleven in height and weighing only eight stone. A colleague amusingly recounted that she would often lose her on school trips as she was not much taller than many of the year 5 children. A family friend noted that one of the issues that Sandra faced was a lack of self-confidence due to her being 'quite short'. Her colleague described her as a "strong, tough cookie" and that she was very strong willed. Sandra's loss has been incredibly difficult for all who knew her.

2.1.2 Sandra's relationships and network

Sandra was an only child and incredibly close to her mother, who she lived with at the start of the review period until her mother's death. We understand that she had a stepbrother and was close to her wider family such as her aunties and uncles[20].

Sandra met Stefan online in late 2018 and went over to Trinidad, where he lived at the time to meet him in person. Her work colleague commented that they could see the joy on her face when she came back from her holiday, she had *"seemed so happy"*. Sandra had longed to become a mother and had considerable trauma through several miscarriages, a still birth and ectopic pregnancy. Sandra was reported to have been thrilled that Stefan already had a daughter and we understand from her colleagues that she had started the process to try and adopt her (although this was never finalised). Both Sandra and Stefan had been married before.

They married in February 2019 which colleagues at the time felt happened very quickly and they had raised their concerns with her, as had her mother. A colleague found there to be some *"red flags"* at that time which seemed to be quite controlling. Once of these examples

[20] Unfortunately, as we were unable to speak with her next of kin, we were unable to get contact details from these members of her family and gain their insights.

included his insistence that they get married in the same church in Trinidad as he had married his first wife in.

Their relationship became strained, which a family member noted was because of his behaviour towards her which was very controlling including him trying *"to change her behaviour and stop seeing her friends"*. Information from the trial noted him to be critical about the money she spent whilst making her pay for his mobile phone and demanding up to £300 a time from her for alcohol. A family friend confirmed that Stefan would always ask her for money, and she had been very concerned about his controlling nature.

2.1.3 About Stefan

Stefan grew up in Trinidad where he lived prior to meeting Sandra. His ex-wife had died in 2014 due to sepsis. He noted that before coming to the UK he had worked in oil and gas for 20 years doing engineering and mechanical work. He noted that he had achieved two scholarships and that he had always worked hard. Growing up he recounted that he had been told he would *"never be nothing in life"* having grown up with *"a stepmother that was abusive and a father who didn't care much"* so he wanted to prove people wrong. He had experienced some trauma in terms of family members with two members of his family he was close to having been murdered in Trinidad. He noted that the latter bereavement occurred at a similar time to Sandra's mother dying which he felt was like a trigger in terms of his own trauma.

2.1.4 Summary of the incident leading to this review

Please see section 1.2 for a summary of the incident.

A postmortem on the 12th October 2020 gave the cause of Sandra's death as burns and inhalation of fire fumes, and cardiomyopathy[21]. Stefan was charged with Sandra's murder and several other offences related to the incident on the 29th April 2020.

His defence was that he did not intend to harm her but claimed that she died accidentally when he was trying to kill himself in front of her. He admitted he was jealous and controlling but insisted he wanted to die in front of her when he started the fire. However, at the trial an eight-second voice note Stefan sent to Sandra a few hours before the incident was played. In it he said *"I hope you suffer and die just like how I suffer and die before I go. I really hope you suffer and die"*. The court also heard that he had Googled 'what is the best way to use a knife and kill someone', 'insanity in English Law' and 'cases where the insanity defence worked'.

The forensic fire report noted that there were 70% burns to Sandra's body and that the medical report stated, *"her injures were not consistent with a short duration, high temperature event such as flash burning but suggestive of accelerant being poured over the head and upper body and then ignited"*. The forensic fire report concluded that the *"burning damage to [Stefan's] clothing is not indicative of a self-immolation but it is consistent with brief exposure to transient flames produced by the ignition of a volatile ignitable liquid vapour cloud"*.

Stefan was found guilty of Sandra's murder and sentenced to a minimum of 32 years on the 8th October 2021, which he intends to appeal.

[21] Cardiomyopathy is a group of diseases that affect the heart muscle, impairing its ability to pump blood effectively. This condition can lead to heart failure.

2.4 Equality and diversity

2.4.1 Protected characteristics

This section will examine the nine protected characteristics under the Equality Act (2010) and explore how these characteristics may be relevant to the review. We will specifically analyse the evidence regarding how these characteristics broadly, can create barriers to accessing services to help contextualise the chronology of events.

