CENTRE FOR SAFER SOCIETY

Brent

DOMESTIC ABUSE RELATED DEATH REVIEW OVERVIEW REPORT

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.

Contents

Trigger warning: This report contains potentially distressing material, including references to violence, harm, and descriptions of injuries. Readers are advised to proceed with care, particularly if they have experienced or been affected by similar issues. Support services and helplines are listed in the appendix D.

Section 1: Introduction 5

1.1 Context 5

1.1.1 About Domestic Abuse Related Death Review's 5

1.1.2 Defining domestic abuse 5

1.1.3 Purpose of this review 6

1.1.4 About Brent 7

1.2 Outline of the incident leading to the review 9

1.3 The scope of the review 10

1.3.1 The review process 10

1.3.2 Terms of reference 11

1.3.3 Methodology 13

1.3.4 Timescales 14

1.3.5 Parallel reviews 15

1.4 Overview of people involved in the review 15

1.4.1 Chair and author of the overview report 15

1.4.2 Involvement of family, friends, work colleagues, and informal networks 16

1.4.3 The review panel and agencies contributing to the review 17

1.5 About this report 19

1.5.1 Confidentiality 19

1.5.2 Dissemination 20

Section 2: The facts 21

2.1 Background information 21

2.1.1 About Sandra 21

2.1.2 Sandra's relationships and network 21

2.1.3 About Stefan 22

2.1.4 Summary of the incident leading to this review 23

2.4 Equality and diversity 24

2.4.1 Protected characteristics 24

2.4.2 The impact of wider needs or vulnerabilities 30

2.3 Chronology of key events 33

2.3.1 Summary of key events prior to the review period 34

2.3.2 Narrative chronology 34
2.3.3 Conclusion 48
2.4 Illustrative chronology of key events 49
Section 3: The lessons 50
3.1 Analysis and learning 50
3.1.1 Analysing Sandra's experience of domestic abuse 50
3.1.2 Analysing the equality and diversity considerations 58
3.1.3 Analysis of the response from agencies 60
3.2 Conclusions 68
3.2.1 Summary 68
3.2.2 Through the eyes of Sandra 70
Section 4: The action 72
4.1 Recommendations for individual agencies 72
4.1.1 Metropolitan Police Service (MPS) 72
4.1.2 Victim support 73
4.1.3 Brent Family Front Door (BFFD) 74
4.2 Multi agency recommendations 74
4.2.1 Brent Community Safety Partnership (CSP) 74
4.3 National recommendations 75
4.3.1 Home Office 75
Appendix A: Full terms of reference 76
Appendix B: References 82
Appendix C: Action plan 85
Appendix D: Home Office feedback form 94
Appendix E: List of support services for readers 98

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.

This report examines agency responses and support given to Sandra prior to the point of her death in April 2020. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer. 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) 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.

What is the Domestic Abuse Act?

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.

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

Through its provisions, the Act seeks to broaden understanding and recognition of domestic abuse, recognising that it extends beyond physical violence to encompass a spectrum of coercive, controlling, and harmful behaviours within intimate and familial relationships. By establishing a statutory definition of domestic abuse, the Act lays a crucial foundation for legal and societal responses, emphasising the need for early intervention, support services, and robust legal frameworks to hold perpetrators accountable. With a focus on safeguarding the well-being of victims, including children affected by domestic abuse, the Act signals a commitment to creating a safer and more equitable environment for all individuals within our communities.

It is recognised that in most cases of domestic abuse, there are patterns of ongoing behaviour which should not been seen in isolation. For example, Kelly & Westermarland (2016) argued that many definitions of domestic abuse are not fit for purpose as referring to domestic abuse as 'an incident' or pattern of incidents reduces it to incidentalism which fails to capture the pervasive nature of abuse. Domestic abuse is often not an isolated incident but a pattern of power and control and even where physical violence is present, this is often accompanied by other forms of abuse which keep the victim/survivor in the relationship and this is supported by extensive research (Stark, 2013; Dobash & Dobash, 1998; 1992). Throughout this review we will consider the statutory definition of domestic abuse, alongside the evidence base and literature, to explore how this compared to Sandra's experience.

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.

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).

What is a Community Safety Partnership?

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.

These partnerships bring together representatives from the police, local councils, health services, fire and rescue services, and other relevant organisations to address issues such as anti-social behaviour, substance abuse, domestic violence, and crime prevention. By working together and engaging with local residents, CSPs develop and implement strategies that ensure a coordinated approach to crime reduction and community safety, aiming to improve the overall quality of life for all community members.

The Domestic Abuse Related Death (DARD) review statutory guidance[2] emphasises the important role reviews have in illuminating the past to make the future safer by adopting a *"professionally curious approach to find the trail of abuse and identify which agencies had contact with the victim, perpetrator, or family"*. This review involves a multi-agency approach and aims to uncover critical insights that inform and improve future practices and policies, ensuring better protection for potential victims.

The review focuses on understanding Sandra's reality, identifying barriers to reporting abuse, and exploring why interventions did not work. Ultimately, the goal is to evaluate whether existing procedures and policies operate in the best interests of victims and to recommend adjustments if necessary.

1.1.4 About Brent

The overview of Brent as a local area in this section is aimed at contextualising this specific case, and the review, within the local landscape. By understanding the demographic composition and prevalence of domestic abuse in Brent, we can better appreciate the unique challenges and opportunities in addressing domestic abuse.

The population of Brent	The 2021 Census highlighted Brent had a population of 339,800 people[3] and was among the top 5% most densely populated English local authority areas at the last census. It is also noted to be one of the most ethnically diverse areas in the United Kingdom. According to the 2021 Census data, Brent's population includes a significant proportion of residents from various ethnic heritages, reflecting the borough's rich cultural tapestry. Approximately 65% of the population is from global majority backgrounds[4]. Specifically, about 18.8% of the population identifies as Black, which includes both African and Caribbean communities, along with other Black identities. Sandra and Stefan were both of Caribbean heritage, which we will explore further in terms of this specific review in Section 2.2. In 2021 6% of the population in Brent identified at Black Caribbean, the 6th highest rate nationally.

[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

[3] How life has changed in Brent: Census 2021

[4] 2021 Census - Ethnicity topic report

Domestic abuse in Brent	There were 3,348 domestic abuse related offences in Brent[5] in the rolling year up to May 2024 which equates to 9.9 offences per 1,000 of the population which is in line with the London average. Brent Community Safety Partnership strategy has a specific priority focussing on domestic abuse which is *"challenging domestic abuse, sexual abuse and preventing violence against women and girls"* which notes they will need to *"prioritise safety and protection for victims/ survivors of abuse, to be safe at home and in our streets"*.
Previous Domestic Homicide Review's	The London Borough of Brent has published six Domestic Homicide Reviews (DHRs) in recent years[6]. Whilst Black individuals represent approximately 18.8% of Brent's population, Black women account for a significant proportion of the Domestic Homicide Review (DHR) cases, with Black Caribbean women particularly overrepresented. If we consider the six published reviews alongside this review (n=7), three (or approximately 43%) involved Black Caribbean women as victims, despite this group comprising only about 6% of Brent's population. This represents an overrepresentation by more than 7 times (43% vs. 6%), highlighting a stark disproportionality. These figures suggest that Black Caribbean women may be disproportionately affected by domestic homicide in Brent, warranting deeper examination into the specific vulnerabilities and systemic factors impacting this demographic. Below, we highlight some of the key points and similarities between this review and the two published reviews involving other Black Caribbean women in Brent, to enable us to consider where we can, any trends or patterns that align with Sandra's experiences. **Alexia (2011)** In this review the victim and perpetrator were recorded to have been Black British by agencies. The review highlighted that neither was in fact a UK citizen and the perpetrator was in the UK illegally. Both individuals were from Jamaica. This bears an interesting similarity to this review in terms of the recording of individuals ethnicity and status correctly. In Sandra's case there was very limited recording in terms of her or Stefan's ethnicity, or his immigration status. Another similarity in the Alexia review with Sandra's case was the role of the family in identifying the perpetrators behaviour. In Alexia's case, her mother and her friends described the perpetrator as controlling and possessive. This is similar to how Sandra's mother and friends described Stefan. Aside from the nature of this review, another striking similarity was evident. There were considerable procedural challenges in the undertaking of the review. In the Alexia review, the initial Chairs submitted an inadequate report to the Home Office in 2012, having undertaken an ineffective review process with no clear terms of reference or scope. Upon the Home Office's rejection of the repot Brent Community Safety Partnership had to engage a new Chair to finalise the review. Notably, this review was over a decade ago and there have been five more reviews published in Brent since this one. Nonetheless, this review has encountered similar challenges which highlights the need for a more robust DHR process to be overseen by Brent

[5] https://public.tableau.com/app/profile/metropolitan.police.service/viz/MonthlyCrimeDataNewCats/Coversheet

[6] https://www.brent.gov.uk/nuisance-crime-and-community-safety/domestic-abuse-and-violence/domestic-homicide-reviews

	Community Safety Partnership in the future. This review will ensure relevant recommendations are made to ensure the issues pertaining to these reviews are not repeated. **Rachel (2018)** There were some striking similarities in relation to this review, with Sandra's case. In this case the victim was noted to have been 'Black Jamaican' and the perpetrator 'Black African'. Similarly to Sandra, the victim in this case had lost her only young child. She had met the perpetrator online via a dating app, similarly to how Sandra met Stefan. In this case the perpetrator had experienced mental health challenges such as depression and anxiety. He had told his brother the day before the homicide that he was going to kill himself or someone else. As we will explore through this review, Stefan had sought support for mental health and told a friend he felt suicidal. Whilst the 'Rachel' review did not articulate any lessons, or indeed make any recommendations around the links between suicidality, mental health and homicide, we will, given the similarities in these reviews be clear that there are lessons to be learned within this area.

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. A more comprehensive summary is included in section 2.1.4.

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

1.3.1 The review process

On the 16th April 2020 Metropolitan Police Service (MPS) informed Safer Brent Partnership of the homicide, and that it was seemingly as a result of domestic abuse. The Community Safety Partnership informed the Home Office of their intention to conduct a Domestic Homicide Review[7] on the 11th May 2020. An Independent Chair was commissioned and shortly afterwards, in May 2020 the Chair made the decision with the CSP to pause the review pending the criminal justice proceedings concluding. An initial panel meeting took place on the 16th September 2021 following the conclusion of the criminal trial, ahead of sentencing.

The police force referred itself to the Independent Office for Police Conduct (IOPC) in relation to their contact with the victim prior to her death. An investigation was carried out by the IOPC which concluded on 16th April 2021. Following the conclusion of this investigation several police officers were disciplined for their actions including one officer being dismissed from the force. In September 2022 this officer appealed against their dismissal and the hearing did not take place until March 2023[8].

At some point[9] during the IOPC process it was identified that the previous Chair of this review, an ex-Metropolitan Police Officer, had in fact line managed the officer who had been dismissed. Although it was initially considered to not impact their independence as a Chair due to the length of time since their retirement, subsequent changes in staff at Brent Council reconsidered this and deemed it inappropriate for them to remain as Chair. Aside from challenges in terms of independence, the panel, CSP and wider organisations had concerns regarding the review process in terms of a) its timeliness and b) the quality of the initial draft report produced by the Chair.

On 12th February 2024, a new Chair was appointed[10], with a handover meeting between the outgoing and incoming Chairs held on 1st March 2024. However, due to incomplete record-keeping and limited information provided during the handover (including documents with lost or incorrect passwords), the new Chair was unable to gain a full and accurate understanding of the actions taken thus far. For instance, it remained unclear how many panel meetings had occurred since the initial meeting on 16th September 2021.

Given the CSP's previous concerns about the quality of the review process, the new Chair faced significant challenges in moving the review forward. Unlike a standard review process, where the Chair would establish a clear and fresh starting point, the new Chair had to piece together fragmented information, including identifying previous contributors who had submitted Individual Management Reviews (IMRs) and other critical data, some of whom were no longer involved.

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[7] Now referred to as Domestic Abuse Related Death (DARD) reviews.

[8] The Police Appeals Tribunal reinstated this officer with an instruction for the MPS to hold a further gross misconduct hearing. The MPS have since submitted an application to the High Court for a Judicial Review in relation to this and the matter remains outstanding.

[9] Due to the records available, we were unable to establish an exact date.

[10] The scope of the new Chair originally was to complete the final Overview Report based on the information gathered by the previous Chair and panel which was already in a 'draft Overview Report'. As we will discuss, this was not possible and additional information and work needed to be completed to make sense of the information and address gaps where possible.

This context required the Chair and panel to carefully balance the need for timely progress, considering the delays already impacting the family, friends, and community, and the importance of delivering a high-quality, meaningful review. As will be highlighted throughout, the Chair and panel have had to make complex decisions to navigate this balance effectively.

The new Chair convened a panel meeting on 2nd April 2024, and this panel met a total of 3 times including 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. These updated TOR can be found in Appendix A. 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.

What are terms of reference?

The terms of reference for a Domestic Abuse Related Death Review set out the purpose and focus of the review. They explain what will be examined (such as the events leading up to the death and how agencies responded), the time period covered, and key questions to be answered. The aim is to identify lessons that can improve future responses to domestic abuse, while maintaining confidentiality and involving the victim's family where appropriate.

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[11]. Based on this information the Chair and panel requested and reviewed the following information:

- **Seven[12] 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.

- **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**[13] 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[14], Sandra's friend[15] and Stefan[16].

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

[12] 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.

[13] By the second Chair.

[14] Undertaken by the second Chair.

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

[16] Undertaken by the second Chair.

- **Engagement with an Expert Panel member** who attended all panel meetings[17] 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[18] women and girls in North and West London[19].

A barrier in terms of the review which impacted the methodology and process was the engagement with UK Visas and Immigration (UKVI) and our international communications with the police service in Trinidad. The new Chair noted a gap in information in relation to Stefan's specific immigration status, with some mixed information across the different agencies, and from his own understanding[20]. To resolve this gap and provide rigor to the panel the Chair requested information from UKVI and requested they attend a panel meeting to provide a presentation on immigration processes including any checks that would be undertaken. Initially the information requested by the Chair was declined as the request needed to come from a statutory, secure email address noting *"you are not listed as a person or organisation that we can release personal data to, and it is also noted that you do not have a secure email address that we could send this information to either"*. The Chair sought support from the CSP commissioners however they did not have a relevant secure email address. The MPS panel member helpfully resubmitted the request via their secure email address, but the response received did not supply the information. The Chair requested this information from Stefan's Offender Manager at Probation, however, was signposted to the Home Office who noted Stefan's consent to share this information was required. In the interest of a timely review, we have had to proceed without this information.

In terms of international information, the Chair wrote to the police service in Trinidad with support from the expert panel member from PLIAS who supplied two relevant contacts. The Chair wrote to these four times but received no response.

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.

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[17] 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.

[18] 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.

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

[20] We understand from some agencies that Stefan was in the UK on a spousal visa, however from our discussion with him he was on a visitors visa. He noted a number of challenges in relation to his immigration status, which we will explore throughout the review, but we have been unable to identify his specific status.

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.

Review	Details
Inquest	North London Coroner's Service opened an investigation on 17th April 2020, which was subsequently suspended[21] 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 IOPC regional director for London said: *"Our thoughts remain with [Sandra]'s friends and family and all of those affected by her tragic death. [The officer[22]] failed to follow reasonable lines of enquiry, which had been set by a supervisor and to ensure appropriate safeguarding was put in place. [The officer] failed [Sandra] in a shocking dereliction of [their] duties as a police officer. [Their] conduct breached the police professional standards of duties and responsibilities and as a result [they] have been dismissed without notice and will be placed on the barred list preventing [them] from working for the police in future"*. The IPOC report has been used to inform this review alongside reports and meetings with the MPS Serious Crime Review Group[23] 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

[21] not resumed.

[22] All names have been redacted to maintain confidentiality of this review.

[23] 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.

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 (STADA). 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 the founder and Chief Executive of the Centre for Safer Society[24], 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.

1.4.2 Involvement of family, friends, work colleagues, and informal networks

The initial Chair wrote to Sandra's next of kin who was her cousin as well as a friend who was identified by the police as part of the investigation. From our understanding the next of kin had not responded, however the previous Chair had met with Sandra's friend and the notes from this interview were shared with the current Chair. This feedback has been included where appropriate throughout the review.

[24] https://centreforsafersociety.co.uk/

The new Chair sought to gain the views of wider family and friends of Sandra and requested support from MPS through the Family Liaison Officer (FLO). Given the elapse of time, the FLO that had supported the family during the case had moved to a new role but was able to provide the details[25] of Sandra's next of kin. The new Chair contacted them by email twice to provide an update on the change in chair and offer an opportunity to be involved in the review. A third and final correspondence was sent when the report was finalised to offer a final opportunity ahead of Home Office submission. No responses to any of the communication was received.

Sandra worked at a primary school for around eleven or twelve years as a teaching assistant. Her colleagues were contacted by the second Chair of the review on the in May 2024 to contribute. The school is small with a very low turnover in staff which meant that her colleagues all knew her incredibly well and were considered in many cases to be friends as well as colleagues. The staff and children at the school have been deeply affected by Sandra's death and the review panel offer both our condolences for their loss, and gratitude for their generosity in sharing their memories of Sandra with us. The Chair met with the headteacher of the school initially to discuss the review. The headteacher subsequently spoke to wider staff within the school, gathering their views, including any key information that was known. The Chair met with the headteacher a further two times and shared parts of the review with them for specific feedback. Throughout this review we will reflect these incredibly valuable contributions.

The new Chair worked with Islington Council[26] to offer an opportunity for Stefan's daughter, who lived with him and Sandra, to be involved in the review process. Her social worker discussed potential involvement with her, and although she noted she would consider being involved, no response was received.

Stefan was invited to participate in the review via letter to which he responded and opted for a face-to-face interview. The Chair met with him within the prison twice to gather his views. These have been incorporated, where appropriate, throughout the review alongside some of the Chair's analysis of these discussions.

1.4.3 The review panel and agencies contributing to the review

The review panel 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[27] 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.

What is the review panel?

[25] An email address.

[26] The authority in which she is a Child Looked After.

[27] 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.

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.

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
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[28]	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

[28] 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.

Name	Role	Organisation	Role within the review
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)[29]	Panel member

There was a gap on the panel in terms of a representative from Education. The first Chair had not sought information from the school that Sandra worked in. The second Chair wrote to them to invite them to participate in the review with a view of inviting them to be a panel member and submit an IMR. However, due to the small size of the school there was no independent individual who could have undertaken an IMR. All staff, including the headteacher knew Sandra, and most were friends with her as well as her colleague, with some interacting with her outside of the work environment. As such the Chair met with the headteacher in the capacity of working with the school as an informal network and seeking Sandra's voice throughout the review. The Chair requested through Brent Council an independent Education representative to support the broader learning for schools across the support and processes for staff within schools experiencing domestic abuse. Despite four attempts to identify a relevant representative, one was not identified, and the decision was made, given the delays already, to proceed with finalising the review. It was agreed that more broadly this learning was able to be identified through an existing panel member through the Head of Safeguarding and Quality Assurance, who is part of the Brent Council Senior Leadership Team and leads the Designated Safeguarding Lead Network in schools, and was able to fulfil the role of sharing identified learning. Additionally, the Chair has met with the individual. The Chair has met with the school to discuss recommendations and learning from the perspective of the school as an employer and incorporated this into the review.

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.

[29] 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.

Individual	Pseudonym	Age at time of death	Ethnicity
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. However, given the current ongoing matters relating to police conduct, in line with our agreement with the IOPC, this report will not be published until this matter is resolved to avoid conflicts of interest or any matters relating to disclosure.

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. The next section of the report will analyse the information contained within this section to consider any lessons that could be learned. This section will explore:

- **Background information** including an overview of Sandra as a person, her close and familial relationships and a summary of the incident leading to this review,
- **Equality and diversity** factors that may impact our later analysis including a review of the protected characteristics that apply and any wider needs or vulnerabilities that may have shaped Sandra's experiences, and;
- **A chronology of events** outlining what happened within the review period, preceded by a brief overview of any key information outside of this timeframe.

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.

A neighbour described her as *"a very nice, pleasant young woman. She always smiled and said hello when she passed"*. She wore her heart on her sleeve, as described by her work colleague said "*you could always tell what Sandra was feeling in her face, if she was having a bad day, it was obvious she was. But when she was having a good day it was really good"*.

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[30].

[30] 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.

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. Sandra's previous marriage ended when her husband was convicted of robbery and deported, whilst Stefan's previous wife who he married in Trinidad had died in 2014[31].

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 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 a daughter prior to meeting him, and they shared a daughter together. He described his ex-wife being "abusive" towards him after she found out he had been having an affair. As noted above, his 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.

[31] We understand from the individuals involved in this review that there was some speculation that Stefan may have been involved in his ex-wife's death, though the source of this information and whether it should be considered 'hearsay' remains unclear. We attempted to gather information from the police in Trinidad, though no response was received, and from the UK Immigration and Visa Service, as the panel assumed they would have reviewed his conviction history. In his meeting with the Chair, Stefan stated his ex-wife had died of sepsis. He recounted being unable to see her immediately afterwards, as her mother and daughter (from a previous relationship) had accused him of being responsible which he categorically denied. While we are not casting any judgment on whether he was involved, we recognise that his ex-wife's family's concern over his behaviour (which was seemingly severe enough for them to have considered such an accusation) may suggest a possible pattern in terms of the dynamics within his relationships. We have therefore included this information in the review, as it feels appropriate and relevant to the context.

2.1.4 Summary of the incident leading to this review

The homicide	In the early hours of the morning in mid April 2020, just over a year after they got married, emergency services received multiple phone calls from the public to respond to a house fire at Sandra's address. CCTV footage from several hours earlier showed Stefan at a nearby petrol station filling a cannister with five-and-a-half litres of petrol. After this, he went to Sandra's house, with separate footage showing him, unbeknownst to Sandra, lingering outside the property. At this point police were in attendance taking a statement from her regarding his ongoing harassment of her and the most recent incident from earlier that day in which he had shared nude images of her. Around 40 minutes after the police had left Stefan poured petrol through the letterbox of Sandra's front door and smashed a window to break into the house. Information suggests that he found Sandra and poured petrol over her head and set her alight after which she immediately ran to her room and locked the door behind her. She was found by the fire service in her bedroom, on the floor by the side of her bed, in the foetal position. She had suffered 70% burns to her body and was taken to hospital but was pronounced dead that same morning. Sandra's auntie and Stefan also both experienced injuries from the fire but were both able to escape. When paramedics found Stefan in the back garden, he was noted to have groaned *"just let me die"*. He spent 12 days in hospital with police by his bedside after initially refusing treatment.
The postmortem examination	A postmortem on the 12th October 2020 gave the cause of Sandra's death as burns and inhalation of fire fumes, and cardiomyopathy[32].
Criminal justice proceedings	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. At the trial he said *"I just wanted to die. She had to see me die.. just so she would be tormented by the fact she had seen me kill myself"*. Stefan maintains this version of events through his meetings with the Chair of this review. 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*

[32] 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.

	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. Friends and colleagues that went to the trial described his attitude as not being particularly remorseful. He would take his shoes off, slouching in his seat. Every time Sandra was talked about, he would put his hands over his ears. The Chair noted that during their two meetings, Stefan appeared to maintain a degree of ill feeling towards Sandra as well as her family and friends. He tended to refer to her as 'my wife' rather than by her name and had no positive remarks about her. Overall, there seemed to be a level of blame directed towards Sandra for the difficulties in their relationship, with Stefan asserting that much of what had come out at trial and subsequently was false. However, he did express remorse for having *"taken someone's life"*. After the trial Sandra's family said: *"Of course we are pleased with the verdict. However, we are not vindictive and bear no ill will. We believe that everyone has freedom of choice but must suffer the consequences of their actions. As you sow, so shall you reap. This ordeal has taken a toll on us both physically and emotionally, so the verdict is helping with the healing process".*

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. Whilst we will bring in some elements throughout this section about this case specifically, we will aim to keep this section as factual as the next section will analyse the impact of these characteristics on the events that happened. Whilst we will discuss each characteristic seperatley, we note that they all intersect, and it is the intersection of these characteristics that form the individuals identity. In Section 3,

we will reflect on any lessons learned through this review, considering how the protected characteristics did, or appeared to have impacted on Sandra's experience of domestic abuse.

Sex

Sandra was female, and Stefan male. Evidence from the Office for National Statistics (ONS) for the year ending March 2023[33] indicates that females are more likely to experience domestic abuse than males. Approximately 5.7% of women aged 16 and over reported experiencing domestic abuse in the last year, compared to 3.2% of men. Furthermore, women are more likely to be victims of domestic homicide. The same ONS data found that between March 2020 to March 2022, 67.3% of domestic homicide victims were female, with the majority of these homicides perpetrated by male partners or ex-partners.

This was a finding mirrored in the Femicide Census report for 2020[34] which revealed that in the same year as Sandra's death there 110 women were killed by men, with 57 of these victims (52%) being killed by current or former partners. A notable finding was that in nearly half of the cases (48%), there was a known history of violence and abuse by the perpetrator towards the victim. This underscores the chronic nature of domestic abuse and the failure of interventions to prevent these fatal outcomes. Like Sandra, many of these women had reported abuse to friends, family, or authorities, yet the abuse persisted and escalated to homicide.

In this case, we have sought to understand the role that sex and gender have played in Sandra's experiences, particularly in terms of how traditional gender norms may have influenced her relationship with Stefan. As we will explore in the next section, there was evidence to suggest that Stefan adhered to certain traditional beliefs about gender roles, including referring to himself as 'the man of the house.' This perspective implies an expectation of authority or dominance within the household, which may have shaped the dynamics of their relationship. Additionally, from the Chair's perspective during the interview with Stefan, he presented as a proud man who appeared deeply insulted by the suggestion that he was financially dependent on Sandra. He strongly refuted this claim, asserting that it was untrue and that he had contributed financially to the household. These elements point to a potential interplay between traditional gender expectations and personal pride, which may have influenced both the relational dynamics and the broader context of abuse.

Race

Sandra and Stefan were both of Black Caribbean heritage. In this section, we examine how race impacts experiences of domestic abuse, particularly focusing on Black Caribbean women, however we note that this is a broad term, and the Caribbean is not one homogenous group with different countries and cultures within it. Where possible in this section we will reflect on and use evidence specifically from the heritage countries in the Caribbean of Sandra and Stefan. We understand Sandra's parents were from St Vincent and Trinidad, and Stafan was from Trinidad. Notably, in terms of national statistics, a breakdown by Caribbean Island is not possible so we will need to make some broader statements. The Crime Survey for England and Wales (CSEW) consistently reports higher rates of domestic abuse among Black and racially minoritised women. For instance, a report by The Interventions Alliance highlights that global majority communities, including Black Caribbean individuals, experience domestic

33 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023

34 https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf

abuse at higher rates compared to their White counterparts. The prevalence of domestic abuse among Black individuals was 7.1%, compared to 5.6% among White individuals[35]. These communities face significant barriers to reporting abuse, such as cultural stigma, distrust of authorities, and fear of deportation due to immigration status, leading to chronic underreporting and longer durations of abuse before seeking help.

Caribbean culture encompasses a complex set of values, traditions, and social norms that can influence the experiences of Black Caribbean women experiencing domestic abuse. These cultural factors can shape both the occurrence of domestic abuse and the responses to it. Cultural norms within Black Caribbean communities, particularly those related to male roles, significantly impact experiences of domestic abuse. Historically, patriarchal norms and power dynamics have been deeply ingrained in Caribbean societies, a legacy from the colonial and post-colonial eras. These norms often normalise male dominance and control, contributing to the perpetuation of domestic abuse[36]. This highlights an intersectionality between sex and race which may have been relevant in terms of Sandra's experiences.

In many Caribbean cultures, traditional gender roles assign men the position of authority within the household. This expectation can lead to abusive behaviours when men feel their authority is challenged. For instance, research in Trinidad and Tobago found that a significant percentage of individuals believed a man was justified in beating his partner for reasons such as talking back or going out without permission[37]. As Stefan had lived in Trinidad prior to moving to the UK when he married Sandra, the learning from this research may be of particular significance in understanding how his views may have been shaped. Throughout this chronology we have evidence that Stefan would stop Sandra from going out to see her friends or family, and that he referred to himself as *"the man of the house"* which may reflect some of these entrenched views around male dominance.

Culture is recognised as a fluid and dynamic concept that extends beyond ethnicity to include various societal layers such as interpersonal relationships, family dynamics, community contexts, and broader societal norms. Agencies often define culture too narrowly, focusing solely on ethnicity, which can lead to misconceptions. When VAWG incidents in Black and minoritised communities are viewed predominantly as cultural issues, it overlooks the underlying issues of patriarchy and gender inequality that affect all forms of gender-based violence. This narrow cultural framing can perpetuate harmful stereotypes and biases, portraying minoritised communities as inherently more violent or backward. Such perspectives can result in the minimisation of risk, the neglect and normalisation of critical indicators of violence, and a failure to provide appropriate, trauma-informed support.

In 2023 the Centre for Women's Justice and Imkaan conducted research examining the obstacles faced by Black and minoritised women who die by homicide or suicide in the context of domestic abuse. They found that whilst they may face many of the same barriers and state failings as all other women experiencing domestic abuse, their deaths are bound up with many issues over and above those faced by white women. The intersectionality of race and gender creates a complex dynamic where Black Caribbean women are disproportionately affected by both societal and institutional biases, resulting in a lack of tailored support that addresses their specific needs. Despite the ongoing debate about racism, there is a persistent silence regarding the under-protection of Black and minoritised women. This under-protection exists alongside the over-policing of Black and minoritised communities. These dynamics can create

[35] https://interventionsalliance.com/domestic-abuse-in-black-asian-and-minority-ethnic-groups/

[36] West, C. M. (2021). Domestic violence through a Caribbean lens: Historical context, theories, risks and consequences. Journal of Aggression, Maltreatment & Trauma, 30(6), 761-780.

[37] Pemberton, C., & Joseph, J. (2018). Intimate partner violence in Trinidad and Tobago. UN Women.

significant barriers for Black women in reporting abuse, as they may fear not being taken seriously or face additional trauma from discriminatory treatment. In fact, the 2022 Crime Survey for England and Wales (CSEW)[38] found that when reporting an instance of domestic abuse, almost half (48%) of Black and ethnic minority respondents felt that the police treated them differently to other people because of their ethnic background or heritage.

Systemic racism and the historical mistrust of law enforcement further complicate the situation. Black Caribbean women often hesitate to involve the police due to fears of racial bias and disproportionate responses that could harm their partners or themselves[39]. The fear of not being taken seriously or facing discriminatory treatment deters many from seeking police assistance. Broader stereotype's such as that of the "strong Black woman" can also play a role in Black women's experiences of abuse. While it can be a source of resilience, it often leaves Black women feeling they must endure abuse silently without seeking help. We know from her friends that Sandra was described as strong, so this internalised expectation could have prevented her from feeling able to reach out for support and exacerbate isolation.

Good practice: Brent Black Community Action Plan

The Brent Black Community Action Plan (BCAP)[40] was developed in response to the need for targeted support and empowerment of Brent's Black community. The plan articulates Council's 10 year commitment to tackling inequalities experienced by the Black community. At the time of this review, the plan was being reviewed, but its current version aims to address systemic inequalities and improve outcomes across various sectors, including employment, education, mental health, and domestic violence support. Actions relating to domestic abuse and mental health include the following:

- **Mental health:**

The BCAP includes specific actions to enhance mental health awareness and support within the Black community through a Mental Health and Wellbeing Event aimed at increasing mental health awareness. The event was set to host up to 500 attendees, including at least 250 young people, with Q&A sessions featuring mental health specialists. The goal is to see a 20% increase in the uptake of mental health services, with data collected to measure the impact over a year.

- **Domestic 'Violence':**

The plan also focuses on educating the community about domestic violence and improving support services. The BCAP supports third-sector organisations to conduct educational sessions for both victims and perpetrators of domestic violence. Additionally, domestic violence champions will assist community leaders in signposting victims to the appropriate support services, ensuring they are well-informed about available resources.

Religion or belief

[38] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingjune2022

[39] Women's Resource Center to End Domestic Violence. (2023). Racial justice and domestic violence.

[40] Brent Black Community Action Plan | Brent Council

Sandra and Stefan were of Christian faith. Sandra and Stefan were of Christian faith, a factor that may have influenced the dynamics of their relationship in various ways. Christianity often intersects with traditional gender roles, particularly within certain sects, emphasising male headship and female submission as part of a divinely ordained family structure (Nason-Clark et al., 2018). In Caribbean cultures, including Trinidadian society, Christianity, particularly denominations such as Anglicanism, Pentecostalism, and Catholicism, plays a significant role in shaping societal norms and expectations, including those around marriage and gender roles (Miller, 2021). These intersections may reinforce patriarchal structures where men are expected to be the primary decision-makers or "heads of the household," as Stefan himself appeared to believe when he referred to himself as "the man of the house."

The role of religion in the context of domestic abuse is complex. On the one hand, Christian teachings on forgiveness, endurance, and the sanctity of marriage may discourage victims from leaving abusive relationships (Hassouneh-Phillips, 2001). On the other hand, church communities can be vital sources of support and intervention. Research suggests that individuals in religious communities often delay seeking help for domestic abuse due to fears of judgment, stigma, or being told to prioritise the preservation of the family unit over their own safety (Levitt & Ware, 2006). For Caribbean women, additional barriers may arise due to cultural stigmas surrounding abuse, compounded by a mistrust of formal support services that may not understand their cultural or religious context (Douglas, 2016).

In this case, Sandra identified as Christian but was not a practicing member of a church community, whereas Stefan noted that he began attending church after moving to the UK. This distinction could have influenced their perspectives on the role of faith in their relationship. Stefan's church attendance may have strengthened his adherence to religiously influenced gender roles, potentially exacerbating relational power imbalances, while Sandra's non-practicing status might have limited her access to religious support systems. Such dynamics illustrate how faith, culture, and personal practice intersect to shape relationship dynamics and the barriers individuals face in addressing abuse.

Key consideration:

This review highlights the importance of addressing the role of religious institutions, such as churches, in supporting families and responding effectively to domestic abuse. Anecdotally, panel members identified the lack of adequate support within faith settings as a recurring theme locally. PLIAS previously delivered a funded programme aimed at raising awareness of domestic abuse within Black-majority churches. However, this funding has since ended, leaving a gap in resources and support for faith communities.

The Brent Black Community Action Plan has identified this gap as an urgent issue, emphasising the need to strengthen the role of religious institutions in safeguarding practices and domestic abuse responses. The programme previously delivered by PLIAS could serve as a valuable foundation for future initiatives to ensure faith settings are equipped to provide support and address domestic abuse effectively.

We will be making a recommendation regarding the involvement of religious institutions in Brent's response to domestic abuse, aiming to address this gap and ensure faith settings are appropriately engaged and supported.

Marriage

Sandra and Stefan were married but separated at the time of the incident. Research from both the Femicide Census and the Office for National Statistics (ONS) highlights the significant link between domestic abuse, homicide, and marital status. The Femicide Census report indicates that a substantial proportion of female homicide victims were killed by their spouse or intimate partner, with 28% of victims killed by their spouse (including former spouses) and 23% by their intimate partner (including former intimate partners).

The report underscores that separation is a critical risk factor, often triggering lethal violence from the perpetrator. This is corroborated by ONS data, which shows that the prevalence of domestic abuse is lower among married individuals compared to those who are separated or divorced. Those experiencing separation or in the process of separation report higher rates of domestic abuse, suggesting that the dissolution of relationships can exacerbate the risk of abuse. This evidence collectively emphasises that marital status, particularly separation or divorce, plays a pivotal role in the dynamics of domestic abuse and the likelihood of domestic homicide.

Marriage can significantly influence the dynamics of domestic abuse, including post-separation risks, legal rights to property, and the ability to seek help. In the scenario where the perpetrator has moved into the victim's inherited home, the marital status introduces complexities that affect both the risk of post-separation abuse and property rights. Research indicates that the risk of lethal violence increases significantly after separation. This period is considered the most dangerous for victims, with a substantial rise in the likelihood of severe abuse or homicide. For instance, the Femicide Census noted that 41% of women killed by a male partner or former partner in 2018 had separated or taken steps to separate from them.

In the case of marital property rights, even if the home was inherited by the victim, the perpetrator may claim rights to the property due to the marriage. This can complicate the victim's ability to retain her home and escape the abusive relationship. According to Rights of Women[41], married individuals have more robust legal avenues to claim a share of marital assets, which can include a home owned solely by one partner. This is contrasted with unmarried partners, who often lack such legal protections.

Disability

We know that Sandra had partial hearing loss due to previously having mumps for which she wore a hearing aid. Research indicates that deaf women experience domestic abuse at significantly higher rates than their hearing counterparts, with estimates suggesting they are two to four times more likely to be victims of domestic abuse[42]. Although we do not have any evidence that her hearing loss impacted her experience of domestic abuse or help seeking, there is a possibility it could have.