- **Sex:** Sandra was female, and Stefan was male. National data from the Office for National Statistics (ONS, 2023) highlights that women are more likely to experience domestic abuse than men, with 5.7% of women and 3.2% of men reporting abuse in the past year. Women are also more likely to be victims of domestic homicide, with 67.3% of victims between March 2020 and March 2022 being female, most killed by a male partner or ex-partner. The Femicide Census (2020) further revealed that 110 women were killed by men that year, with 57 (52%) killed by a current or former partner, and that 48% of these cases had a known history of abuse. Sandra's case aligns with these findings, underscoring how domestic abuse often follows chronic patterns that escalate to homicide, even when abuse has been reported to family, friends, or authorities.

- **Race:** Both Sandra and Stefan were of Black Caribbean heritage, specifically from St Vincent and Trinidad (Sandra) and Trinidad (Stefan). Data from the Crime Survey for England and Wales (CSEW) shows higher rates of domestic abuse among Black and racially minoritised women, with a 7.1% prevalence among Black individuals compared to 5.6% among White individuals. Black Caribbean women face unique barriers to reporting abuse, including cultural stigma, distrust of authorities, and fears related to immigration status, leading to chronic underreporting and prolonged exposure to abuse. Patriarchal norms within Caribbean cultures further complicate these experiences, as research in Trinidad and Tobago found that some individuals believed a man was justified in hitting his partner for "talking back" or going out without permission. Sandra's experience reflects this, as Stefan controlled aspects of her life, such as restricting her social activities and referring to himself as "the man of the house", suggesting deeply entrenched gendered power dynamics that may have influenced the abuse she endured.

- **Religion or Belief:** Sandra and Stefan were both of the Christian faith, a factor that may have shaped their relationship dynamics. Christian teachings on forgiveness, endurance, and male headship in the household have been found to discourage some victims from leaving abusive relationships. In Caribbean Christian communities, particularly in denominations such as Pentecostalism and Catholicism, gender roles often reinforce male authority, which Stefan appeared to align with. Research suggests that religious women are often advised to preserve the family unit rather than prioritise their own safety, and faith leaders are not always equipped to support survivors effectively. While Sandra was not an active churchgoer, Stefan attended church regularly, which may have reinforced his adherence to traditional gender roles. This review highlights the lack of engagement from faith institutions in domestic abuse responses and recommends strengthening religious settings' role in safeguarding practices.

- **Marriage:** Sandra and Stefan were married but separated at the time of her death. Research from the Femicide Census and ONS highlights that separation significantly increases the risk of domestic homicide, with 28% of female homicide victims killed by a spouse (including ex-spouses) and 23% by an intimate partner (including former partners). The Femicide Census (2018) found that 41% of women killed by a male partner had recently separated or taken steps to separate, reinforcing that the period following separation is one of the most dangerous for victims. In Sandra's case, her marital status may have also introduced legal complexities regarding property rights, as perpetrators can sometimes claim rights to a victim's home, making it harder for them to leave safely.

- **Disability:** Sandra had partial hearing loss due to a past case of mumps and wore a hearing aid. While there is no direct evidence that her hearing loss influenced her experience of abuse or help-seeking, research suggests that deaf and hard-of-hearing women experience domestic abuse at rates two to four times higher than hearing individuals. Barriers such as communication difficulties, isolation, and a lack of accessible services can further exacerbate vulnerability and delay help-seeking.

- **Pregnancy:** Sandra was not pregnant at the time of her death, but she had experienced multiple pregnancy losses, including a stillbirth at eight months. This history likely had a significant emotional impact and may have influenced her decision to marry Stefan, as his existing child could have offered her an opportunity to fulfil a maternal role. Research shows that women who have experienced pregnancy loss are at greater risk of domestic abuse, as the psychological trauma can exacerbate vulnerability and increase dependency on a partner. In Sandra's case, her past experiences may have shaped her emotional investment in the relationship and her reluctance to leave, despite the abuse she endured.

Broader characteristics in this case which may have been of relevance and will be explored within the analysis are discussed below:

- **Alcohol use:** Stefan regularly consumed alcohol, reportedly demanded money from Sandra to buy alcohol, and she was frightened of his behaviour when he was intoxicated. While alcohol is not a cause of domestic abuse, it can exacerbate the frequency and severity of violence. Research consistently highlights the strong correlation between alcohol use and domestic abuse, with studies showing that two-thirds of police-reported domestic incidents involve alcohol (Gadd et al., 2019). In Trinidad and Tobago, alcohol was identified as one of the most common factors linked to physical abuse against women (Nagassar et al., 2010). Data from the Home Office Homicide Index also shows that between March 2020 and March 2022, 27% of female domestic homicide victims and 42% of male domestic homicide victims were in cases where alcohol was a factor. While alcohol use was not a direct factor in Sandra's death, its role in Stefan's behaviour likely intensified the abuse and fear Sandra experienced.