Pregnancy

Sandra was not pregnant at the time of her death, nor was she pregnant during the scope of this review. However, we know that she did experience numerous pregnancy losses, including a still birth at eight months. This had a detrimental impact on her and is relevant as it may have

[41] https://www.rightsofwomen.org.uk/wp-content/uploads/2023/12/guide-to-domestic-violence-housing-and-homelessness.pdf

[42] Crowe, T. V. (2021). Intimate Partner Violence in the Deaf Community. JADARA, 46(3). Retrieved from https://nsuworks.nova.edu/jadara/vol46/iss3/4

underpinned her decision to marry Stefan as he already had a daughter which could have provided her with an opportunity to fulfil a maternal role. Ultimately her history of pregnancy loss likely made her more vulnerable to abuse due to the compounded trauma.

2.4.2 The impact of wider needs or vulnerabilities

Alcohol use

We understand that Stefan would regularly drink alcohol, demand money from Sandra to buy alcohol and that she would be frightened of his behaviour when he had drunk alcohol. To be clear, alcohol is not the cause of domestic abuse; responsibility always lies solely with the perpetrator. While alcohol consumption may heighten the risk or severity of abusive incidents, it does not cause abuse but rather serves as a contributing factor that exacerbates existing patterns of control and violence. This section will explore the role of alcohol use, with this fact in mind.

Research consistently demonstrates a strong link between alcohol use and the perpetration of domestic abuse. Gadd et al. (2019)[43] found significant evidence linking alcohol consumption with increased rates and severity of domestic violence. A study in Australia found alcohol-related domestic abuse is twice as likely to involve physical violence, including life-threatening injuries[44]. In the UK, approximately two-thirds of domestic incidents reported to the police involve alcohol, with increased aggression and a direct effect on the behaviour of those involved.

There are arguments that suggest that alcohol's disinhibiting effect may contribute to impulsive violent episodes yet, others have argued that the perpetrators use of alcohol is a rationale for the abuse (Lacey et al[45]). In Trinidad and Tobago, drugs and alcohol were found as the most commonly cited factor in physical abuse against women (Nagassar et al., 2010[46]).

The Home Office Homicide Index data[47] shows that alcohol is a significant factor in domestic homicides. From the year ending March 2020 to the year ending March 2022, 27% of female domestic homicide victims and 42% of male domestic homicide victims were involved in cases where alcohol was a factor. These include deaths where alcohol was a factor in the homicide itself however, which was not relevant in this specific case. The Home Office analysis of domestic homicide reviews found that 71% of the perpetrators were considered to have a vulnerability and the most common were: illicit drug use, mental ill-health, and problematic alcohol use.

Mental health and experiences of trauma

We understand that Stefan was experiencing challenges related to his mental health, which he self-reported during the review period. Neither Sandra or Stefan had an official diagnosis

[43] Gadd, D., Henderson, J., Radcliffe, P., Stephens-Lewis, D., Johnson, A., & Gilchrist, G. (2019). The Dynamics of Domestic Abuse and Drug and Alcohol Dependency. The British Journal of Criminology, 59(5), 1035-1053.

[44] Mayshak, R., et al. (2020). Alcohol-involved domestic violence: Gender differences in predictors. Journal of Interpersonal Violence, 35(17-18), 3483-3506.

[45] Lacey, K. K., West, C. M., Matusko, N., & Jackson, J. S. (2016). Prevalence and factors associated with severe physical intimate partner violence among U.S. Black women: A comparison of African American and Caribbean Blacks. Violence Against Women, 22 (6), 651–670. doi:10.1177/1077801215610014

[46] Nagassar, R. P., Rawlins, J. M., Sampson, N. R., Zackerali, J., Chanadyal, K., Ramasir, C., & Boodram, K. (2010). The prevalence of domestic violence within different socio-demographic classes in central Trinidad. West Indian Medical Journal, 59(1), 20–25.

[47] https://www.gov.uk/government/publications/homicide-sub-type-data/homicide-sub-type-data

relating to any mental health condition, however we will explore the extent to which there may have been symptoms present. In terms of Stefan, he disclosed to a friend prior to the murder that he was feeling suicidal, but when police attended, he denied these feelings. When the Chair met with him, Stefan admitted that he had minimised his suicidal ideation due to feelings of shame, reflecting the intersectionality of issues such as gender, culture, and religion, which can create barriers to help-seeking. While it remains unclear whether Stefan's mental health challenges were entirely circumstantial, he attributed them to stress, we also understand that his experiences were compounded by significant family and childhood trauma. Stefan described an abusive relationship with his stepmother and an emotionally absent father, as well as the murders of two family members and the death of his ex-wife. These cumulative stressors highlight the complexity of his mental health needs. However, it is important to state unequivocally that none of these factors excuse his behaviour or actions. Rather, they underscore the need to explore whether appropriate mental health support might have mitigated some of these challenges.

Research consistently highlights the complex relationship between mental health, domestic abuse, and homicide. Perpetrators of domestic abuse often experience mental health challenges, which, while not the root cause of abuse, may exacerbate risk. For instance, Oram et al. (2013) found that individuals who commit domestic homicide are more likely to have a history of mental health difficulties, including suicidal ideation. Suicidality in perpetrators is a significant risk factor for homicide, particularly in intimate partner violence, as it can indicate desperation, loss of control, or a sense of ownership over the victim, leading to lethal outcomes (Monckton-Smith, 2022). This highlights the importance of identifying and addressing mental health issues in perpetrators, not as a justification for their actions, but as a preventative measure.

Cultural and gender norms can further complicate help-seeking behaviour. Men may feel shame in acknowledging mental health struggles, particularly in cultural contexts that emphasise masculinity as strength and stoicism (Cleary, 2012). In Stefan's case, his reluctance to disclose his suicidal thoughts may have delayed opportunities for intervention. Additionally, his experiences of loss and trauma, including the murders of family members and the death of his ex-wife, suggest the need for a trauma-informed approach in addressing his mental health.

In summary, while Stefan's mental health and trauma history do not excuse his actions, they raise questions about whether earlier intervention or support might have mitigated some of the contributing factors. The link between suicidality and perpetration of domestic homicide underscores the importance of robust risk assessments and support mechanisms that address mental health within the context of domestic abuse.

We also recognise that Sandra may have experienced mental health needs related to her own bereavement and trauma, which we will explore in the next section. The emotional toll of caring for unwell family members, combined with her experiences of abuse, highlights the intersection of mental health and vulnerability in victims of domestic abuse. Research indicates that victims of domestic abuse are at higher risk of developing mental health conditions, including depression, anxiety, and post-traumatic stress disorder (Trevillion et al., 2012). These findings further emphasise the need for comprehensive support systems that address the mental health impacts of both perpetrators and victims.

Bereavement, long term and terminal illness

Sandra experienced considerable loss due to pregnancy loss which we have already explored. However, within the review period she also lost her mother as a result of a terminal illness.

During this time, her auntie moved into the home who was also unwell and receiving chemotherapy. This meant Sandra had compounded experiences of loss and bereavement.

Research indicates that bereavement can be a significant risk factor for domestic abuse and homicide. The loss of a loved one can lead to increased vulnerability due to emotional distress, which may exacerbate existing abusive dynamics within a relationship. For example, Monckton-Smith et al. (2022)[48] highlight that bereavement and other traumatic life events can escalate the risk of serious harm or homicide in abusive relationships. This increased risk is often due to the heightened emotional and psychological stress that can follow such losses, making individuals more susceptible to coercive control and violence.

Moreover, the emotional instability and grief associated with bereavement can impair judgment and decision-making, potentially leading to a reliance on the abuser for emotional support. This dependency can be exploited by the abuser to exert greater control and perpetrate further violence[49]. Additionally, research from the Centre for Justice indicates that individuals experiencing significant life stressors, including bereavement, may face increased risks of domestic abuse due to their emotional and psychological vulnerabilities[50].

These findings emphasise the importance of considering bereavement and other significant life events in risk assessments for domestic abuse and homicide, ensuring that support services are attuned to these heightened vulnerabilities.

Immigration status

Stefan was a Trinidadian national who met Sandra while living in Trinidad before moving to the UK following their marriage. Throughout the review period, his immigration status remained unclear, as the Visa and Immigration Service at the Home Office declined to share information requested by the Chair, citing that the Chair did not represent a statutory agency. This review will recommend measures to ensure that future reviews can access vital information from immigration authorities to provide a fuller understanding of relevant contexts.

From discussions with Stefan, we understand that he was on a visiting visa, requiring him to return to Trinidad every six months. Additional information from Sandra's workplace suggests that she worked additional hours to save money to fund Stefan's visa applications, highlighting the financial strain this placed on her. Conversely, Stefan expressed frustration, suggesting that Sandra had not taken sufficient steps, in his opinion, to secure his permanent residency, which he felt contributed to his precarious immigration status. Although exact details of his status remain unknown, it is evident that Stefan faced significant restrictions due to his limited rights, such as being unable to work or open a bank account. We will explore through the review the impact of his insecure status on the responses from agencies.

Throughout the review, it is important to acknowledge the broader context of the hostile immigration environment in the UK, which may have added layers of complexity to Sandra's situation. While we do not seek to hypothesise or assume, it is possible that Sandra's reluctance to fully access support services was influenced by concerns that doing so could risk Stefan's deportation, particularly prior to their separation.

[48] Monckton-Smith, J., Siddiqui, H., Haile, S., & Sandham, A. (2022). Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide. University of Gloucestershire

[49] ReShare (2022). Domestic Homicide: Interviews with Families, Survivors and Professionals and Analysis of Domestic Homicide Reviews, 2019-2022.

[50] Centre for Justice (2020). Briefing Paper Series April 2020 Issue 3

The COVID-19 pandemic

During the review period the UK went in to its first lockdown due to the pandemic.

The COVID-19 pandemic has significantly influenced the landscape of domestic abuse in the UK, with noticeable increases in both recorded incidents and the demand for support services. Police data[51] shows a marked rise in offences flagged as domestic abuse-related during the pandemic, continuing a trend observed in recent years. Between March and June 2020, the Metropolitan Police Service (MPS) in London recorded a 12% increase in calls-for-service for domestic incidents compared to the same period in the previous year, largely driven by third-party reports. This surge is likely due to the increased time people spent at home during lockdown, providing more opportunities for neighbours and relatives to observe and report abuse.

Support services for domestic abuse victims experienced heightened demand during the pandemic, especially helplines, as lockdown measures eased. This increase does not necessarily indicate a rise in the number of victims but suggests an escalation in the severity of abuse and a reduction in available coping mechanisms, such as the ability to leave the home or attend support services.

Imkaan's research[52] highlights that Black and minoritised women are particularly impacted by both the pandemic of violence against women and girls (VAWG) and COVID-19. During these dual pandemics, racialised discrimination and structural inequalities had become more pronounced, further marginalising these communities. Black and minoritised women reported feeling more isolated and having fewer support options during the lockdown. This isolation is compounded by a lack of culturally appropriate services and support, which further alienates them from the available resources. Whilst further research[53] found the pandemic created barriers to accessing support services and housing for Black and minoritised women, creating an epidemic within the pandemic, which meant minoritised women and the organisations that supported them had to overcome structural barriers and racism.

In Sandra’s case, her employer (a primary school) was a considerable source of support. During the lockdown schools closed, except for children of key workers and vulnerable children. This likely limited Sandra's opportunities to disclose ongoing abuse or access support, as working from home reduced her interactions with colleagues and 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 and finalise this section with an illustrative chronology diagram.

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51 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020#:~:text=There%20has%20generally%20been%20an,of%20abuse%20being%20experienced%2C%20and

52 https://www.imkaan.org.uk/updates/2020/dualpandemics

53 Magill, S. (2023), "The “epidemic within the pandemic”: meeting the needs of racially minoritised women experiencing domestic abuse during the Covid-19 pandemic", Journal of Aggression, Conflict and Peace Research, Vol. 15 No. 3, pp. 187-200. https://doi.org/10.1108/JACPR-05-2022-0717

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.

2.3.2 Narrative chronology

2019

In February 2019 Stefan and Sandra got married in Trinidad.

Reflective information from colleagues

After the wedding in Trinidad Sandra was described to have been *"on cloud nine".* She started working every hour she could with school clubs to get enough money together for Stefan to come to the UK and eventually he relocated and moved in with Sandra and her mother, who Sandra lived with at the time. He had a teenage daughter who also moved in.

However, things began to take a negative turn with a work colleague recounting coming into the staff room to see Sandra crying and she confided in them that she and Stefan had had an argument which resulted in him trashing the house. A few days later another incident happened in which he had gotten 'really angry' at Sandra's mother.

A colleague described how Sandra had lost part of her support network as she wasn't allowed to see her friends anymore. When the school had an event, Stefan would turn up to check on her.

At the start of December Sandra's auntie had moved into the family home at the request of Sandra's mother as she had concerns about Stefan's behaviour. She was worried that given her terminal illness he may be a risk to Sandra when she was no longer around. Sandra's auntie was also unwell, and although the dates are unknown, that she was receiving chemotherapy.

On the 18th December Sandra's mother sadly died as a result of her illness. A family friend confirmed that shortly before her death, Stefan's Visa had expired, so he briefly went back to Trinidad which is where he was when she died. Before her death, Sandra's mother had told her sister (Sandra's auntie) that she believed Stefan was *"a dangerous man"* and would kill Sandra and take the house. She had echoed her concern of this to Sandra's uncle too, expressing she was fearful for Sandra's life and kept saying that Stefan was going to kill her.

Stefan returned from Trinidad soon after Sandra's mother had died, on what we believe to have been a spousal visa however from Stefan's interview it may have been a visitor's visa. At the wake for Sandra's mother, whilst intoxicated he was seen to be shouting at Sandra about her former boyfriends being in attendance stating, *"I'm the man of the house"*.

After her mother's death family and friends noticed Sandra had become withdrawn and some had noticed confrontational exchanges between her and Stefan.

2020

First recorded domestic abuse related incident

In the early hours of the morning on the 26th January Sandra's auntie called the police stating that there had been a fight between*, "husband and wife and family, the guy's gone berserk drinking and carrying on want to hurt the wife"*. She also said Sandra had *"only just married Stefan and he's wanting to beat her up and take over her home and everything else"*. When police arrived, they spoke to Stefan and his daughter upstairs, and Sandra and the rest of the family downstairs. They completed a 124D form (Domestic Violence Investigation/Arrest form) with Sandra which included a Domestic Abuse, Stalking and Harassment (DASH) risk assessment.

What is a 124D form?

The 124D form is a paper booklet designed as an aide memoire for officers. The information collected on the form is transferred on to the police IT system and the physical booklet is filed. A 124D must be completed for every reported incident of domestic abuse.

The form captures comprehensive details about the incident, including the nature of the abuse, the individuals involved, and any immediate risk factors. It is designed to ensure a thorough and standardised approach to recording domestic abuse incidents, facilitating better protection and support for victims. The information collected in a 124D form helps in assessing the risk to the victim and planning appropriate interventions, including referrals to specialist support services.

What is a Domestic Abuse, Stalking and Harassment (DASH) risk assessment?

The DASH risk assessment is a structured tool used by professionals to identify and assess the risk of harm to victims of domestic abuse, stalking, and honour-based violence.

The assessment consists of a series of questions designed to gather detailed information about the nature and severity of the abuse, the behaviour of the perpetrator, and the vulnerabilities of the victim. The responses help professionals determine the level of risk and the need for urgent intervention or support. The DASH risk assessment aims to ensure a consistent and thorough approach to identifying high-risk cases and facilitating appropriate protective measures and referrals to specialist services.

During this discussion Sandra explained she and Stefan had had a verbal argument. She confirmed that she was scared of him when he was drunk and that he was verbally abusive. It was recorded on the form that she was advised to call the police again if there was any escalation in Stefan's behaviour. The outcome of the DASH risk assessment was that Sandra was at 'standard risk', which means, *"current evidence does not indicate risk of causing serious harm"*. She was offered support from a specialist domestic abuse service however it was recorded that she confirmed she did not wish to be referred.

Upon their attendance the police had called for an ambulance to attend as Stefan had an injury to his head. However, the police escorted him to Accident and Emergency at Northwick Park Hospital[54].

A few hours later, when he was back home, Stefan called the police to request they attend the property to take a statement from him regarding the incident and told them that his head was hurting. As police had already attended the call a few hours ago it was closed, and an ambulance was requested to attend. The London Ambulance Service (LAS) attended the property and met Stefan at the front door. He explained his injury and said this was due to being assaulted by a family member and that he had already been taken to hospital by the police earlier that day however he discharged himself due to a misunderstanding.

He told ambulance staff that he had been pushed and fell onto a heater hitting the back of his head on the corner but had no loss of consciousness. On examination he had a minor head injury, 2cm graze with no bleeding or obvious deformity, swelling or bruising. He complained of a headache and tenderness and reported that he had been stressed and was recorded to have appeared stressed and anxious. He had drunk a bottle of brandy the previous evening but was reportedly not intoxicated by the time ambulance staff arrived. He was advised to go back to Accident and Emergency however he declined this as he wanted to sleep. He was advised of the risks but continued to decline and as he was deemed to have capacity to do so he was left at home 'in the care of his wife' and was advised to call back if his condition worsened. The ambulance staff documented that they had no welfare or safeguarding concerns.

Reflective information from friends

Information from one of Sandra's friends regarding this incident was that she had received around twelve missed called from Sandra on this evening. When she called her back, she had explained that Stefan and her uncle had a fight. She offered to attend the property, but Sandra had asked her not too.

Two days later, on the 28th January, the incident was closed by the police as a 'Non-Crime Domestic Incident'.

What is a Non-Crime Domestic Incident?

A Non-Crime Domestic Incident refers to situations where the police are called to an incident involving disputes or concerns that do not constitute a criminal offence. These incidents typically involve arguments or disagreements between individuals who are personally

[54] It is unclear what happened at the hospital. Checks as part of the review process found no record of him having attended based on either his name or national insurance number.

connected, such as family members or partners, but where no crime, such as assault or property damage, has occurred.

The primary purpose of documenting Non-Crime Domestic Incidents is to ensure that there is a formal record of the incident, which can be crucial for identifying patterns of behaviour and potential risks.

Second recorded domestic abuse related incident

On the 1st of February in the early hours of the morning Sandra's auntie called the police stating there was *"an altercation going on with a crazy fellow here"* and Sandra had been *"held up"* by Stefan. She said, *"we called the police for him last week already"* and *"there's an argument going and last week there was fighting and everything and he's done it again tonight"*. When police arrived Sandra's friend was also present.

Reflective information from Sandra's family friend

Sandra's friend who was present at the time engaged in this review and gave some context to this incident. She explained that whilst she was downstairs with Sandra's auntie, they heard a dispute between Sandra and Stefan upstairs in which he was asking her for money. When they went upstairs Stefan had pushed passed them and pushed Sandra in to the living room locking the door. Sandra's friend eventually broke into the room and found Stefan had Sandra in a 'stranglehold' and demanded he released her. Whilst at the address she confirmed that she had noticed that there were cameras around different areas of the house including bedrooms and the bathroom.

Police separated Sandra and Stefan to speak with them both seperatley. Sandra described to police that Stefan had taken her into the front living room, by the wrist, and locked the door behind him, not allowing her to leave. Stefan, speaking with a separate officer confirmed this to be the case but that he had done so to prevent Sandra's auntie and friend from coming in to interfere. The officer noted that Stefan had *"appeared sincere in his explanation of what occurred"*.

Police advised Sandra and Stefan that the incident would be treated as a 'Non-Crime Domestic'. They removed Stefan from the property and checked that his key did not fit the lock, advising him that police action may escalate should be return. They waited outside the address for a short period to ensure he did not loop the block and return. A 124D Form was not completed[55] with Sandra which included the DASH risk assessment.

Third recorded domestic abuse related incident

Later that day Sandra called the police reporting that Stefan has installed a light bulb in her bedroom which contained a camera. She explained that he had *been "very intimidating, he's grabbed my arms and he's tried to lock me in my room"* last night. When police asked her where he was, she was unsure stating *"he should be at Wembley police station I think… they took him last night"*.

[55] It is unclear why this was not completed and likely to have been a missed opportunity.

Police attended and Sandra was asked if she had any evidence that it was Stefan who had installed the camera, however as she did not, they informed her that they were unable to arrest him. It is recorded that Sandra did not support police action, but rather wanted the issue recorded. A 124D form was completed with Sandra and a crime report was created as an allegation of voyeurism. It was however sent for closure as it was recorded that Sandra was "unsupportive of prosecution" and there was "no suspect identified". It was not flagged on the police system as a domestic abuse related incident.

What is voyeurism?

In the UK, voyeurism is a criminal offence that involves gaining sexual gratification by observing someone without their consent while they are in a private setting, such as when they are undressing, naked, or engaged in sexual activity.

This behaviour is considered highly invasive and a serious breach of privacy. The Sexual Offences Act (2003) specifically addresses voyeurism, making it illegal to observe or record someone in these circumstances without their knowledge. The offence can lead to significant legal penalties, including imprisonment.

What is a crime report?

A crime report is a formal document used to record details of a reported crime. This report is crucial for documenting the circumstances surrounding the crime, the individuals involved, evidence collected, and any actions taken by the police.

The crime report is entered into the police database and forms the basis for further investigation, prosecution, and statistical analysis. It ensures a systematic approach to handling crime and aids in the transparency and accountability of police operations.

On the same day (1st February) Stefan contacted Brent Family Front Door (BFFD) Emergency Duty Team (as it was a Saturday) requesting support around housing as his wife had asked him to leave the home following an argument the previous night. He stated that he was homeless as he was financially dependent on Sandra as he could not work due to *"not being naturalised in the UK"*. At this point his daughter was going to reside with her maternal grandmother in a another London Borough.

He noted that a particular concern he had was Sandra talking about their personal problems with her friends and relatives and that the argument had started with her transferring "only" £15 to him for his night out with friends. He accused Sandra's Auntie of causing difficulties between them as she was currently living at their home and has *been "inciting his wife against him"*. It was noted that he had called the Emergency Duty Team from the front office at Wembley police station where he had gone to ask the police to accompany him to his marital home to collect his belongings. There was no record of this on police systems.

About the Brent Council Emergency Duty Team

The Brent Emergency Duty Team is a dedicated service designed to provide immediate assistance and support to families and individuals in crisis situations outside of regular working hours. This team operates 24/7, ensuring that urgent cases involving children and vulnerable adults receive timely intervention and protection.

There was No Further Action (NFA) following this call with records stating that his daughter *"is not homeless, she has been taken to stay with her Maternal Grandmother. there are no safeguarding concerns"*.

Reflective information from colleagues

Following Sandra's separation from Stefan the school started getting three or four phone calls a day from him and he would regularly turn up at the school. The headteacher at the time spoke to him to tell him he needed to stop, and the school office were instructed to not take his phone calls anymore.

He was described as demonstrating controlling tendencies in his communication with the school as he would only speak to one particular member of staff that worked in the office, refusing to speak with anyone else. He started bringing in 'little gifts' for Sandra, but her colleague highlighted the manipulative nature of these including a bunch of flowers with a leaflet about mental health from 'Mind' attached to them. He would continue to turn up and say he needed to see her to which the school would always decline. He continued to do this until a male site manager on one occasion asked him to leave.

Sandra was described by a colleague as being 'different' in terms of her usual self at this point, seeming to have a low mood. She was visibly scared and would get taxis to work rather than use public transport.

Information from Islington Mind highlighted that Stefan self-referred to their service through their 'Integrated Community Support Service on 3rd February.

On the 4th February Sandra was referred to Victim Support's London Victim and Witness Service through the Metropolitan Police Automatic Data Transfer (ADT) system for an alleged offence of Exposure and Voyeurism.

What is the Automatic Data Transfer (ADT)?

The Metropolitan Police Automatic Data Transfer (ADT) system plays a crucial role in facilitating effective communication and information sharing between the police and the Victim Support and Witness Service. This integration ensures that victims and witnesses of crimes receive timely and appropriate support throughout the investigative and judicial process.

The system automatically transfers relevant data from police databases to the Victim Support and Witness Service. This includes details of the crime, the individuals involved, and any immediate needs or risks identified by the police. This seamless transfer of information ensures that support services are promptly notified and can begin their outreach efforts without delay.

An Independent Victim Advocate (IVA) tried to make initial contact via the phone number provided in the referral the same day in accordance with Victim Support's Domestic Abuse Operating Procedure[56]. The policy also outlines that calls will be made from a 'withheld

[56] As the original Voyeurism incident was not flagged as domestic abuse it is unclear why the domestic abuse pathway was followed, this may be as the service identified the offender was Sandra's ex-partner.

number' to ensure the service does not increase the risk to the victim. Sandra did not answer, and the IVA did not leave a message which was also in accordance with the service's policy.

On the 6th February Stefan called the police requesting their assistance to retrieve his passport and some documents from Sandra's house. He stated, *"I've asked her for it on several occasions because she blocked me from calling and messaging and everything so I no longer have contact, she said that she sent it but it's nowhere amongst my things"*. An appointment was booked with him to meet officers at Sandra's property at 4pm in two days' time (8th February). There is no record to indicate that Sandra was made aware of this or had agreed to it.

In the early hours of the morning on the 8th February London Ambulance Service (LAS) received an emergency call reporting that a male (later confirmed to be Stefan) had been assaulted and stabbed. Ambulance staff recorded that Stefan noted he had been attacked from behind by two or three unseen assailants who struck him multiple times, and that he had seen *"a shiny object"*. He had a left palm laceration, haematoma to his left eyebrow and left occipital region. He also had several small pinprick type wounds to his left palm and reportedly had lost consciousness for an unknown length of time. He was taken to Whittington Hospital.

Due to the nature of the incident the police were called to attend. Stefan told the officer that whilst he was leaving the building two men, *"grabbed him from behind and punched him multiple times"*. He said the men who did this to him said, *"this is a message to stay away"* to him. He confirmed he had recently separated from his wife. Police records highlight that Stefan had had two bumps to his head and six, *"very small puncture wounds"* to his left hand. It was recorded as the opinion of officers and ambulance staff at scene that the wound on his hand was not consistent with defensive wounds. They were also of the opinion that he had very little in terms of injuries for a prolonged assault by two men. Whilst they could not confirm it, they noted the injuries appeared to be self-inflicted. A crime report was created for assault but sent for closure as no suspects had been identified.

Later that day, as previously agreed with Stefan, police accompanied him to Sandra's address to collect his belongings. It was noted that Sandra was surprised by their attendance, and she stated she had not been contacted regarding Stefan being escorted to her address but that she was happy for him to enter and collect his belongings as long as the police were present. Police informed Stefan that he was not permitted to speak to Sandra and that a police officer would be present with him at all times. At this point the officer realised Stefan was intoxicated however they decided that it was not to the extent that it would have been inappropriate to continue. Once he had collected his belongings, they waited with him whilst he ordered a taxi to leave.

Reflective information from colleagues

A colleague recounted that the day after Stefan had been to collect his belongings from the house, that Sandra had confided in a colleague that her mother's gold necklace had been stolen, which was incredibly sentimental to her, and she believed it was Stefan. She was certain that he had taken it.

Subsequently, he turned up at the school office with their wedding photograph album and a gold chain. He asked to see Sandra to give these things to her, which the staff refused given their previous instruction. When they told Sandra about this and described the chain, she was certain it was the same one that was missing. This was the last time he turned up at the school however colleagues noted this was not the end of his behaviour. He would

continue to knock on her door, follow her and post things on her social media page including personal pictures which had the school's name on them. Sandra reportedly changed her telephone number three or four times and closed all her social media accounts.

Following his self-referral earlier in the month, Stefan was due to attend Islington Mind on 10th February for a scheduled induction meeting. Staff had sent him a text message to remind him, but he did not attend.

Fourth recorded domestic abuse related incident

On the 10th February Sandra called the police to report that she was being harassed by Stefan. She said he was, *"sending me emails and he has been writing posts on social media about false information about me"* and in the messages he was*, "accusing me of having him beaten up, and that I am crazy, that I am not in my right mind"*. She also said he had, *"threatened to put it on my workplace board, because I work in a school, and he has threatened also to put posters up"*.

Reflective information from colleagues

Once Stefan was unable to attend the school anymore, he started to write on the school's website and would send in photographs of Sandra and her friends and colleagues accusing her of being physically violent towards him. The school did not reply, and Sandra and a colleague rang the police to tell them about it.

An appointment was booked for Sandra to be visited by police officers in three days' time on the 13th February. At this appointment she raised a number of points with the officers including that:

- she had changed the locks since separating with Stefan
- she had blocked Stefan on her phone, WhatsApp, Instagram and Facebook
- Stefan had taken a gold chain that had belonged to her mother when he came to collect his belongings[57] and that she believed he had done this to try and initiate contact with her.
- he had turned up to her workplace on at least two occasions. Once to return the chain and on another occasion with flowers. He kept calling the school office asking what her reaction to the flowers was.
- he had posted on social media about her accusing her of being in a relationship with a female friend and that she had him beaten up, which she showed officers.
- he had emailed the secretary at her workplace. She had a printout of the email she showed to officers.
- he had been calling her friends, family and colleagues to try and get them to speak to her.
- he had sent her messages from someone else's phone.
- he continued to try to contact her on private number or different numbers.
- he had told her he had been recording her and her Auntie in the housing and had sent a recording of her to her friend.

[57] It is notable that during the IOPC investigation the OIC raised that they felt this was what Sandra seemed to be most impacted by. They recounted that she seemed to be annoyed at the police for this as they escorted him and that she was considering making a complaint.

Sandra was observed by officers as being restless and she was struggling to understand *"why he wouldn't just leave her alone".* She said she was finding it hard to sleep at night and that she *"just wanted him to stop behaving like this"*. Officers completed a 124D form[58] including DASH risk assessment with Sandra which indicated several high-risk markers including that she was fearful of him, threatened her friends who were also now frightened of him, that they had recently separated, his behaviour was becoming more persistent, he was controlling and jealous, he abused alcohol, he had threatened suicide, and she did not think he was mentally well. Sandra shared with officers that her mother had expressed, before she died, her fear that Stefan would kill Sandra. She confirmed **she wanted the officers to take action**, including in relation to the light bulb in her room, she wanted Stefan to be arrested and would be happy to attend court if necessary.

The DASH outcome was medium risk which means, *"there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances"*. The officer reopened the previous voyeurism crime report and updated it to confirm that Sandra now supports prosecution. They also created an arrest enquiry for Stefan for harassment, theft and voyeurism.

On the 12th February, after attempting to contact Sandra several times leaving four voicemails and turning up at her workplace, Stefan sent a threatening text message to one of her friends which said *"watch your back, you and your sons"*. He also attempted to contact Sandra by using alternative telephone numbers including his daughters, his grandmother's and his friends' numbers.

Three days later on the 16th February **the arrest enquiry was closed stating that the victim was *"unwilling to pursue this matter"***. The IOPC investigation explored this, and it was seemingly a mistake, presumed to have been an officer misreading the previous voyeurism crime that had logged Sandra as not supporting police action rather than the updated re-opened crime. The OIC was asked about this in the investigation in terms of their decision making to not re-open it or create a new arrest enquiry and they stated, *"if I had thought the victim was vulnerable, or genuinely scared, despite her refusing to participate in any investigation, I would have still carried on with a view to arresting and interviewing"*.

The Victim Support London Victim and Witness Service's Independent Victim Advocate (IVA) made a further attempt to contact Sandra on the 17th February however the phone did not ring and the call was forwarded to voicemail, which again as per the service's policy, no message was left. The next day the service received a second Automatic Data Transfer (ADT) referral relating to Sandra, this time for the alleged harassment offence. Sandra's details were checked on Victim Support's case management system, and it was identified that there was an open case for her so the two referrals were linked.

On the 17th February Stefan attended his Islington Mind to complete an induction in to the service including a risk assessment. The next day, through standard eligibility checks it was noted that as he had no formal connections to Islington which meant he was not able to access the service and was advised to contact services local to him.

On the 18th February Stefan called the police stating he had further evidence relating to the assault he experienced on the 8th February. He alleged that he had a recording of Sandra and her Auntie discussing getting men to beat him up. Police made an appointment with him for

[58] In the subsequent IPOC investigation the 124D forms were unable to be located by the Metropolitan Police Service.

later that day which was subsequently cancelled, although there was no record as to why this was.

The Independent Victim Advocate (IVA) from victim support attempted to make contact with Sandra on the 19th February but there was no answer and a message was not able to be left. The Independent Victim Advocate sent an email to police to inform them that they had been unable to establish contact and would close the case.

Fifth recorded domestic abuse related incident

On the 20th February Sandra submitted evidence of her previous allegations and reported ongoing harassment including:

- On the 15th February Stefan called her house phone three times and left messages. He also got a friend to call her house phone.
- He sent two "hurtful" emails.
- On the 16th February he attempted to set up a fake WhatsApp group by using her mothers phone.
- On the 19th February he called the house phone twice and left messages and in the early hours of the 20th February he called her mobile leaving a voice message.
- On the 20th February he made an Instagram post "with lies again about me".

An appointment was made with Sandra on for three days' time and on the 23rd February the police attended Sandra's home. A 124D form was completed including a DASH risk assessment[59] and evidence of the contact Stefan had been making was captured. This included a number of voicemails in which he made various accusations against her and complaints about their marriage ending. In one of the messages, he mentioned a recording he had of her, and in another he said, "*you will suffer, you will suffer, trust me".*

In her statement she confirmed she had made a previous report of harassment to the police on the 13th February and since then, *"I have been contacted by my husband another numerous times which I would like report"*. She added that **she fully supports police action** and noted *"[I] want my husband to be arrested"*.

On the 24th February a friend of Stefan's contacted the police as they had received a text message from him saying he was thinking of hanging himself as *"it all seems too much"*. The London Ambulance Service (LAS) received an emergency from the police to attend Stefan's grandmother's address, which is where he had been staying. The LAS request was later cancelled by the police as there was no trace at the address. Police had attended and found his grandmother to be confused, and Stefan was not present. However, he returned whilst they were there and said that he was upset due to the recent separation from his wife but that he was just venting his frustration and had no intention of harming himself. He was noted to have seemed embarrassed that police had attended and that he did not wish to be referred to any support services.

Contextual point from Stefan

In his interview with the Chair, Stefan confirmed that he had minimised his feelings of suicidality at this point due to feelings of shame.

[59] The IOPC investigation found the Metropolitan Police Service were unable to locate these. As such the risk level is unknown.

On the same day Stefan contacted Brent Children's Social Care Children & Information Service (CFIS) stating he wanted to report abuse from Sandra against his daughter. The next day on the 25th February, his email was forwarded from CFIS to Brent Family Front Door (BFFD).

What is Brent Children's Social Care Children & Information Service (CFIS)?

The Brent Children and Families Information Service provides information on a range of services and activities for children and young people aged 0 to 19 years old (and up to 25 years for young people with special needs).

What is Brent Family Front Door (BFFD)?

Brent Family Front Door (BFFD) is a Multi-Agency Safeguarding Hub, or MASH which co locates a range of agencies; including police; local authority children's social care; health professionals; with access to other council services to share information and spot emerging problems early, and to make risk assessments based on as full a picture as possible.

All initial contacts are considered alongside the Brent levels of Need and the thresholds for Children in Need and a decision made within 24 to 48 hours regarding the level of response required.

On the 2nd of March BFFD contacted Stefan to discuss his allegations. This was outside of the usual 48 hour expected response time which was noted to be due to a high volume of contacts during this time. During the discussion with Stefan, he explained that his wife's auntie had *"managed to get in his wife's head"* and that the two of them had been verbally abusing his daughter. He suggested that when he raised his concerns to his wife it led to an argument in which he and his daughter were *"kicked out"*. He confirmed that his daughter was were residing with his wife's friend, and he believed the location to be safe, and that he was currently living with friends. He noted he required support around housing. He was advised that there were no safeguarding concerns and therefore, no need for children social care intervention and advised about housing services support. Consent for multi-agency checks did not appear to have been considered and this did not progress to an assessment.

On the 9th March police contacted Stefan to request he attended the police station on the 10th March for an interview. This was subsequently cancelled by the Officer in the Case (OIC). Stefan contacted the OIC on the 11th March to follow up

What is an Officer in the Case (OIC)?

An Officer in the Case (OIC) is a police officer assigned primary responsibility for managing and overseeing a criminal investigation. The OIC's duties include gathering and securing evidence, interviewing witnesses and suspects, coordinating with forensic experts, and liaising with victims and their families. They play a crucial role in ensuring that the investigation proceeds efficiently and that all procedural and legal requirements are met. The OIC is also responsible for preparing reports and presenting findings to senior officers and, ultimately, to the Crown Prosecution Service (CPS) for potential prosecution.

On the 11th March Sandra emailed Stefan requesting he returned the gold chain that had belonged to her mother. She forwarded his responses to the OIC which included him asking her to discuss the matter over the phone, multiple images with quotes about marriage, asking her to contact him, and accusing her of not caring about him.

Someone who introduced themselves as Stefan's "legal representative" called the BFFD Emergency Duty Team in the evening on the 12th March stating that he and his daughter were homeless and that he was actively experiencing suicidal ideation and was extremely vulnerable. The team contacted Stefan who raised no concerns regarding his mental health. He explained that he had no recourse to public funds and was homeless. He was advised to contact the housing department in the morning. The BFFD deputy team manager reviewed the information and requested a social work assistant make contact to better understand Stefan's mental health.

On the 14th March there was anonymous information reported to Crimestoppers reporting that Sandra was taking Class A and Class B drugs to the school in which she works, and that she was selling drugs from her home address.

On the 15th March the OIC contacted Stefan again to invite him in for an interview on the 19th, and asked him to check in the morning to confirm it would still go ahead.

Contextual event: On 16th March the prime minister announced that "now is the time for everyone to stop non-essential contact and travel" due to the coronavirus.