- **Mental health and experiences of trauma:** Stefan self-reported mental health challenges but did not have a formal diagnosis. He disclosed suicidal thoughts to a friend before the homicide but later denied these feelings to the police, highlighting the intersection of gender, culture, and stigma in help-seeking. He also had a history of significant trauma, including an abusive stepmother, an emotionally absent father, the murders of two family members, and the death of his ex-wife. While mental health issues do not excuse abusive behaviour, research shows that suicidal ideation in perpetrators is a key risk factor for domestic homicide, as it can indicate desperation,

a loss of control, or a sense of ownership over the victim (Monckton-Smith, 2022). Additionally, men often face barriers to seeking support due to cultural expectations of masculinity (Cleary, 2012), which may have contributed to Stefan's reluctance to engage with services. Sandra may also have experienced mental health challenges linked to bereavement and trauma, particularly following the loss of her mother and the ongoing abuse she endured. Research shows that victims of domestic abuse are at greater risk of developing depression, anxiety, and PTSD (Trevillion et al., 2012). This highlights the critical need for mental health support services that address both victim and perpetrator vulnerabilities while maintaining clear accountability for abusive behaviour.

- **Bereavement, long-term and terminal illness:** Sandra experienced significant bereavement, including pregnancy losses and, more recently, the death of her mother from a terminal illness. She also cared for her aunt, who was undergoing chemotherapy, compounding her emotional and physical stress. Research highlights that bereavement can increase vulnerability to domestic abuse, as grief and emotional distress can exacerbate power imbalances and coercive control (Monckton-Smith et al., 2022). Sandra's grief and caregiving responsibilities may have intensified her dependency on Stefan, making it more difficult for her to leave the abusive relationship.

- **Immigration status:** Stefan was a Trinidadian national who met Sandra while living in Trinidad before moving to the UK on a visitor's visa. His immigration status remained unclear, and the Visa and Immigration Service at the Home Office refused to share information with the Chair. Stefan was unable to work or open a bank account, which increased his financial dependency on Sandra. Sandra's workplace suggested that she worked additional hours to fund his visa applications, while Stefan expressed frustration that Sandra had not done more to secure his residency. Research highlights how immigration insecurity can create power imbalances in abusive relationships, with perpetrators exploiting their dependent status to exert control over victims (Anitha, 2011). Sandra may also have hesitated to seek help due to concerns that reporting Stefan's abuse could lead to his deportation, reflecting wider fears linked to the UK's hostile immigration environment. This review highlights the need for improved access to immigration-related information in Domestic Homicide Reviews (DHRs) and a more nuanced understanding of how immigration status intersects with domestic abuse.

- **The COVID-19 pandemic:** Sandra's abuse occurred during the COVID-19 pandemic, which had a profound impact on domestic abuse rates and victims' access to support. Police data showed a 12% increase in domestic incidents reported to the Metropolitan Police Service (MPS) between March and June 2020, with a notable rise in third-party reports as neighbours and family members became more aware of abuse. Support services also reported a surge in demand, particularly for helplines, as victims had fewer opportunities to leave home or access in-person support. M Black and minoritised women faced additional challenges during this period. Imkaan (2020) highlighted that structural inequalities worsened during COVID-19, increasing isolation and barriers to accessing culturally appropriate services. Research also found that housing and financial instability disproportionately affected Black and minoritised women, creating an "epidemic within the pandemic". Sandra's workplace was a key source of support, but school closures during lockdown may have reduced her ability to disclose abuse to colleagues. This highlights the need for stronger outreach strategies during crises to ensure victims can still access support networks.

2.3 Chronology of key events

This section will provide a narrative chronology of what happened during the review period. We will begin with some contextual background prior to this period to support our understanding.

2.3.1 Summary of key events prior to the review period

Sandra lived in Brent with her mother, who she had a very close relationship with. Sadly, her mother was diagnosed with cancer some point prior to the review period, although the date of this diagnosis is not known.

Around 2009 Sandra started working as a teaching assistant at a primary school in the Borough of Islington, neighbouring where she lived in Brent. Her colleague recounted that she had been pregnant in the year that she started, however she faced significant trauma when she lost the baby at eight months. This devastating loss required her to go through the process of giving birth. Her son was subsequently buried in the back garden of her home.