On the 16th March Stefan called the police to request they escorted him to Sandra's property to retrieve some mail and car parts. Initially an appointment was made for the 18th March but subsequently closed stating it was something Stefan should arrange with the Safer Neighbourhood Team directly rather than the Emergency Response and Patrol Team. It is unclear what was communicated with Stefan at this point.

What is the Safer Neighbourhood Team (SNT)?

The Safer Neighbourhood Team (SNT) is a community policing initiative by the Metropolitan Police Service aimed at improving safety and reducing crime in local neighbourhoods across London. Each SNT is dedicated to a specific ward or local area, focusing on addressing the concerns and priorities of the local community.

What is the Emergency Response and Patrol Team?

The Emergency Response and Patrol Team (ERPT) is a crucial unit within the Metropolitan Police Service responsible for providing immediate response to emergency calls and incidents. The team operates 24/7 to ensure that police presence is quickly established at the scene of an incident, enhancing public safety and maintaining law and order.

On the morning of the 19th March when Stefan was due to attend his interview, he messaged the OIC as requested, to check it would still go ahead. The OIC confirmed that they had already seen him and that they would see him next week. It is unclear why this happened with somewhat mixed recollections from the officer in the IOPC investigation.

Sixth recorded domestic abuse related incident

On the 20th March Stefan called the police from outside Sandra's house stating he had an appointment with someone to attend at 5pm to collect his belongings. He was given a telephone number to check whether officers would be attending.

Around five minutes later Sandra's brother called the police stating, *"my sister is just having some problems with her ex-husband and he's been told to stay away from the house and she's just called me in hysterics and said he's banging on the door and everything"*. He said Sandra was too scared to go outside and check whether he was still there.

Police attended and initially Sandra had told them that Stefan had just left highlighting that he had attended after continuously emailing and texting her and had put a letter through her door for her and some other items in her food bin.

Whilst they were there, he was seen walking towards them. One officer went to speak with him whilst the other remained with Sandra. Sandra told the officer that Stefan had been arrested in February, which of course had not been the case due to the arrest enquiry being cancelled. The officer discussed protective orders with her and advised her to obtain a non-molestation order as he could be arrested for breaching it. Stefan was told that he would be arrested for harassment if he did not stop contacting Sandra.

What is a non-molestation order?

A non-molestation order is a legal injunction issued by a family court to protect individuals from abuse or harassment by someone they have a personal relationship with, such as a current or former partner or family member. The order aims to prevent the abuser from threatening, harassing, or contacting the victim.

Breaching a non-molestation order is a criminal offence and can result in arrest and prosecution. If there is an initial or a minor breach the abuser will face a fine rather than a custodial sentence. However, very serious or repeated breaches can lead to a sentence of up to five years imprisonment. This legal protection helps ensure the safety and well-being of the victim and any children involved.

The officers checked the police system, and it was noted that Stefan did have an appointment to attend to collect his belongings. Sandra was not aware of this and had not been contacted. They also found that the arrest enquiry from February had been cancelled which was discussed with Sandra, including the reason which was noted to be that she *"did not want to take it any further"* to which she replied *"no, they've got that wrong"*. Sandra was informed to update her OIC that Stefan had turned up.

A DASH risk assessment was completed with a number of high risk markers including that he would email her at least four or five times a day starting at 7am asking if they could reconcile, that she was afraid of him, that they had separated, that she had contacted a solicitor, he had sent her naked photographs of herself via email, he was controlling and told her what she should spend her money on, he had issues with drinking and was aggressive when drunk and that he had threatened suicide on at least three occasions.

The outcome recorded for the risk assessment was 'standard' risk and the crime report was labelled as a 'Non-Crime Domestic'. Body worn video (BWV) from the incident highlighted the officer indicating they would make a referral for her to get a non-molestation order and Sandra consenting to her details being referred to a domestic abuse support agency. There is no record of this being followed up.

What is Body Worn Video (BWV)?

Body Worn Video (BWV) refers to small cameras worn by police officers to record their interactions with the public. These devices capture video and audio, providing a real-time, first-person perspective of incidents and encounters. BWV is used to enhance transparency, accountability, and evidence collection in policing. The footage can be crucial in investigations, court proceedings, and improving police-community relations by providing an objective record of events.

Contextual event: On 23rd March the prime minister announced the first lockdown in the UK, ordering people to "stay at home" with lockdown measures legally coming into force. On the 26th.

On the 24th March Stefan messaged the OIC to enquire as to whether his interview was taking place the following day given the lockdown restrictions. The OIC responded to say the interview would need to be cancelled but did not confirm why this was.

On the same day BFFD contacted Stefan following his call on the 13th March, which was noted to be outside the services expectation for completing actions. Stefan confirmed he had not made a homelessness application due to the coronavirus situation. He explained that his daughter was staying with family/friends and that his mental health was "ok". The contact was subsequently closed without living and childcare arrangements for his daughter being clarified, or to establish private fostering arrangements.

On the 30th March the OIC made several updates to the crime reports including information from Sandra that she was reporting Stefan to the Trinidad Immigration Embassy[60] as she would like his spousal visa[61] to be removed. It was recorded that she was in the process of a divorce and obtaining a non-molestation order however added that Sandra did not want to substantiate the allegation as she was grieving her mother's death. Seven days later on the 6th April the OIC closed the voyeurism and harassment crimes. In doing so they noted the risk to be "standard". The subsequent IOPC investigation questioned this as the previous risk assessment had been "medium" and the OIC confirmed they *"did not believe Sandra was vulnerable or in a position whereby she was threatened"*. As such, they *"saw no need for the risk to remain at medium".* A Domestic Violence Prevention Notice/Order (DVPN/O) was noted to be not applicable.

What is Domestic Violence Prevention Notice/Order (DVPN/O)?

A DVPN is a notice issued to act as an emergency non molestation order and eviction notice. Within 48 hours of the DVPN being issued, an application for a DVPO must be made to a magistrate's court. A DVPO is an order for the perpetrator not to return to the victim's address or contact them for up to 28 days.

The Independent Victim Advocate (IVA) from Victim Support made their final attempt to contact Sandra on the 6th April (around six weeks after the previous attempt), but there was no answer. Due to four unsuccessful contact attempts the case was closed.

[60] It is unclear what this is specifically and may have been an incorrect term. Reporting regarding revoking a spousal visa would have had to have been to the UKVI service.

[61] As noted previously, it is unclear which visa type Stefan had obtained.

On the 15th April Stefan posted a photograph of himself smiling with a police officer, whom he had his arm around, on one of his social media accounts *stating "sometimes saying goodbye is hard but we have to let go of things. So am letting go of the past and looking forward"*.

Just before midnight on the 15th April Sandra called the police to report that Stefan had been posting nude photographs of her online. She said that he had also sent them to her and others by email with her place of work written underneath. She confirmed Stefan did not live with her, but that she believed him to be in the area. Police attended around 30 minutes later and she confirmed that as well as posting the photographs he had continued to send her multiple emails, including one in which he stated he was going to kill himself. She explained that she was in process of getting a divorce and injunction but was experiencing delays with her solicitors due to coronavirus. A DASH risk assessment was completed with her. Sandra said police *"this incident has left me feeling emotionally drained.. there seems to be no end to his behaviour, and I do not expect a personal picture of mine to be published publicly. I feel anxious about leaving my house as his behaviour is so unpredictable and I just want to live my life without that worry of Stefan"*. She confirmed she would like her details to be shared with a specialist domestic abuse support service.

Reflective information from friends and colleagues

Information from the trial noted that when one of Sandra's friends called him to complain about the pictures he had posted *"he cackled down the phone and hung up"*. Another friend who rang him about the picture was told *"let her suffer like I did and feel humiliated like I do"*.

A colleague noted that the last time Sandra changed her number was the night before the incident when she messaged everyone to inform them of her new number. A colleague asked her if she was okay, and she told them she was *"just being cautious".*

Sandra told another colleague, who was also a close friend, that she didn't feel safe anymore and they agreed that she would go to stay at their house. Sandra said she would pack her bag and see them in the morning.

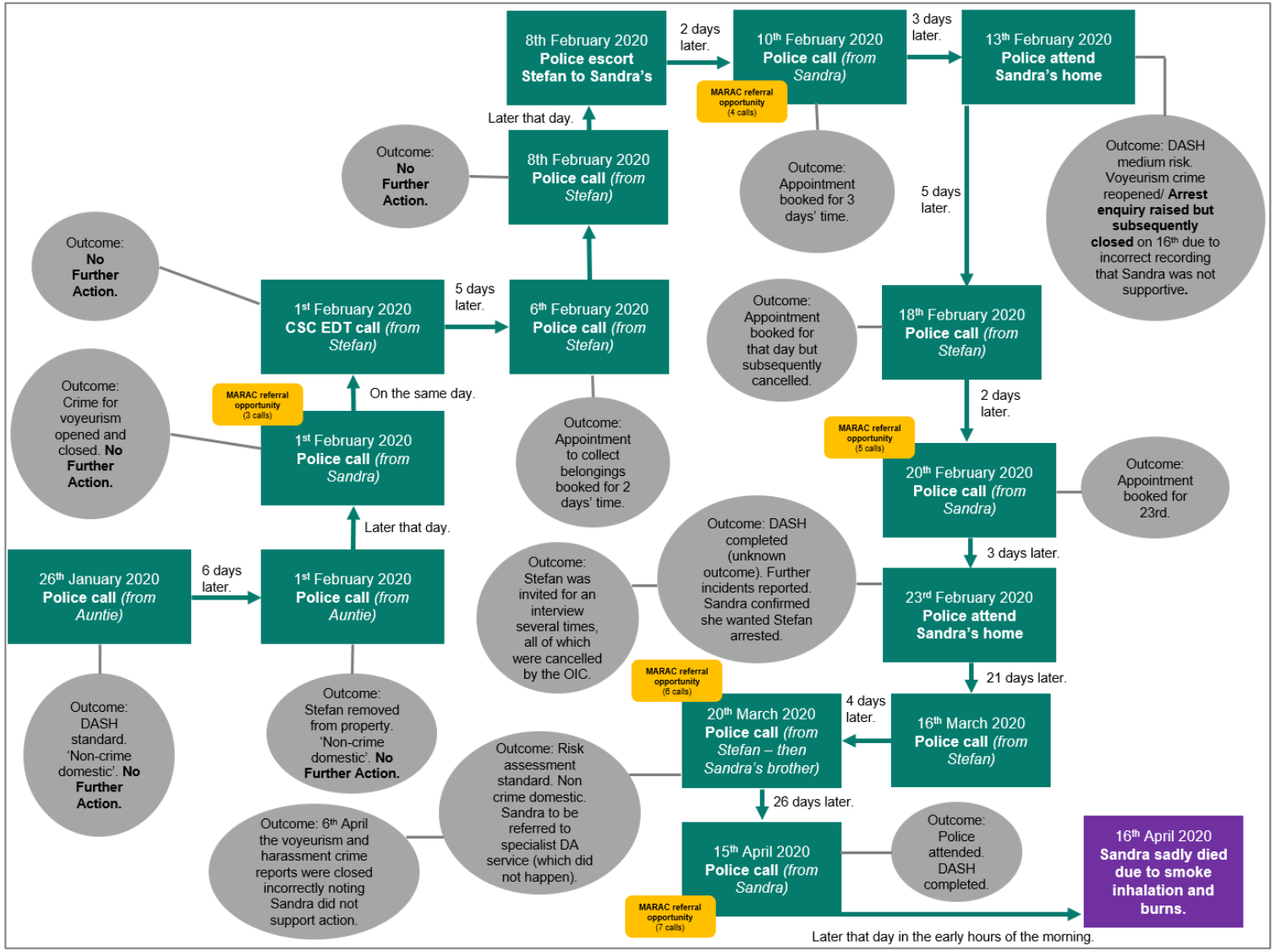
2.3.3 Conclusion

Sadly, by the next morning Stefan had already attended Sandra's home and killed her. Around 40 minutes after the police had left Sandra's property, her home was engulfed in flames. We have given the details of the incident in section 2.1 which we will not seek to repeat here. Rather, we would like to reflect on the human reaction to the incident.

A colleague from Sandra's work recounted the morning they found out about the incident as the hardest morning of their entire career as they had to ring every member of staff to tell them what had happened. Since this time the school have done a whole school piece of work on hope and many of the staff have accessed therapeutic support.

The review panel would like to offer their utmost gratitude to Sandra's family, friends and colleagues who were able to contribute to the chronology of events outlined in this section of the report. It is recognised that revisiting these traumatic memories after four years has been a difficult process for everyone involved.

2.4 Illustrative chronology of key events



Section 3: The lessons

This section will present the analysis and lessons to be learnt. The analysis will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken, including whether different decisions or actions may have led to a different course of events. The key learning at the end of each section will summarise the learning to be drawn from the case and how it will be translated into recommendations in Section 4 for action. We will highlight any early learning identified during the review process and whether this has already been acted upon.

3.1 Analysis and learning

3.1.1 Analysing Sandra's experience of domestic abuse

The nature of the domestic abuse

In Section 1 we outlined the definition of domestic abuse in line with the Domestic Abuse Act (2021)[62]. It highlights the range of behaviours that are abusive. In this section we explore Sandra's experiences of these behaviours and how this may have shaped her experiences and ability to seek support.

Physical abuse *(including violence, threats of violence or sexual abuse)*

Sandra experienced physical abuse at the hands of Stefan, including incidents where he grabbed her and locked her in a room, events that were serious enough to warrant police involvement. While these specific acts of physical violence may appear "lower level" compared to more overtly severe forms of abuse, research highlights that such behaviours should not be underestimated in risk assessments. Stark (2007) notes that physical violence in domestic abuse is often intertwined with broader patterns of coercive and controlling behaviour, which can escalate over time. The perception of "low-level" violence can skew professional assessments, leading to an underestimation of the danger posed by the perpetrator and the victim's vulnerability to severe harm or even homicide. We saw this play out through the downgrading of risk within the police, as well as through the IOPC interview of an officer which highlighted a lack of understanding of risk and vulnerability in which it was stated: *"if I had thought the victim was vulnerable, or genuinely scared, despite her refusing to participate in any investigation, I would have still carried on with a view to arresting and interviewing"*.

Sandra's case also demonstrates how non-physical abuse can compound the impact of physical violence. Stefan's threats, including stating that he wanted Sandra to "suffer," exemplify the psychological manipulation often present in abusive relationships. Such non-specific threats may not have been taken seriously by professionals at the time, reflecting a potential lack of understanding about how psychological abuse, coercive control, and physical violence intersect to create significant risks (Monckton-Smith et al., 2022). Non-specific or implicit threats are a recognised tactic within the framework of coercive control, (which has been a specific crime since 2015), where the abuser uses fear, intimidation, and manipulation to exert power over their victim without overt acts of physical violence (Stark, 2007).

[62] https://www.legislation.gov.uk/ukpga/2021/17/part/1

In addition to physical abuse, Sandra endured sexualised coercion through Stefan's actions. One particularly invasive behaviour was Stefan posting naked pictures of Sandra, an act that falls under the scope of voyeurism as defined by the Sexual Offences Act (2003). While voyeurism typically involves the perpetrator gaining sexual gratification by observing or recording someone without their consent, it is likely that Stefan's motive in this case was not sexual, but rather to humiliate and exert control over Sandra. Research has shown that such acts of sexualised coercion are a form of psychological abuse, intended to undermine the victim's sense of safety, dignity, and autonomy (Hester & Lilley, 2014).

The failure of professionals to explore or recognise this behaviour as a form of coercive control further highlights gaps in understanding domestic abuse dynamics. Sandra's experience underscores how the misuse of intimate imagery, even if not explicitly sexual in motive, represents a significant breach of privacy and a mechanism of control. Research by McGlynn and Rackley (2017) on image-based sexual abuse identifies that such behaviours can inflict severe emotional and psychological harm, compounding the effects of physical abuse and limiting a victim's capacity to seek help.

Sandra's experiences reveal the need for professionals to adopt a holistic view of domestic abuse that recognises the interconnectedness of physical violence, psychological abuse, and coercive control. Acts that may seem isolated or "lower level" in severity should be understood within the broader context of power and control dynamics, where even seemingly minor behaviours can signal substantial risk. The Governments review of Domestic Homicide Reviews[63] found coercive control was recorded in 48% of reviewed cases. This demonstrates its prevalence as a risk factor even when physical violence is absent or minimal. This finding underscores that reliance on physical violence alone as an indicator of high risk may lead to underestimations in cases with significant psychological and emotional abuse. Their qualitative analysis the year prior[64] found that only 18% of victims were referred to Multi-Agency Risk Assessment Conferences (MARACs), and coercive control was often a factor when MARAC referrals were overlooked. This reflects systemic gaps in understanding coercive behaviours as key risk escalators.

Only 18% of victims were referred to Multi-Agency Risk Assessment Conferences (MARACs), and coercive control was often a factor when MARAC referrals were overlooked. This reflects systemic gaps in understanding coercive behaviours as key risk escalators

Non physical abuse *(including controlling and coercive behaviour, economic abuse, and psychological and emotional abuse)*

Sandra experienced extensive non-physical abuse from Stefan, including controlling and coercive behaviours, economic abuse, and psychological and emotional abuse. Evidence from Sandra, her family, friends, and colleagues paints a clear picture of a sustained campaign of harassment, manipulation, and intimidation that escalated following their separation. This pattern of abuse aligns with behaviours defined under the Domestic Abuse Act (2021), particularly in relation to coercive and controlling behaviour, which seeks to isolate, dominate, and instil fear in the victim.

[63] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews-september-2021-to-october-2022-accessible

[64] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/45e0af7e-1ef4-4a6a-9128-622be0f024c8

Stefan's actions demonstrated a calculated effort to maintain control over Sandra even after their separation. Sandra described numerous incidents to the police, including:

- Changing the locks to her home to protect herself from Stefan.
- Blocking Stefan on her phone, WhatsApp, Instagram, and Facebook in an effort to cut ties, only for Stefan to circumvent these barriers by contacting her through other means.
- Taking a gold chain belonging to Sandra's late mother during a visit to collect his belongings, a deliberate act that she believed was intended to initiate contact.
- Showing up uninvited at her workplace on multiple occasions, including once with flowers, and persistently calling the school office to inquire about her reaction to his gestures.
- Posting false and damaging accusations on social media, alleging Sandra was in a relationship with a female friend and had orchestrated his assault.

These behaviours, along with his persistent phone calls, messages, and attempts to contact her through friends, family, and colleagues, exemplify stalking behaviours. Stalking is recognised as a significant indicator of increased risk in domestic abuse cases, often escalating to severe violence or homicide (Logan & Walker, 2017). Stefan's actions demonstrate a clear pattern of intrusion into Sandra's personal, professional, and digital life, creating an environment of fear and anxiety.