We understand she went on to have several miscarriages including in 2012 when she had called an ambulance due a miscarriage which was reported to have been her second at this time. In 2013 Sandra experienced an ectopic pregnancy and received relevant medical care. In 2014 following a post-operative assessment she told staff at University College London Hospital (UCLH) that it was her fifth miscarriage, the advice was to refer to a recurrent miscarriage clinic. We understand from Sandra's friends that she had a strong desire to be a mother, and these losses were significant to her. In late 2018 she met Stefan online and they began a relationship.

2019

Sandra and Stefan married in February 2019 in Trinidad. Following the wedding, Sandra was described as being "on cloud nine" and worked additional hours to fund Stefan's relocation to the UK. Once he arrived, he moved in with Sandra, her mother, and his teenage daughter.

However, colleagues noticed concerning changes. Sandra confided in a colleague that Stefan had trashed the house after an argument, and shortly after, he became aggressive towards her mother. Sandra also became increasingly isolated from her support network, with Stefan turning up at school events to check on her.

In December 2019, Sandra's mother, who had a terminal illness, invited her sister to move in due to concerns about Stefan's behaviour. Before her death on 18th December 2019, she warned family members that Stefan was "a dangerous man" and feared that he would kill Sandra and take the house. Stefan was in Trinidad at the time due to visa issues but returned shortly after her passing. At the wake, he was seen intoxicated and shouting at Sandra, asserting that he was "the man of the house."

Following her mother's death, Sandra became withdrawn, and family and friends noticed increasingly hostile exchanges between her and Stefan.

2020

On 26th January, Sandra's aunt called the police in distress, reporting that Stefan had been drinking heavily and "gone berserk." She feared for Sandra's safety. When officers arrived, Sandra disclosed that she was afraid of Stefan when he was drunk and that he was verbally abusive. A Domestic Violence Investigation Form (124D) was completed, recording a "standard risk" outcome. She declined a referral to specialist domestic abuse services.

Stefan sustained a head injury during the altercation, and police took him to Northwick Park Hospital. Hours later, he called the police himself, claiming he had been assaulted by a family member and that his head was still hurting. The London Ambulance Service (LAS) attended, but Stefan declined further medical treatment. Two days later, police closed the incident as a "Non-Crime Domestic Incident."

On 1st February, Sandra's aunt again called the police, reporting that Stefan was acting aggressively and had "held up" Sandra. Officers attended and separated the couple. Sandra disclosed that Stefan had grabbed her wrist, pulled her into the living room, and locked the door to prevent her from leaving. Despite this, the incident was also recorded as a "Non-Crime Domestic", and no risk assessment was completed.

Hours later, Sandra called the police to report a hidden camera that Stefan had installed in a lightbulb in her bedroom. She also disclosed that he had been physically intimidating, had grabbed her arms, and had tried to lock her in a room. Police informed her that without evidence linking Stefan to the camera, they could not arrest him. A voyeurism crime report was created but later closed, citing "no suspect identified."

That same day, Stefan contacted Brent Family Front Door (BFFD) Emergency Duty Team, stating that Sandra had asked him to leave and that he was homeless and financially dependent on her. BFFD determined there were no safeguarding concerns, as his daughter was staying with her maternal grandmother.

On 3rd February, Stefan self-referred to Islington Mind for mental health support. On 4th February, Sandra's case was automatically referred to Victim Support following police involvement.

On 6th February, Stefan called the police to request assistance retrieving his passport and documents from Sandra's home. An appointment was booked for 8th February, but Sandra was not informed or consulted.

In the early hours of 8th February, Stefan called 999, claiming he had been attacked by two or three unknown assailants. He had minor head injuries and small puncture wounds to his hand, but police and ambulance staff noted his injuries were inconsistent with his account and possibly self-inflicted.

Later that day, police accompanied Stefan to Sandra's home to collect his belongings. Sandra was unaware of this arrangement but allowed him in under police supervision. Officers noted Stefan was intoxicated but did not intervene.

Stefan was scheduled to attend a mental health induction with Islington Mind on 10th February but failed to turn up.

On 10th February, Sandra called the police to report ongoing harassment. Stefan was sending false accusations about her via email and social media and had threatened to publicly shame her at work. Police scheduled a visit for 13th February.

During this meeting, Sandra disclosed that Stefan's behaviour was escalating—he was controlling, jealous, abusing alcohol, making suicide threats, and frightening her friends. She also revealed that her mother, before passing away, had warned that Stefan would kill her. A DASH risk assessment classified her case as "medium risk."

On 12th February, Stefan sent a threatening message to one of Sandra's friends: "Watch your back, you and your sons."

On 16th February, the police mistakenly closed the arrest enquiry, wrongly stating that Sandra did not wish to pursue the case. The IOPC investigation later found this was due to an administrative error, as officers had misread her previous voyeurism report.

On 17th February, Stefan finally attended his Islington Mind induction. However, he was deemed ineligible due to a lack of local connection and was advised to seek support elsewhere.

On 18th February, Stefan called the police, claiming he had recordings of Sandra and her aunt plotting to have him attacked. The appointment to assess this new "evidence" was later cancelled with no reason recorded.

On 20th February, Sandra provided police with evidence of Stefan's continued harassment, including multiple calls, messages, and social media posts. She confirmed she fully supported police action and wanted Stefan arrested.

On 24th February, a friend of Stefan's contacted police, stating that Stefan had sent a message saying he was thinking of hanging himself. When officers attended, Stefan minimised his distress, appeared embarrassed, and refused referrals for support.

That same day, Stefan contacted Brent Children's Social Care, accusing Sandra and her aunt of verbally abusing his daughter. On 2nd March, BFFD finally responded to his allegation, but determined there were no safeguarding concerns.

On 9th March, police contacted Stefan to request he attend an interview the following day. The appointment was later cancelled without explanation.

On 11th March, Sandra emailed Stefan demanding the return of her mother's gold necklace, which she suspected he had stolen. His responses included manipulative messages about their marriage.

On 12th March, someone claiming to be Stefan's legal representative called BFFD's Emergency Duty Team, stating that Stefan was homeless and suicidal. When BFFD contacted Stefan directly, he denied mental health concerns and was advised to seek housing support.

On 15th March, police re-invited Stefan for a 19th March interview. On 16th March, he requested police assistance to retrieve his mail and car parts from Sandra's house.

On 20th March, Stefan turned up unannounced at Sandra's house, prompting her brother to call 999. Police attended, discovering that Stefan had previously booked an appointment to collect belongings—but Sandra had not been informed.

A new DASH risk assessment identified multiple high-risk markers, including Stefan's persistent emails, controlling behaviour, alcohol abuse, and previous suicide threats. Despite this, the police classified the risk as "standard."

On 24th March, Stefan messaged police about his interview, which was cancelled due to lockdown restrictions.

On 30th March, Sandra informed police she was reporting Stefan to the Trinidadian Embassy to revoke his visa.

On 6th April, police closed Sandra's case, citing "standard risk" despite her previous medium-risk classification.

On 15th April, Sandra called the police again—Stefan had posted intimate photos of her online and sent them to her employer. Police attended, and a DASH risk assessment confirmed she was deeply distressed, afraid to leave her house, and struggling to cope.

Sandra planned to leave her home the next morning to stay with a friend.

Just 40 minutes after police left Sandra's home, Stefan arrived. By morning, Sandra was dead, and her house engulfed in flames.

A colleague described the morning they received the news as "the hardest day of my career." The school later led a whole-school project on hope and ensured staff received therapeutic support.

The review panel extends its deepest gratitude to Sandra's family, friends, and colleagues. Their willingness to revisit this traumatic experience is a testament to their love for Sandra and their commitment to ensuring her story is heard.

Section 3: The lessons

This section will present the analysis and lessons to be learnt.

3.1 Analysis and learning

3.1.1 Analysing Sandra's experience of domestic abuse

1. **Opportunities to identify and address coercive control**

Sandra's experience highlights a significant gap in the understanding and recognition of coercive control by professionals. The minimisation of "lower-level" physical violence and non-specific threats, such as Stefan's statement that he wanted Sandra to "suffer," underscores a lack of awareness about how these behaviours signal escalating risk. Greater professional training is needed to identify coercive control as a key risk factor for domestic homicide.

2. **Recognition and response to stalking**

Stefan's stalking behaviours, including persistent contact, workplace intrusion, and the misuse of technology to humiliate and control Sandra, were not adequately identified or addressed. Research consistently highlights stalking as a high-risk behaviour, often preceding severe violence or homicide. Sandra's case demonstrates the need for professionals to treat stalking as a critical warning sign and intervene accordingly.

3. **Addressing escalating risk behaviours**

Stefan's behaviours, including suicidal ideation, false accusations to authorities, and public humiliation tactics, represent clear escalation. These were opportunities for intervention that could have disrupted the trajectory toward homicide. Improved multi-agency risk assessment and information-sharing processes are required to identify and respond to such escalation effectively.