Spotlight on stalking

What is stalking?

Stalking is a criminal offense under the Protection from Harassment Act (1997), which was amended by the Protection of Freedoms Act (2012) to specifically address stalking behaviours. The Crown Prosecution Service (CPS) **defines stalking as *a pattern of fixated, obsessive, unwanted, and repeated behaviours that cause alarm, distress, or fear of violence in the victim***. Stalking behaviours can include following a person, contacting them repeatedly (in person or digitally), spying on them, or interfering with their property. The offense of stalking is committed when a person pursues a course of conduct that amounts to stalking and knows, or ought to know, that their behaviour causes harassment or fear of violence (CPS, 2024).

In Sandra's case, Stefan's behaviours met multiple criteria for stalking. He repeatedly contacted her through various means, despite her efforts to block him, and intruded into her workplace uninvited on multiple occasions. His use of technology, such as setting up a hidden camera and posting intimate images of her online, added a further invasive element to his stalking behaviours. Moreover, his persistent attempts to contact her friends, family, and colleagues to force communication demonstrated his obsessive focus on Sandra.

The impact of stalking on victims

Stalking has profound and far-reaching impacts on victims, often leading to significant psychological, emotional, and physical harm. Victims frequently experience heightened anxiety, hypervigilance, depression, and post-traumatic stress disorder (PTSD), with some reporting a sense of entrapment due to the stalker's persistent and invasive actions (Sheridan & Davies, 2001). Research also indicates that stalking victims are often forced to make significant lifestyle changes to ensure their safety, such as moving home, changing jobs, or altering daily routines, all of which exacerbate feelings of isolation and fear (Logan

& Walker, 2017). In Sandra's case, we know from colleagues she started to pay for taxi's to and from work to avoid bumping in to Stefan on public transport and from her statements to police about feeling anxious to leave her house, changing her telephone number several times and needing to change her locks illustrate the debilitating impact Stefan's stalking behaviours had on her well-being.

Stalking and risk of violence

Stalking is recognised as a high-risk behaviour in domestic abuse cases, with research showing that 50% of stalkers carry out their threats (Mohandie et al., 2006). This statistic underscores the critical need for professionals to identify and address stalking behaviours early, as they are often precursors to severe violence or homicide. In Sandra's case, Stefan's threats that he wanted her to "*suffer",* combined with his obsessive and controlling actions, should have been treated as significant warning signs. However, his behaviour was not correctly identified as stalking, and the broader context of his coercive and controlling actions may not have been fully understood by professionals.

Had Stefan's behaviours been correctly identified as stalking, professionals might have taken his threats more seriously and recognised the increased risk Sandra faced. Research by Monckton-Smith et al. (2022) highlights that stalking, particularly when combined with coercive control, represents one of the highest-risk indicators for intimate partner homicide. This evidence emphasises the importance of understanding the patterns of stalking and coercive behaviours in risk assessments to prevent escalation to lethal violence.

Missed opportunities to intervene

Stefan's actions, persistent contact, workplace intrusion, public humiliation, and technological surveillance, demonstrate a clear pattern of stalking that should have been recognised and addressed. Sandra has shared with the police Stefan's threatening message that she would "suffer" and this did not prompt further action. More concerningly, when Sandra reported the camera's within the lightbulb to police on one occasion officers asked her whether she had any evidence it was him, and as she did not, they told her they could take no action. By failing to identify his behaviours as stalking, opportunities were missed to implement risk management strategies and protective measures for Sandra. These could have included the application of stalking protection orders (introduced in 2020), increased monitoring of Stefan's activities, or more robust support for Sandra in managing the risk he posed.

Sandra's statements highlight the profound psychological impact of Stefan's actions. His unpredictable and relentless behaviour caused her significant distress, as she expressed feeling anxious about leaving her house and unable to live her life without constant worry. Stefan's emotional abuse was further evidenced by his threats and manipulative tactics, such as sending hurtful emails, leaving messages on her house phone, and attempting to set up a fake WhatsApp group using her mother's phone. This behaviour underscores the cumulative toll of coercive control, as Sandra's autonomy, sense of safety, and emotional well-being were systematically eroded.

Stefan's use of technology to monitor and intimidate Sandra further illustrates the depth of his controlling behaviour. He secretly installed a hidden camera disguised as a lightbulb in Sandra's bedroom and posted intimate images of her online, accompanied by her maiden name, job, and workplace. He also emailed Sandra, informing her that he had uploaded these pictures to adult websites. This form of image-based abuse is a particularly invasive and

traumatic expression of coercive control, intended to humiliate and assert power over the victim (McGlynn et al., 2017). Stefan's denial of using the camera for spying, despite evidence to the contrary, reflects his pattern of minimising and deflecting responsibility for his actions.

Statements from Sandra's family and friends provide further insight into Stefan's controlling behaviours. A family friend described how Stefan sought to isolate Sandra by attempting to control her behaviour and restrict her social interactions. This aligns with broader patterns of coercive control, where isolation is used to sever victims' support networks and increase their dependency on the perpetrator (Stark, 2007).

Stefan's behaviours created a pervasive atmosphere of fear and entrapment for Sandra, as evidenced by her need to change her locks, block him on all platforms, and consistently manage his ongoing intrusions. His stalking behaviours, coupled with his manipulation of technology and public humiliation tactics, demonstrate a systematic attempt to dominate Sandra's life. Such patterns of abuse not only escalate risk but also make it exceedingly difficult for victims to escape or seek help.

The homicide timeline

Jane Monckton Smith, a criminologist and forensic expert, developed an eight-stage timeline to describe the process that leads to domestic homicide[65]. The timeline provides a framework for understanding how abusive relationships can escalate to lethal violence, offering critical insights for prevention and intervention. It can be used to identify patterns and potential warning signs that could indicate a risk of domestic homicide. By understanding these stages, professionals working in criminal justice, social services, and healthcare can better recognise high-risk situations and intervene more effectively to prevent lethal outcomes. In this section we analyse Sandra's experiences in line with this framework and consider opportunities for identification and intervention.

Stage	Description	Evidence
Pre relationship history	Criminal record or allegations from former partners of control, domestic abuse or stalking. Victims often aware but do not aways report.	Stefan's criminal history or previous allegations are unclear to the review due to him only moving to the UK once he had met Sandra. As we noted in a previous section, we are aware of some anecdotal speculations that there were some challenges in terms of his relationship with his ex-wife, including her mother and daughter suggesting he had something to do with her death (which we reiterate, he has categorically denied).
Early relationship	Relationship sped up with early declarations of love, possessiveness and jealousy.	Sandra and Stafan's relationship escalated quickly following them meeting online and very quickly getting married a few months later. This was a concern of many of Sandra's friends, colleagues and family members. There were signs of controlling behaviour at this point as well as possessiveness and jealousy as was demonstrated at Sandra's mother's wake. He admitted himself during the trial "I would say I was jealous" agreeing that he would not let other men dance with his wife at parties.

[65] https://eprints.glos.ac.uk/6896/1/6896%20Monckton-Smith%20%282019%29%20Intimate%20Partner%20Femicide%20using%20Foucauldian.....pdf

Stage	Description	Evidence
Relationship	Relationship dominated by coercive control, usually with some of the high-risk markers.	Stefan exhibited jealousy and possessiveness, particularly regarding Sandra's interactions with others, seeking to control who she could speak to. He admitted during the trial to being "controlling," acknowledging this as a source of tension in their relationship, particularly in the weeks leading up to her death. His obsessive behaviours extended to monitoring Sandra's communications, including his stated intent to *"see who [Sandra] was talking to"* and *"try to understand why [their] marriage was not working."* Stefan's own account reveals that his actions were influenced by feelings of rejection and frustration, exacerbated by substance use, such as consuming an entire bottle of Courvoisier and ruminating on Sandra's behaviour toward him. These behaviours demonstrate a persistent need to dominate and control Sandra's autonomy, a hallmark of coercive control that significantly increases the risk of violence in domestic abuse cases.
Trigger(s)	An event occurs which threatens the control of the perpetrator. Usually, separation or its potential. May be a physical or mental illness or financial problems.	At this stage, an event occurred that threatened Stefan's control over Sandra: she asked him to leave the house, signalling the end of their relationship. This act of separation significantly destabilised Stefan and appeared to exacerbate other underlying stressors, including his mental health challenges and financial difficulties. Stefan had expressed suicidal ideation to a friend, prompting the friend to call emergency services, though Stefan later minimised these feelings when speaking to professionals. Additionally, his inability to work or access financial resources due to his immigration status likely compounded his economic struggles, further heightening his sense of loss of control. These intersecting factors; relationship breakdown, mental health challenges, and financial instability, created a volatile situation, escalating the risk of serious harm and aligning with this critical stage in the timeline of domestic homicide.
Escalation	An increase in frequency or severity of control tactics, like suicide threats, begging, violence and stalking. Attempts to reinstate control.	Stefan demonstrated attempts to reinstate control over Sandra through a combination of emotional manipulation, false accusations, and relentless contact. He expressed suicidal ideation multiple times, including telling a friend he was thinking about hanging himself, prompting the friend to call the police. In April, he told Sandra he still loved her and was planning to kill himself, leveraging emotional blackmail to maintain a connection with her. Stefan's efforts to undermine Sandra also extended to external systems. He called Brent Children and Young People's Services to falsely accuse Sandra and her aunt of abusing his daughter and seemingly provided anonymous information to Crimestoppers, falsely claiming Sandra was taking and selling drugs. These actions reflected a deliberate attempt to damage Sandra's reputation and exert influence

Stage	Description	Evidence
		over her life. His incessant texting and calling became so overwhelming that Sandra was forced to change her phone number, further highlighting the extent of his stalking and harassment. Stefan also accused her of having an affair with the woman he blamed for their breakup, reinforcing his fixation and jealousy. These escalating behaviours underscore a desperate and dangerous attempt to reassert control, placing Sandra at significant risk.
Change in thinking	Feelings of revenge, injustice or humiliation mat drive a decision to resolve issues, through either moving on, revenge or potentially homicide.	At this stage, Stefan's actions were driven by feelings of humiliation, injustice, and a desire for revenge, escalating his behaviour to dangerous levels. He admitted to posting intimate images of Sandra online, explicitly stating that his intention was to make her *"suffer like [he] did"* and feel the same humiliation and shame he experienced. Stefan also confessed to sending two of these images to Sandra and her friend, further amplifying the emotional harm and public humiliation he intended to inflict. In his own words, Stefan acknowledged that his actions were not right but framed them as a desperate attempt to regain control, stating, "*I just wanted my wife back."* These statements highlight how his feelings of rejection and loss of power led to retaliatory behaviours designed to punish and degrade Sandra. His decision to target Sandra's dignity and reputation underscores the intersection of emotional turmoil, coercive control, and escalating risk at this critical stage. In addition, Stefan made multiple attempts to undermine Sandra by lodging potentially unfounded accusations against her. These included alleging that she orchestrated an attack on him, an assertion that police and ambulance staff assessed as likely self-inflicted, claiming she abused his daughter in reports to Brent Family Front Door (BFFD), and contacting Crimestoppers as well as her employer with allegations of her involvement in drug use and dealing, seemingly intended to jeopardise her employment.
Planning	May include buying weapons, seeking opportunities to get the victim alone, stalking and threats.	Evidence shows that Stefan took deliberate steps to facilitate his actions, including purchasing petrol and waiting for the police to leave Sandra's vicinity before acting. These actions suggest premeditation and a calculated effort to create an opportunity to harm Sandra without interference. Further evidence of Stefan's intent is found in his online searches, which included phrases such as "what is the best way to use a knife and kill someone," "insanity in English Law," and "cases where the insanity defence worked." These searches demonstrate not only a focus on the means to carry out violence but also an attempt to explore potential legal justifications or defences for his actions. Together, these

Stage	Description	Evidence
		behaviours reflect stalking, planning, and the seeking of opportunities to isolate Sandra, highlighting the critical escalation of risk at this stage and the imminent danger she faced.
Homicide	May involve extreme violence, suicide, suspicious death.	As reflected throughout this review, Stefan murdered Sandra and was sentenced to 32 years for this crime.

Key learning points:

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[66]:** 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

The role of cultural competency and intersectionality in domestic abuse responses

This review highlights gaps in how equality and diversity considerations were integrated into agency responses to Sandra and Stefan. Despite the protected characteristics of both individuals and the known impact these can have on the experience and dynamics of domestic abuse, there was a lack of consistent recognition or application of these factors in the provision of services. Agencies did not routinely ask about or record Sandra's or Stefan's ethnicity, a critical oversight given the role of race and culture in shaping experiences of abuse and access to support. This lack of information contributed to a lack of identification and addressing specific support needs that might have been relevant to Sandra's and Stefan's identities and circumstances.

The absence of tailored support is particularly concerning when viewed through the lens of the existing evidence base on Black individuals' experiences with statutory services. Research consistently shows that Black communities often face systemic barriers, including mistrust of authorities, fear of discrimination, and the perception of being under-protected by services. Sandra's consistent reporting of incidents to the police should have been recognised as a positive indicator of her proactiveness and willingness to engage with the system, an opportunity to build trust in a context where trust is often eroded. However, this engagement was overlooked, and the referral made by the police to Victim Support, a generic service, may not have reflected Sandra's specific needs or felt accessible or relevant to her as a Black Caribbean woman. The provision of more culturally tailored services, such as a referral to a by-and-for organisation with expertise in supporting Black women experiencing domestic abuse, may have increased Sandra's confidence in accessing support and provided a more meaningful pathway for intervention.

The lack of consideration for the role of Sandra's and Stefan's cultural background also extends to the broader interactions with services. There was no evidence that agencies considered the potential significance of race, culture, or ethnicity in shaping the dynamics of abuse or informing the types of support that might have been most effective. This oversight represents a missed opportunity to engage with Sandra in a way that acknowledged her lived experiences and the intersectional challenges she may have faced as a Black Caribbean woman navigating abuse and systemic responses.

Reflecting on these gaps, it is evident that the absence of a culturally competent and intersectional approach undermined the ability of agencies to fully understand Sandra's needs and to tailor interventions appropriately. In communities where trust in statutory services is often fragile, the failure to adopt an inclusive and proactive approach to supporting Sandra likely contributed to missed opportunities for meaningful engagement and intervention. This underscores the importance of embedding equality, diversity, and cultural competence into all

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

aspects of service delivery, ensuring that victims of domestic abuse are met with responses that are not only effective but also affirming of their identities and lived experiences.

Had agencies taken a more intersectional approach, with a proactive focus on identifying and addressing the specific needs of Black women experiencing domestic abuse, they might have been better positioned to provide Sandra with the support she needed. By overlooking these considerations, the response to Sandra's situation fell short of recognising and addressing the structural and systemic barriers that shape access to services for minoritised communities. This review underscores the critical need for training, awareness, and the development of pathways that explicitly incorporate considerations of race, culture, and intersectionality to ensure that all victims of domestic abuse receive equitable and effective support.

Contextual reflective point: **The murders of Bibaa Henry and Nicole Smallman, and Louie Casey's review of the Metropolitan Police Service (MPS)**

Whilst it is unusual to reflect on broader cases within a DARD review, in this instance we believe there is need to do so. Less than two months after Sandra's murder, another woman who lived in Brent was murdered alongside her sister who lived in a neighbouring Borough.

In June 2020 Bibaa Henry, a resident of Wembley, and her sister Nicole Smallman[67] were murdered in a park in Brent. Following their murders two officers from the MPS were convicted and sentenced to 33 months imprisonment for taking photographs of the bodies of Bibaa and Nicole at the crime scene and sharing them in a police WhatsApp group which included racist and misogynistic conversations. This incident led to a third officer also being fired for using a 'racial slur' in the WhatsApp messages in response to the shared photographs.

We consider this case within this review, as Mina Smallman (the mother of Bibaa and Nicole) noted her experiences of attempting to seek action from the MPS in the midst of her daughters being missing was a challenge. She noted *"each time we spoke to officers, increasingly worried, it sounded like they were curled up with a cup of tea. There was no urgency".*

Sadly, this was seemingly Sandra's experience too. Sandra reached out to MPS on several occasions, with minimal response or action taken to keep her safe, and as noted in our review an officer was dismissed for misconduct in relation to this. Mina Smallman has called for a specific change to the way violence against women and girls is dealt with noting *"we should have separate units, outside of the police sector, with specialist officers trained to deal with domestic violence, trauma, rape, murder and missing persons with tact and sensitivity. Right now, walking into that environment, nothing about it feels safe"*.

Mina highlighted in the aftermath of her daughter's murders that reform was needed within the MPS to address the institutional issues or racism and misogyny within the organisation. This was echoed in Louise Casey's 2023 review of the MPS.

The patterns identified in this review, alongside the cases of Alexia, Rachel[68], and the broader context of Brent, emphasise the urgent need to address systemic shortcomings in responses to domestic abuse involving Black women. The overrepresentation of Black Caribbean women

[67] Who was not a resident of Brent, but a neighbouring Borough.

[68] See section 1.1.4 regarding previous published reviews.

as victims of domestic homicide in Brent highlights deep-rooted vulnerabilities that demand targeted intervention. Despite Sandra's proactive engagement with police, a significant opportunity to build trust with a demographic often alienated from statutory services, this engagement was met with a default reliance on generic referrals rather than culturally specific support. This lack of tailored interventions mirrors broader issues identified in other reviews, where agencies consistently failed to identify and address the intersectional needs of Black women experiencing abuse.

The cases of Bibaa Henry and Nicole Smallman further underscore the institutional challenges within the Metropolitan Police Service (MPS) and the need for reforms to ensure culturally competent, trauma-informed responses. As Mina Smallman has advocated, creating specialised units outside traditional police structures could address domestic abuse, violence, and trauma with the sensitivity and expertise these cases demand. This approach would be particularly relevant in Brent, where evidence from DHRs consistently demonstrates the need for culturally tailored support services and the proactive engagement of by-and-for organisations to address barriers faced by Black women.

To advance meaningful change, Brent must ensure its DHR processes and broader safeguarding systems prioritise intersectionality and cultural competency. This includes embedding tailored risk assessments, fostering trust through community partnerships, and implementing actionable recommendations that reflect the unique vulnerabilities faced by Black women in abusive situations. By addressing these gaps, Brent has an opportunity to lead the way in developing inclusive and effective responses to domestic abuse, ensuring equity and safety for all residents.

Key learning points:

7. **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.

8. **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.

9. **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

The Independent Office for Police Conduct (IOPC) conducted a thorough investigation into the police response to Sandra's case, focusing specifically on their terms of reference, which included: a) examining the contact Sandra had with the police between January and April

2020; b) assessing whether the police response to the incidents she reported was appropriate; and c) evaluating the adequacy of the police safeguarding response to Sandra. While this Domestic Homicide Review does not seek to duplicate the IOPC's work, it builds upon its findings by providing an overview of the key learning points from their investigation. Additionally, this review incorporates the reflections and broader lessons identified by the Specialist Crime Review Group (SCRG), particularly in relation to multi-agency working and systemic responses, to ensure a comprehensive understanding of the circumstances and opportunities for improvement.