4. **Understanding of technology-facilitated abuse**

Stefan's use of intimate imagery, hidden cameras, and social media to harm and humiliate Sandra underscores the growing need for professionals to recognise and address technology-facilitated abuse. This form of abuse can exacerbate victims' psychological trauma and should be explicitly included in domestic abuse risk assessments. However, it is also important to acknowledge the constraints in policing this space. Challenges include the rapid evolution of technology, limitations in law enforcement resources and expertise, jurisdictional issues for online platforms, and the difficulty of collecting and preserving digital evidence. These constraints highlight the importance of multi-agency collaboration and investment in specialised training and resources to address technology-facilitated abuse effectively.

5. **Monitoring perpetrators' behaviour**

Despite several police calls and allegations made by Stefan, there was insufficient monitoring of his escalating behaviours. Sandra's case highlights the need for proactive

management of high-risk perpetrators through tools such as stalking protection orders, perpetrator intervention programs, and consistent oversight by law enforcement.

6. **Impact of external stressors and perpetrator behaviour**[22]

Stefan's mental health challenges, financial instability, and feelings of humiliation were contributing factors that amplified the risk he posed. These factors should be considered within the framework of domestic abuse risk assessments, with appropriate interventions to address mental health and economic vulnerabilities without excusing abusive behaviour.

3.1.2 Analysing the equality and diversity considerations

1. **Embed cultural competency and intersectionality in responses**

Agencies must consistently recognise and integrate protected characteristics, such as race, ethnicity, and cultural background, into their responses to domestic abuse. A proactive approach to cultural competency and intersectionality is essential to ensure that interventions are inclusive, equitable, and reflective of diverse needs.

2. **Tailor support through culturally specific services**

Victims from minoritised communities, such as Sandra, often face systemic barriers and mistrust of statutory services. Referrals to culturally specific and by-and-for organisations can provide more accessible and meaningful support, fostering trust and improving outcomes.

3. **Addressing overrepresentation and structural inequities**

The overrepresentation of Black Caribbean women in domestic homicide cases underscores the need for targeted interventions to address systemic vulnerabilities. This requires reforms that explicitly prioritise equality, diversity, and inclusion across all safeguarding processes.

3.1.3 Analysis of the response from agencies

Metropolitan Police Service

1. **The need for holistic, evidence-led approaches**

Police responses must move beyond incident-focused actions to identify patterns of coercive control, stalking, and harassment. This includes leveraging corroborative evidence from victims' networks, such as workplaces and families, to build a comprehensive picture of escalating risk.

2. **Police communication with victims**

Clear and consistent communication with victims is critical to ensuring they feel supported and informed. Miscommunication and failure to notify Sandra of key developments, such as Stefan's police-facilitated visits, exacerbated her fear and eroded trust. Regular,

[22] This does not excuse or justify their behaviour but is relevant in assessing the risk they may pose in terms of escalation.

transparent updates are vital, particularly when perpetrators attempt to exploit systems to maintain control.

3. **Strengthen safeguarding practices**

Effective safeguarding must include practical measures such as target hardening, emergency phones, and protective orders. In Sandra's case, missed opportunities for MARAC referrals and insufficient consideration of escalating risk highlighted gaps in safeguarding frameworks. Embedding cumulative risk assessments and ensuring timely multi-agency interventions are essential.

Brent Children, Young People and Families Service

1. **Involving children in decision making:**

Greater focus on the welfare of Stefan's daughter was needed. Multi-agency partners did not raise concerns about his daughter or make referrals. As information was presented to the BFFD by the father directly, without broader contextual information, the BFFD was not aware of the broader concerns around domestic abuse[23]. Direct engagement with the child as part of exploring the informal care arrangements which could have included liaising with her school, and conducting multi-agency checks to verify the suitability of her living arrangements would have ensured her safety.

2. **Proactive response to referrals for support**

Stefan's vulnerabilities including issues such as his housing instability, NRPF status, and mental health challenges were not addressed by the multi-agency partners he approached. In terms of BFFD a more proactive approach to signposting him through direct referrals would have been beneficial as navigating these pathways was likely to have be overwhelming. Children's services have a 'Duty to Refer' which requires them to identify and refer someone who is homeless or may be threatened with homelessness, to a local housing authority of the service user's choice. As such this direct referral should have been completed.

3. **Recognition of private fostering arrangements**

Stefan's daughter's repeated placements with family or friends without formal oversight highlighted the need for robust processes to identify and address potential private fostering arrangements and appropriate information sharing with the local authority where she was living.

Victim Support

1. **Flexible contact strategies**:

Victim Support and similar agencies should consider using a more flexible contact strategy, including exploring multiple modes of communication (e.g., email or letters) and leaving generic, non-specific voicemails where it is safe to do so.

[23] We will discuss this further in the multi-agency learning section. BFFD is considerably reliant on information from partner agencies to make effective safeguarding decisions.

2. **Proactive multi-agency collaboration**:

Stronger collaboration with referring agencies, such as the police, is critical. Confirming updated contact details and validating the safety of communication methods can enhance the likelihood of successful engagement.

3. **Victim-centric policies**:

Blanket policies such as the "no voicemail" approach should be reviewed to ensure they are adaptable to individual cases. A balance must be struck between maintaining victim safety and creating opportunities for meaningful engagement.

4. **Risk-informed approaches**:

Cases involving victims who are being actively stalked or harassed require additional consideration. Tailored approaches that account for the victim's specific circumstances, such as frequent changes to contact information, should inform the contact strategy.

Section 4: The action

This section outlines the recommendations to be implemented by agencies, based on the learning identified in the preceding section.

4.1 Recommendations for individual agencies

4.1.1 Metropolitan Police Service (MPS)

- Implement the findings and learning from the Independent Office for Police Conduct (IOPC) investigation[24], ensuring all recommendations are addressed systematically to improve domestic abuse responses.

- Review and enhance culturally specific training for officers responding to domestic abuse[25], ensuring a robust understanding of stalking. This should include recognising high-risk behaviours and integrating them into risk assessments.

- Create a briefing for officers regarding supporting individuals collecting belongings from a property. This should include a requirement to contact the individual living at the property to gain consent and assess risks, ensuring victim safety is prioritised.

- Review and update protocols to ensure that vulnerability markers, including suicidality noted on risk assessments[26], are consistently applied as a flag to case records. This will enhance officer awareness of risk factors in future interactions.

- Ensure compliance with best practice by mandating MARAC referrals for victims reporting three or more domestic abuse incidents within 12 months and create an assurance mechanism to ensure this happens[27].

- Address systemic workload pressures through staffing reviews and enhanced support mechanisms for officers managing complex domestic abuse cases, ensuring consistent case management and reducing the risk of missed opportunities[28].

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[24] These were accepted at the time of writing by the MPS Department of Professional Standards (DPS).

[25] Since this incident there was a roll out in 2021/22 of DA training for officers, this is to be repeated within the delivery of DA Matters training or equivalent to 11,700 officers and staff over the course of financial year's 24/25 and 25/26. In addition, 25 officers are to receive a DA Matters 'Train the Trainer' course to provide resilience, allowing the learning from the training to embed, and sustain culture change in our response to domestic abuse post project. A revamp of recruit training and Trainee DC pathways was revised/updated this year & CSU course – the risk factors i.e. stalking/suicide/post separation. Patterns of behaviour are also now considered, with a focus on utilising intelligence to identify and focus on high harm offenders (VAWG100).

[26] The MPS has moved away from DASH for initial reporting and now uses DARA (copy attached) Q11 specifically deals with perpetrator suicide ideation.

[27] Within this it should be made clear that the criteria is not solely basing referrals on 3+ incidents and officers should also to use professional judgement where other referral criteria may not be met and basing this on other vulnerabilities and concerning risk factors.

[28] The MPS has moved resources from specialist crime and operations in order to re-focus on frontline policing as a key objective for management board. This has led to an uplift in staff with public protection units across London with a focus on supervision.

- A briefing or targeted guidance should be developed and disseminated to all officers to reinforce the importance of identifying and considering any children connected to both the victim and the perpetrator during domestic abuse incidents. Officers should be reminded that safeguarding notifications (e.g., through the CONNECT system) must be generated for all children related to the individuals involved, regardless of whether the children are physically present at the scene. This guidance should emphasise:
  - The legislative changes introduced by the Domestic Abuse Act, recognising children as direct victims of domestic abuse in their own right.
  - The necessity of proactive enquiries during incidents to identify any children who may not be immediately visible but are still potentially affected by the dynamics of domestic abuse.
  - How to effectively use the CONNECT system or other relevant notification processes to ensure timely safeguarding referrals are made.

A recommendation was explored around automatic referrals to support services such as mental health and substance use services, mirroring the automatic referrals to Victim Support. However, given recent changes in the MPS which has just completed the roll out of a £150 Million IT project called CONNECT, it was deemed not to be feasible. The new system will ensure all safeguarding alerts will be created on this system and passed to the Multi Agency Safeguarding Hub (MASH) to assess, develop and pass to relevant partner agencies.

4.1.2 Victim support

- Review policies on victim contact to incorporate more flexible approaches, such as emails, safe letters, or leaving generic voicemails where safe and appropriate. This would improve engagement with victims who may frequently change contact details due to stalking or harassment.