Evidence led policing

This case highlights areas for improvement in evidence-led policing, particularly in recognising patterns of coercive control, stalking, and harassment. Police action largely focused on individual incidents rather than examining Stefan's behaviour holistically to identify a broader pattern of abuse. This approach may have contributed to missed opportunities to fully assess the escalating risk Sandra faced. A more comprehensive evidence-led approach would have involved more effective linking individual incidents to build a clearer picture of Stefan's actions and their impact on Sandra.

Opportunities to gather corroborative evidence were not fully utilised, particularly through engagement with Sandra's wider network, including her family and employer. Stefan's persistent harassment extended to Sandra's workplace, where he frequently called the school office, arrived uninvited, and caused distress. The school implemented internal measures to protect Sandra, demonstrating their awareness of the risks she faced. This could have been an invaluable source of evidence, yet it appears not to have been fully explored. The school noted that they had no communication with, or were ever approached by police and there is no record within MPS suggesting they did either. Strengthening the use of external sources like workplaces could provide additional insight and help substantiate victims' accounts.

The investigation into this case revealed some challenges in the policing response, including issues with evidence collection and supervision. The Independent Office for Police Conduct (IOPC) investigation identified areas where supervision practices could have been stronger. Interviews with officers from the Community Safety Unit (CSU) highlighted capacity pressures within the Metropolitan Police Service (MPS), which is a recognised issue affecting the force's operations[69]. Junior officers were assigned complex cases, while supervisory officers managed high caseloads, which may have contributed to inconsistencies in evidence gathering and case progression.

Although resource constraints are a well-known challenge, they underline the importance of prioritising practices that support evidence-led investigations. There were instances where supervision prompted action, showing the potential for effective oversight. However, follow-through on these directives was inconsistent, suggesting that stronger case management practices could enhance outcomes.

[69] Met Police faces lowest staffing levels in decade, says chief - BBC News

Communication with victims

Effective communication with victims is a cornerstone of good practice in domestic abuse responses, ensuring victims feel informed, supported, and respected throughout the process. In Sandra's case, there were shortcomings in terms of how police communicated with her, leaving her uninformed about their actions and contributing to confusion and potential mistrust.

There were instances where Sandra believed Stefan had been arrested when, in fact, he had only been removed from the property. For example, on one occasion, Sandra told officers that she believed Stefan was at the police station following police attendance, but this was not the case. Such misunderstandings highlight a lack of clear communication, which could have left Sandra with a false sense of security and hindered her ability to assess her own safety.

Additionally, Stefan frequently contacted the police as part of his ongoing attempts to control Sandra, requesting their support to attend her property. On two occasions, officers accompanied Stefan to Sandra's home to collect belongings, which resulted in him taking a necklace of great sentimental value to her. Despite the intrusive nature of these visits, there is no evidence that the police informed Sandra beforehand. This lack of communication likely exacerbated her sense of powerlessness and fear, particularly given Stefan's history of using such interactions to maintain control and initiate contact. From Sandra's perspective, these events may have felt like a minimisation of her concerns and an indication that Stefan's actions were not being taken seriously.

The absence of clear communication with Sandra highlights a critical gap in victim-centred policing. Research shows that poor communication can undermine victims' trust in law enforcement, exacerbate feelings of isolation, and deter them from seeking further help (Robinson & Stroshine, 2021). Moreover, it can contribute to a perception that their safety is not a priority, leaving victims vulnerable to further abuse. This lack of responsiveness may also lead to victims deciding not to report future incidents if they feel earlier concerns were dismissed or unresolved. It is important to acknowledge that the incidents documented in the Metropolitan Police Service records may not reflect the full extent of what occurred, as victims often refrain from reporting abuse due to such experiences, leaving the true number of incidents, both reported and unreported, unknown. In contrast, best practice emphasises regular, transparent communication with victims to keep them informed of police actions, explain processes, and provide updates on case developments. This approach fosters trust, empowers victims, and ensures they remain central to safeguarding efforts.

Partnership working with advocacy services, such as Independent Domestic Violence Advisors (IDVAs), is widely recognised as an effective means of ensuring victims are kept informed and supported. IDVAs can act as a bridge between victims and statutory agencies, helping to ensure that victims' voices are heard, and their safety needs are prioritised. In Sandra's case, no advocacy service was in place. Victim Support, the service to which she was referred, was unable to provide assistance, as we will discuss in the next section. As a result, the responsibility for maintaining effective communication fell solely to the police.

Safeguarding

The safeguarding measures implemented for Sandra were insufficient and did not reflect the escalating risks she faced. Practical options that could have been employed to enhance her safety were not utilised. For example, target hardening measures, such as securing her property with additional locks or alarms, were not explored. Alerts could have been placed on her address to ensure immediate police attention in the event of further incidents, and she

could have been issued a TecSOS emergency phone to enable rapid contact with the police in case of danger. Additionally, protective measures such as Domestic Violence Protection Notices (DVPNs) or Orders (DVPOs) were not pursued, despite their potential to restrict Stefan's access to Sandra and reduce opportunities for harm.

A critical shortfall in this case was the failure to identify and respond to the escalating risk posed by Stefan's behaviour. As noted earlier, risk assessments such as the DASH (Domestic Abuse, Stalking, and Honour-Based Violence) were conducted on individual incidents but did not take into account the cumulative evidence of escalating abuse. This piecemeal approach hindered the identification of a clear and increasing pattern of risk. Best practice, as outlined by SafeLives, recommends that three or more domestic abuse incidents within a 12-month period should automatically trigger a Multi-Agency Risk Assessment Conference (MARAC) referral based on escalating risk. In Sandra's case, despite at least five opportunities for such a referral to be made, this critical safeguarding step did not occur. However it is important to note that aside from the volume of incidents, Sandra disclosed several high-risk factors, such as strangulation, coercive control, and technology-facilitated abuse, which are recognised indicators of significant harm and could have on their own triggered a MARAC referral based on professional judgment, even if Sandra's DASH or 124D scores were not high. The DASH framework explicitly encourages professionals to use their judgment in cases where the risk may not be fully captured through scoring alone, recognising the importance of considering the broader context and severity of disclosed behaviours.

Had a MARAC referral been made, it would have allowed for a holistic, multi-agency response to Sandra's situation, bringing together key partners to develop a coordinated plan to safeguard her. This could have included actions such as enhanced police monitoring, culturally specific tailored interventions from support services, and practical safety measures. The absence of this coordinated approach left Sandra without the full scope of protection and support she was entitled to receive.

Aside from safeguarding concerns relating to Sandra, there were missed opportunities to consider the broader risks posed to Stefan's daughter. We will discuss the specific response from BFFD (who only engaged with the family based on Stefan contacting them) in the next section. However, it is evident that their response might have been different had they received relevant notifications regarding the domestic abuse incidents known to the police.

A key learning point within this review is that Stefan's daughter was not consistently visible to officers in the majority of incidents. As she was the perpetrator's daughter and neither were living with Sandra at the time, officers did not create the relevant MERLIN notifications. However, there were occasions where she was present, including the initial incident on 26th January 2020, which should have triggered a safeguarding referral. This highlights a missed opportunity for officers to proactively identify her presence and make further enquiries, which could have led to a referral.

The Domestic Abuse Act, which came into effect after Sandra's death, establishes that all children living in circumstances involving domestic abuse should be recognised as direct victims in their own right, rather than being viewed in passive terms such as 'witnesses.' It is hoped this national change will enhance how officers respond to families as a whole. However, this case underscores the importance of ensuring proactive enquiries are made about children connected to both the victim and the perpetrator, rather than relying solely on which children are present during incidents.

The lack of safeguarding measures reflects broader systemic challenges, including fragmented responses to domestic abuse incidents, insufficient risk assessment processes, and a failure to embed multi-agency collaboration as standard practice. These gaps not only compromised Sandra's safety but also missed opportunities to address the escalating risk proactively and effectively.

Proactive support and signposting

The police response to Stefan's mental health and suicidality underscores critical gaps in addressing known risk factors that can escalate domestic abuse and increase the likelihood of homicide. Stefan's suicidal ideation was reported on at least three occasions: Sandra disclosed his threats through the 124D form and DASH risk assessment on February 13th and February 20th, noting he had threatened suicide three times, and a friend contacted the police with concerns on February 24th. Despite the well-documented link between suicidality and intimate partner homicide, particularly in homicide-suicide cases (Campbell et al., 2003; Monckton-Smith et al., 2022), the response lacked a proactive or structured intervention. Police visits and advice were provided, but there was no evidence of further engagement or referral to mental health support services. A consent-based referral model, similar to the Automatic Data Transfer (ADT) system used for victims, could have facilitated access to appropriate mental health care. Such an approach aligns with the "Right Care, Right Person" model adopted by the MPS, which emphasises specialist interventions for mental health-related incidents. Additionally, societal stigma surrounding male mental health likely created barriers to help-seeking, as men often view accessing support as a challenge to their identity. Stefan's self-referral to Mind, however, indicates that when appropriately engaged, perpetrators may demonstrate a willingness to address their mental health needs.

Stefan's substance use, particularly his problematic alcohol consumption, was another significant risk factor that was insufficiently addressed. Sandra repeatedly expressed her fear of Stefan's behaviour when he had been drinking, raising concerns during her initial and subsequent calls to the police. Police officers also observed Stefan intoxicated during a visit to Sandra's home, which could have served as an opportunity for intervention. Alcohol misuse is closely associated with heightened aggression and impaired judgment in domestic abuse contexts, as research highlights its role in exacerbating risk factors and reducing impulse control (Gilchrist et al., 2003). Despite these warning signs, no efforts were made to discuss his alcohol use with Stefan or to signpost him to relevant substance use services. Such actions could have addressed a key driver of his abusive behaviour, potentially reducing risk to Sandra. A trauma-informed and accountability-focused approach is essential, ensuring officers recognize the impact of substance use on domestic abuse and act to connect perpetrators with specialist services. Strengthening these interventions requires embedding referral pathways and equipping officers with the skills to address alcohol misuse as part of a comprehensive risk management strategy.

Key learning points:

10. **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.

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

12. **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

The brief involvement of Brent Family Front Door (BFFD) in this case highlights a small number of procedural and practice issues. While the interactions demonstrated some good practice, there was a missed opportunity to identify a potential private fostering arrangement and share information with the local authority/ies where Stephan's daughter was living. A key contextual point in terms of BFFD's response was the missed opportunities from other agencies in sharing information regarding the domestic abuse incidents and flagging there was a child. This was explored in the previous section in terms of police contacts, but has notably limited the action the BFFD could have taken.

Stefan made two contacts with the BFFD Emergency Duty Team, beginning with a request for housing support on 1st February 2020. He described being asked to leave the family home and provided information about his financial dependency on Sandra and his inability to work due to his immigration status. He stated that his then 14-year-old daughter was residing with her maternal grandmother in a neighbouring borough. Stefan reiterated these concerns in March, describing how these tensions allegedly led to his daughter being "kicked out" and living with Sandra's friend.

As Stefan's daughter was not residing in Brent at the time this came to the BFFD attention and the BFFD was not aware of the history of domestic abuse concerns, additional support was not provided to Stefan or his daughter. BFFD did not explore these informal care arrangements or share this information with the local authority where Stefan's daughter was living. Stefan was clear that he felt his daughter was safe and, as information regarding domestic abuse was not shared by the police with BFFD, the context of his behaviour was not known and he was deemed to have appeared to be protective.

Stefan contacted the BFFD on two occasions, beginning with a request for housing support on 1st February 2020. He described being asked to leave the family home and provided information about his financial dependency on Sandra and his inability to work due to his immigration status. Notably, he stated that his daughter was residing with her maternal grandmother in a neighbouring borough. BFFD did not explore these informal care arrangements or verify their suitability, such as by speaking directly to his daughter or liaising with her school. While housing was outside the remit of BFFD, the lack of further enquiry into Stefan's situation and his daughter's living arrangements represented a missed opportunity to establish a more comprehensive understanding of their circumstances.

In addition, Stefan's allegations about Sandra, including claims of verbal abuse by Sandra and her aunt toward his daughter, were not further explored. There was no identified safeguarding need identified at this point however it is notable that this decision was made without conducting multi-agency checks, speaking to the child, or verifying the suitability of the care

arrangement. It is notable that based on the information BFFD had at the time, there would have been limited information to trigger any safeguarding concerns, whereas had they have had notifications from police regarding the domestic abuse, a different conclusion may have been reached. A more thorough exploration into the child's circumstances, including engaging her school or other services, would have been consistent with a child-first approach. However, this review must also consider proportionality, and every contact to the service would not be possible to explore[70]. A reflection may be however that the service considers, particularly with older children, a minimum standard of seeking consent then speaking with the child as part of decision making.

Further concerns arose when a person identifying as Stefan's "legal representative" contacted BFFD on March 12th, stating that he and his daughter were homeless, and that Stefan was experiencing suicidal ideation. The team followed up with Stefan, who denied he had any concerns about his mental health, but once again there was not a proactive response, including identifying where his daughter was residing and sharing information with the relevant local authority.

There was a delayed progression of actions by BFFD. For instance, it took until March 24th to follow up on the concerns raised on March 13th, which exceeded the expected service timeframes. While the follow-up was a positive step, the contact ultimately concluded without clarifying living or childcare arrangements for Stefan's daughter or addressing potential private fostering implications.

A key factor driving Stefan's attempts to return to Sandra was his housing instability and his lack of financial and practical support. Stefan himself expressed that his situation was significantly affecting his mental health, and the intersection of his vulnerabilities, homelessness, NRPF status, and mental health challenges, created a context that may have exacerbated his stress and contributed to an escalation in his behaviour. While this context does not in any way excuse his actions, addressing his immediate basic needs might have provided an opportunity to reduce his stressors.

Supporting Stefan and his daughter through a coordinated approach could have addressed some of these challenges. For example, proactive referrals to housing services under the Duty to Refer[71] (Homelessness Reduction Act 2017) or support from organisations specialising in NRPF cases might have met his support needs.

Key learning:

13. **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[72]. 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.

[70] There were 2,418 contacts in February 2020 which was an average of 120 contacts per day. Since this time there has been an increase in contacts and the service currently receives around 150 contacts per day.

[71] A guide to the duty to refer - GOV.UK

[72] 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.

14. **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.

15. **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

On February 4th, Sandra was referred to Victim Support's London Victim and Witness Service through the Metropolitan Police Automatic Data Transfer (ADT) system following an alleged offence of exposure and voyeurism. Attempts were made by an Independent Victim Advocate (IVA) to contact Sandra on four occasions between February and April. Each call was made from a withheld number, in line with Victim Support's Domestic Abuse Operating Procedure, which aims to prevent increasing risk to victims. Sandra did not answer these calls, and no messages were left, also in accordance with the service's policy. Despite multiple attempts, contact was not established, and the case was closed due to a lack of response.

Victim Support's approach demonstrated procedural adherence but lacked adaptability to Sandra's circumstances. Calling from a withheld number, while designed to safeguard victims, may not have been effective in this case. Victims of stalking and harassment, such as Sandra, are likely to be wary of unknown or withheld numbers. This method, without confirmation of a safe number for contact, may have unintentionally created a barrier to engagement. A more tailored approach, such as liaising with the police to confirm Sandra's updated contact information or alternative safe details, could have increased the likelihood of contact.

Furthermore, Sandra had changed her phone number multiple times to evade Stefan's persistent attempts to control and contact her. This critical information does not appear to have been factored into Victim Support's contact strategy. A proactive approach, such as confirming whether Sandra's number was still valid with the referrer (in this case, the police), could have addressed the challenges posed by her changing contact details.

Victim Support's policy of not leaving voicemails in cases of domestic abuse, though well-intentioned, may be overly restrictive. There are instances where leaving a voicemail, particularly one that is generic and does not disclose sensitive information, could facilitate contact without compromising the victim's safety. In this instance, conferring with the referrer on whether it was safe to leave a voicemail or asking them to share Victim Support's contact details with Sandra could have been a straightforward solution.

Additionally, while attempts to call Sandra were made, there is no evidence that alternative methods, such as email or letters, were explored. Email, in particular, could have been a viable option if considered safe, as it would provide a written record of attempts to reach out and allow Sandra to respond at a time that felt secure to her. This lack of alternative communication

highlights a need for more flexible engagement strategies, especially in cases where victims are known to be at high risk.

There is no evidence of meaningful interaction between Victim Support and other agencies to establish contact with Sandra. As a referral-based service, Victim Support relied heavily on the information provided in the initial referral and did not appear to follow up with the police to explore alternative ways to contact Sandra. This represents a missed opportunity for multi-agency collaboration, where the police could have provided updated information or insights into Sandra's circumstances that might have facilitated contact.

Key learning:

16. **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.

17. **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.

18. **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.

19. **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.

3.2 Conclusions

3.2.1 Summary

The conclusions will highlight the main themes emerging from the review, including gaps in equality and diversity considerations, the adequacy of agency responses, the effectiveness of multi-agency collaboration, and the systemic barriers that limited proactive intervention. Where relevant, early learning identified during the review process has been included, alongside details of any immediate actions taken to address those findings.

By identifying what would need to change in future responses to prevent similar outcomes, this section seeks to ensure that Sandra's experiences lead to meaningful reform and better safeguarding for others in similar circumstances.

A critical theme in this review is the need for agencies to better understand and address the behaviours of perpetrators like Stefan, particularly patterns of coercive control, stalking, and escalating abuse. Stefan's persistent and invasive behaviours—including workplace intrusions, use of technology to monitor and humiliate Sandra, and false allegations to authorities—

demonstrated a trajectory of increasing risk. These actions were not consistently identified as part of a broader pattern, nor were they adequately addressed by the agencies involved.

This case underscores the importance of recognising stalking and coercive control as high-risk indicators for domestic homicide. Intervening early, through tools such as stalking protection orders or perpetrator intervention programs, could have disrupted this trajectory. Furthermore, proactive monitoring of perpetrators' behaviours is vital to prevent escalation, especially in cases where systemic vulnerabilities, such as Stefan's housing instability and financial difficulties, intersect with abusive conduct.

Sandra's experiences highlight gaps in safeguarding that failed to adequately protect her from escalating risk. Safeguarding responses were often fragmented and reactive, focusing on individual incidents rather than a holistic assessment of cumulative risk. Opportunities to implement protective measures, such as MARAC referrals, target hardening, or emergency devices like TecSOS phones, were missed.

Victim-centred approaches require timely and coordinated interventions that place the victim's safety and agency at the forefront. In this case, Sandra's safety could have been better supported by embedding cumulative risk assessments into safeguarding practices and ensuring regular communication to keep her informed and involved in decisions affecting her protection.