- Introduce a supervision mechanism for cases closed due to lack of contact, ensuring all opportunities for multi-agency collaboration have been explored before closure. This should include ensuring consistent feedback loops with referring agencies, and evidence of making efforts to have innovative approaches to offer support services where victims may be difficult to contact.

- Build partnerships with by-and-for organisations to provide culturally specific and accessible services for minoritised communities. These organisations should be integrated into referral pathways to foster trust and improve victim outcomes.

4.1.3 Brent Family Front Door (BFFD)

- BFFD should work with housing to ensure all staff within the front door have received adequate training in relation to the Homelessness Reduction Act (2017), with particular focus on the Duty to Refer and the local pathway/processes for doing so.

- BFFD should ensure all staff processing contacts are aware of identification of private fostering arrangements and ensuring these children receive an appropriate response in line with statutory guidance.

4.2 Multi agency recommendations

4.2.1 Safer Brent Partnership

Safer Brent Community Safety Partnership should develop a local Domestic Homicide Review protocol which clearly articulates the local process, including:

- the decision-making process for commissioning an Independent Chair to ensure suitably skilled individuals are selected, which includes a clear assessment of their independence and a requirement for Chairs to disclose conflicts immediately if they arise.
- an agreed contract monitoring and quality assurance mechanism between the commissioner and the DHR Chair to ensure an agreed approach to timelines and updates is implemented.
- an information management process is embedded to ensure business continuity where a Chair may be unable to fulfil their obligations so the CSP maintains access to all relevant information where a new Chair may need to be sought.
- an agreed standardised reporting mechanism to the CSP to provide robust updates on review progress to the CSP.
- an escalation process where the CSP and/or commissioner has concerns about the performance of a Chair to ensure timely action is taken (including consideration of a termination clause within Chair contractual agreements where swift mitigation action is not taken).

Safer Brent Community Safety Partnership should work as part of the review of the Brent Black Community Action Plan (BCAP) to strengthen the incorporation of domestic abuse and violence against women elements including consideration of:

- A focus on wider forms of abuse such as coercive control and stalking as well as the current focus on ‘domestic violence’, ensuring the appropriate definitions and language is adopted.
- The incorporation of scoping of local by-and-for organisations to ensure their participation on the plan and that the CSP is supporting raised awareness of access to these services across the community.
- Working with the by-and-for organisations in Brent, or the wider London footprint, to review existing awareness materials around domestic abuse to ensure cultural relevance, and develop new materials where gaps are observed.
- A focus on funding relevant training around domestic abuse for the Black community and voluntary sector organisations around domestic abuse, to build on the existing actions around champions to support community leaders.
- An approach to involving Black majority churches and religious institutions in domestic abuse partnership working to ensure they have access to the knowledge and resources to identify and respond to domestic abuse.

Safer Brent Partnership should develop or commission a culturally appropriate domestic abuse awareness programme tailored specifically for African and Caribbean communities in Brent. This programme should include training for organisations, ensuring it

is informed by the lived experiences of communities[29] and designed to address their specific needs.

Safer Brent Partnership in collaboration with housing services and perpetrator-focused programmes such as DRIVE, should integrate housing considerations into local perpetrator management strategies. This should include leveraging the Duty to Refer and housing support as a tool to reduce risk, disrupt abusive behaviour, and promote behavioural change among perpetrators. This approach should be embedded into multi-agency responses and risk management frameworks.

The VAWG delivery group (working with the VAWG forum and Local Safeguarding Children's Board) should develop a guidance briefing for schools across Brent to support them in understanding how to support employees/colleagues experiencing domestic abuse.

4.3 National recommendations

4.3.1 Home Office

The Home Office Domestic Homicide Review team should agree a new information sharing process with the UK Visas and Immigration service to ensure effective participation in providing data on Domestic Homicide Review (DHR) subjects.[30]

[29] This should include the lived experiences gleaned from Domestic Abuse Related Death Reviews. Broader lived experience involvement could be done in partnership with community and voluntary sector organisations, such as PLIAS, as part of the BCAP.

[30] The Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) in 2024 and will be publishing the new guidance in the coming months. The draft statutory guidance includes a dedicated section outlining the relevant data protection considerations for processing information, in accordance with General Data Protection Regulation (GDPR) and Data Protection Act 2018. It is currently outside the scope of the next iteration of the statutory guidance to introduce an information sharing process with the UK Visas and Immigration service, who are not included as a relevant body within the legislation underpinning DHRs, however, we will take this recommendation into consideration for future policy development.

Appendix A: References

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