Additionally, agencies must consider how perpetrators exploit systemic gaps to maintain control over victims. Stefan's manipulation of the police to facilitate visits to Sandra's home illustrates the importance of robust procedural safeguards to prevent such exploitation. Clearer guidance and consistent training on victim-centred safeguarding practices are essential to addressing these gaps.

This review revealed significant opportunities for improving multi-agency collaboration. Fragmented responses and siloed working contributed to delays and missed opportunities to share information and coordinate interventions. For example, the lack of communication between Brent Family Front Door (BFFD) and other agencies limited the ability to fully understand and address Stefan's circumstances, such as his daughter's living arrangements or his housing instability.

Effective collaboration requires not only timely information-sharing but also a shared understanding of roles and responsibilities among agencies. Establishing clear pathways for multi-agency engagement, supported by robust oversight mechanisms, is critical to ensuring that victims like Sandra receive comprehensive and coordinated support.

The absence of cultural competency in agency responses was a notable shortcoming. Sandra's experience as a Black Caribbean woman was not sufficiently considered in the context of her interactions with statutory services. Agencies failed to proactively address the systemic barriers and mistrust that often hinder victims from minoritised communities from accessing support. Referrals to generic services, such as Victim Support, may not have aligned with Sandra's needs, and culturally specific services could have provided more accessible and meaningful pathways for help.

Embedding cultural competency and intersectionality into practice requires agencies to actively consider the protected characteristics of victims and their unique experiences. This includes tailoring interventions to address structural inequities and ensuring that all victims feel seen, understood, and supported.

Effective communication with victims is a cornerstone of victim-centred responses. In Sandra's case, poor communication from agencies, such as the police and Victim Support, exacerbated her feelings of fear and isolation. The reliance on withheld numbers and rigid no-voicemail policies by Victim Support limited their ability to engage with Sandra, particularly given her attempts to evade Stefan by changing her contact details.

Agencies must adopt flexible and tailored communication strategies, ensuring that victims are informed of actions being taken on their behalf and have safe, accessible channels to engage with services. Proactive collaboration between agencies, such as validating contact details with the police, could have facilitated more meaningful engagement in Sandra's case.

Stefan's case highlights how systemic vulnerabilities, such as housing instability, mental health challenges, and no recourse to public funds (NRPF), can amplify risks in domestic abuse cases. While these vulnerabilities do not excuse his actions, addressing them through coordinated support could have mitigated stressors that contributed to the escalation of his behaviour. For instance, proactive referrals to housing services or NRPF support organisations might have reduced Stefan's dependency on Sandra and alleviated some of the pressures driving his actions.

Agencies must adopt a holistic approach to assessing and addressing systemic vulnerabilities in domestic abuse cases. This includes recognising how such factors intersect with abusive behaviours and developing interventions that address both the victim's and perpetrator's circumstances without compromising the safety and autonomy of the victim.

Stefan's daughter was a key figure in this case, yet her welfare was not consistently prioritised. BFFD's limited engagement with her, failure to verify her living arrangements, and lack of exploration into potential private fostering arrangements represent missed opportunities to ensure her safety. Adopting a child-first approach would have involved direct engagement with the child, multi-agency checks, and proactive safeguarding measures.

This theme highlights the need for child safeguarding to be fully integrated into domestic abuse responses, ensuring that children's voices and experiences are prioritised alongside those of the adult victim.

Sandra's tragic death was solely the responsibility of Stefan, whose actions culminated in this devastating outcome. This review seeks to honour Sandra's memory by ensuring her experiences lead to meaningful change. We extend our sincere gratitude to all agencies, family members, and friends who contributed to this review, whose insights have been invaluable in shaping the findings

3.2.2 Through the eyes of Sandra

Sandra is no longer here to tell her story, and while we have made every effort to ensure her voice is central to this review, we felt it was important to conclude the learning section in a way that truly honours her. To this end, the panel invited our expert panel member from PLIAS Resettlement to write a reflection in Sandra's voice. This provides a powerful and poignant perspective, helping us to better understand her experiences, challenges, and the systemic barriers she faced.

Thank you, Danielle Sharp, for taking up the mantle to conclude my Domestic Homicide Review (DHR). Your dedication to providing reflective insights from my family, personal friends, and colleagues has brought depth and context to this report. Their contributions

have illuminated who I was as a person, friend, and colleague. Beyond this, you have highlighted the devastating impact that domestic abuse and violence had on my psychological and emotional health and wellbeing, which contributed to my reluctance to fully disclose my fears or share my feelings openly.

A heartfelt thank you to PLIAS Resettlement for keeping my memory alive and persistently advocating for justice[73]. Your efforts have been instrumental in pushing for a resolution to the lengthy timescale and review of my untimely death.

As a Black woman, my life journey has been marked by numerous challenges, including assumptions, misinterpretations, missed opportunities, and systemic inequalities. These barriers extended into the very services I turned to for support. Key aspects of my heritage, cultural background, and nuances were overlooked, and the intersectionality of my experiences was misunderstood. The lack of urgency and depth in understanding from various service providers only exacerbated my situation.

This created an environment where my psychological safety was gravely impacted. I lived in constant fear of reprisals from my ex-husband while feeling dismissed and disbelieved by the police and other agencies I contacted for help.

The trauma of abuse often leads to a complex web of psychological responses, including ongoing vulnerability to coercive and controlling behaviour by abusive partners. My experience was no exception. These factors compounded the difficulties I faced and hindered my ability to seek and receive the protection I so desperately needed.

Although I am no longer here, my voice endures. It calls for immediate action to address the inequities and gaps in service provision for Black African and Caribbean women. There is an urgent need for services to adopt more inclusive, equitable, and culturally informed approaches. Understanding the lived experiences of women like me is vital to comprehending the full scope of the challenges we face and developing nuanced, comprehensive support systems that can effectively assist those seeking to escape abusive relationships.

I urge service providers to invite more Black women into the conversation from the outset. Their voices and lived experiences provide essential context and structure, ensuring that support systems are not only more informed but also truly responsive to the realities we face.

Let my story be a catalyst for change, and may my voice inspire a future where no woman feels unheard, unseen, or unsupported.

[73] 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.

Section 4: The action

This section outlines the recommendations to be implemented by agencies, based on the learning identified in the preceding section. These recommendations are designed to address the gaps and opportunities highlighted during the review process, ensuring that the lessons learnt are translated into tangible actions to improve practice and outcomes. Each recommendation is informed by the analysis of events, decisions, and actions taken or not taken, and reflects the key themes and areas for development identified through the review. Where relevant, examples of good practice are also acknowledged to reinforce and build upon existing strengths within the system.

The Community Safety Partnership (CSP) will take overall ownership of these recommendations and develop a comprehensive action plan to ensure their implementation. The CSP will oversee progress, ensuring that agencies are supported to embed the learning into practice effectively and sustainably.

These recommendations aim to provide clear, actionable steps for agencies to enhance their responses and support for individuals and families, ensuring that the learning from this review is embedded into practice. It is notable that given the lapse in time since Sandra's death, there have been a number of changes to individual and mutli agency practice. Where this is the case, we have highlighted this in the recommendations which positively means some have already been completed.

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[74], ensuring all recommendations are addressed systematically to improve domestic abuse responses.

- Review and enhance culturally specific training for officers responding to domestic abuse[75], 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.

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

[75] 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).

- Review and update protocols to ensure that vulnerability markers, including suicidality noted on risk assessments[76], 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[77].

- 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[78].

- 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.

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

[77] 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.

[78] 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.

- 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[79] 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.[80]

[79] 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.

[80] Home office response: 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: Full terms of reference

Preliminary note: These TOR were handed over to the new Chair from the previous Chair. They were dated July 2021. As the review was at its concluding stages when the new Chair began, a review of these took place and some additions and ammendments were made, primarily in regards to the key lines of enquiry which were seemingly absent.

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Brent Council has commissioned this review, following notification of the death of [name redacted]

1.2 All other responsibility relating to the review commissioners (Brent Council) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership

1.3 The resources required for completing this review will be secured by the chair of the Brent Council.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of [name redacted].

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

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair. Additionally, the criminal justice process will impact on timescales so that key relatives and friends can be contacted for involvement without prejudicing the criminal proceedings, although the statutory guidance is clear a DHR should be commenced and concluded as soon as possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the guidance.

4 Scope of the review

4.1 To review events up to the domestic abuse related death of [name redacted] on [day redacted] of April 2020. This is to include any information known about [name redacted] previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies from [added by new Chair: January 2019[81]] preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

Key lines of enquiry [added by new Chair]

In order to critically analyse the incident and the agencies' responses to Sandra and Stefan, this review will specifically consider the following points through our analysis of the information gathered by the previous Chair:

- Analyse the communication, procedures and discussions, which took place within and between agencies.

[81] Information gathered was from a range of timeframes so it was unclear the direction the IMR authors had been given. However the new Chair agreed at the initial restart panel that January 2019 would be the scope for analysis in the report as this was the date in which Sandra and Stefan were married and he moved to the UK.

- 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.

As these have been retrospectively added to our TOR following the IMR submissions, we will consider these questions at the relevant panel meetings, and request further information from agencies where required.

Below are some additional points, set out in the original terms of reference, which will be considered through our analysis too. These should have been responded too in the IMR's, and will further be considered and discussed at the relevant panel meetings.

Exploration of protected characteristics

- To what extent did Sandra and 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?

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers [name redacted] faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 To include any learning/information arising from the Community Rehabilitation Company's "Serious Further Offence Review" which is running in parallel.

4.8 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

5 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the Brent Council Chair)

6 Domestic Homicide Review Panel

6.1 Membership of the panel will comprise [section incomplete by original Chair, the panel listed below are those on the panel at the point of the new Chair being commissioned]:

Name	Agency

The above will be confirmed at the first DHR Review Panel Meeting

6.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

7 Liaison with Media

7.1 Brent Council as lead agency for domestic abuse for the Brent Council will handle any media interest in this case.

7.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

Appendix B: References

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Appendix C: Action plan

Recommendation	Action	Scope	Lead Agency	Target Date	Completion Date and Outcome
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.	N/A	National	Home Office	N/A	The Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) in 2024 and published the new guidance in September 2026. 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, this recommendation will be taken into consideration for future policy development.
Safer Brent Community Partnership should develop a local Domestic Homicide Review protocol which clearly articulates the local process	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.	Local	Community Safety Team, Brent Council		Completed
	An agreed contract monitoring and quality assurance mechanism between the commissioner and the DARDR Chair to ensure an agreed approach to timelines and updates is implemented	Local	Community Safety Team, Brent Council		Completed
	An information management process is embedded to ensure business continuity where a Chair may be unable to fulfil their obligations so the SBP maintains access to all	Local	Community Safety Team, Brent Council		Completed

	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	Local	Community Safety Team, Brent Council		In progress
	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).	Local	Community Safety Team, Brent Council		Completed
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	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.	Local	Community Safety Team, Brent Council		Ongoing
	The incorporation of scoping of local by-and-for organisations to ensure their participation on the	Local	Community Safety Team, Brent Council		Ongoing

	plan and that the SBP 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.	Local	Community Safety Team, Brent Council		Ongoing
	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.	Local	Community Safety Team, Brent Council		In progress
	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.	Local	Community Safety Team, Brent Council		Ongoing

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 and designed to address their specific needs.	Local	Community Safety Team, Brent Council	December 2026	Ongoing
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.	Local	Domestic Abuse Housing Team and Community Safety Team, Brent Council	December 2026	Ongoing
The VAWG delivery group (working with the VAWG forum and Brent Safeguarding Children Partnership) should develop a guidance briefing for schools across Brent to support them in understanding how to support employees/colleagues experiencing domestic abuse.		Local	Brent Safeguarding Children Partnership and Community Safety Team, Brent Council, and VAWG Delivery Group partners	October 2026	Ongoing
Implement the findings and learning from the Independent Office for			Metropolitan Police Service (MPS)		Ongoing

Police Conduct (IOPC) investigation, ensuring all recommendations are addressed systematically to improve domestic abuse responses.					
Review and enhance culturally specific training for officers responding to domestic abuse, ensuring a robust understanding of stalking. This should include recognising high-risk behaviours and integrating them into risk assessments.			Metropolitan Police Service (MPS)		Ongoing
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.			Metropolitan Police Service (MPS)		Ongoing
Review and update protocols to ensure that vulnerability markers, including suicidality noted on risk assessments, are consistently applied as a flag to case records. This will enhance officer awareness of risk factors in future interactions.			Metropolitan Police Service (MPS)		Ongoing

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.			Metropolitan Police Service (MPS)		Ongoing
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.			Metropolitan Police Service (MPS)		Ongoing
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	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		Metropolitan Police Service (MPS)		Ongoing

individuals involved, regardless of whether the children are physically present at the scene.	CONNECT system or other relevant notification processes to ensure timely safeguarding referrals are made.				
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.	Review and update victim contact policies i.e. implement flexible communication methods	Local	Victim Support		Completed
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.	Establish a review process to ensure all multi-agency collaboration opportunities have been explored before closing cases due to lack of contact. Ensure consistent communication with agencies to track victim engagement efforts and explore alternative support strategies.	Local	Victim Support		Completed
Build partnerships with by-and-for organisations to provide culturally	Integrate culturally specific organisations into referral pathways	Local	Victim Support		Completed

specific and accessible services for minoritised communities. These organisations should be integrated into referral pathways to foster trust and improve victim outcomes	to improve accessibility and trust for minoritised communities.				
BFFD to 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.	Provide targeted training for BFFD staff on the Duty to Refer and local housing pathways to improve homelessness prevention responses. Develop and disseminate guidance on how BFFD staff should engage with housing teams when identifying families at risk of homelessness.	Local	Children's Social Care		Ongoing
BFFD to 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.	Train BFFD staff on recognising private fostering arrangements and ensuring appropriate safeguarding responses. Regularly review referrals and responses to ensure compliance with both homelessness and private fostering statutory requirements.	Local	Children's Social Care		Ongoing

Appendix D: Home Office feedback form

Home Office

Interpersonal Abuse Unit 2
Marsham Street London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Nisha Das
Interim Violence & Vulnerability Coordinator
Community Safety Team
Brent Council, Civic Centre
Wembley
HA9 0FJ

25th November 2025

Dear Nisha,

Thank you for submitting the Domestic Homicide Review (DHR) report (Sandra) for Brent Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 5th November 2025. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Sandra
COMMUNITY SAFETY PARTNERSHIP	Brent
DATE REVIEWED BY QA BOARD	5th November 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• Given the challenges involved from the beginning, the QA Board wish to commend the Chair for her perseverance to achieve the outcomes within this review. The note from the Chair provides clear consideration for all those concerned about the process. • The review demonstrates strong engagement of appropriate experts, ensuring credibility and depth. • It is a clear, well-written report that should be highlighted as an example of good practice. • The review incorporates pertinent research that effectively illustrates the vulnerability of certain women and circumstances, adding real value to the analysis. • It is good to see that the author has reviewed learning from previous DHRs in Brent with similar themes. This continuity strengthens the recommendations and demonstrates a commitment to iterative improvement. • There is a very impactful tribute to Sandra from friends and work colleagues which provided an insight to her as a person, teaching assistant and her love of the children at her school. This effectively highlights her personality and that she was a very warm person, creative and that she loved Caribbean music. • The equality and diversity section is well addressed and considered the specific protected characteristics relating to this case and intersectionality to domestic abuse.
FEEDBACK FOR FUTURE DHRs	• IOPC Investigation Reports: In cases where there is an Independent Office for Police Conduct (IOPC) investigation, the final report should also be shared with the DHR Quality Assurance Board where possible and appropriate to ensure transparency and learning. • Pen Portraits: The pen portrait in this case beautifully reflects who Sandra was. This element is vital in DHRs as it keeps the memory of the person alive and gives readers a real sense of their life and character. This practice should be consistently encouraged. • Timeline Visuals: Page 50 of the Overview Report contains a highly useful timeline diagram. Including such visual aids should be encouraged in future DHRs to help readers understand the sequence of events clearly.

	• Use of Homicide Timeline: The Chair effectively uses the Homicide Timeline to demonstrate the trajectory of abuse. This is an excellent example of applying structured tools to illustrate patterns. • Glossary of Terms: Introducing different terms and teams in the Overview Report as a glossary is a strong practice that aids clarity for all readers. • Victim's Voice: Section 3.2.2 *"Through the eyes of Sandra"* is a powerful way to bring the victim's perspective into the review. This approach should be highlighted as best practice

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
	Title Page	No amendments required.
1	Contents Page	No amendments required.
2	Pen Portrait	No amendments required.
3	Condolences	No amendments required.
4	Confidentiality and Anonymity	No amendments required.
5	Terms of Reference	No amendments required.
6	Equality and Diversity	No amendments required.
7	Background Information	No amendments required.
8	Combined Chronology	No amendments required.
9	Overview	No amendments required.
10	Analysis	No amendments required.
11	Conclusions	No amendments required.

12	Lessons learnt and recommendations	It would be helpful to see the IOPC recommendations and for them to be included within this report if possible and appropriate.
13	Timescales	No amendments required.
14	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	Please ensure the report is shared with the Domestic Abuse Commissioner's Office.
21	Action Plan	The Action Plan requires RAG timescales with clear lines for monitoring the specific outcomes, which should be stated.
22	Has there been a request to withhold publication? If Yes, include the reason for the request. Is it proportionate and appropriate?	No request to withhold publication.
23	Any other comments	There are many lessons to be learnt from this tragic case. The QA Board would urge the CSP to consider how best to promulgate these lessons. This case underscores the importance of recognising stalking and coercive control as high-risk indicators for domestic homicide.

Appendix E: List of support services for readers

Service	Contact details	About
National Domestic Abuse Helpline	0808 2000 247 www.nationaldahelpline.org.uk	24/7, free, confidential. For women and children experiencing domestic abuse.
National Stalking Helpline	0808 802 0300 https://www.suzylamplugh.org/refer-someone-to-us	For anyone affected by stalking.
Rape Crisis England & Wales	0808 500 2222 www.rapecrisis.org.uk	For anyone affected by sexual violence.
Respect Phoneline	0808 802 4040 www.respectphoneline.org.uk	For people worried about their own abusive behaviour.
Samaritans	116 123 www.samaritans.org	24/7 listening support.
Mind	0300 123 3393 www.mind.org.uk	Mental health information and support.
Victim Support – National Homicide Service	0808 1689 111 www.victimsupport.org.uk	Practical and emotional support for those bereaved by homicide.
AAFDA (Advocacy After Fatal Domestic Abuse)	07768 386 922 www.aafda.org.uk	Advocacy and support for families after domestic abuse-related deaths.
FRANK	0300 123 6600 www.talktofrank.com	Drug and alcohol information and advice.

Confidential

CONTROLLED