Domestic Homicide Review

Safta

July 2022

Overview Report

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Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

Review completed: 15 February 2024

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1. Glossary

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation / Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
ACEs	Adverse Childhood Experiences
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
DARA	Domestic Abuse Risk Assessment
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
GP	General Practitioner
HST	Housing Solutions Team
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
KCSP	Kent Community Safety Partnership
KMDASVEG	Kent and Medway Domestic Abuse & Sexual Violence Executive Group
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium 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.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse, defined by the Domestic Abuse Act 2021, states:

(1) 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.

(2) Behaviour is "abusive" if it consists of any of the following—

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

(d)economic abuse (see subsection (4));

(e)psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(3) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b)obtain goods or services.

(4) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

- *emotional*

Controlling behaviour is:

a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

2. Safta

2.1 Safta is described by her stepdaughter, Tanta, as having a lovely personality and that she loved children. Tanta stated that as Safta and herself were close in age, they had a close relationship looking on Safta more as a sister. They would often go out together and Safta would like to have a good time and loved to dance. Safta is described as a lovely mother who did everything she could to look after her child. The panel wish to send their sincere condolences to Safta's family.

3. Timescales

3.1 This overview report has been commissioned by the Kent Community Safety Partnership (on behalf of the local CSPs including the Medway Community Safety Partnership) concerning the death of Safta which occurred in 2022.

3.2 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 16th May 2022. The Core Panel is made up of representatives from the 'responsible authorities' of the Community Safety Partnership. The panel agreed that the death of Safta met the criteria for a DHR, and this review was conducted using the DHR methodology. That agreement was ratified by the Chair of the Kent Community Safety Partnership.

3.3 Family members were contacted via the Victim Support Homicide Case Worker in June 2022 to inform them a review had been commissioned and were later contacted directly by the Chair and invited to take part in the review.

3.4 The Terms of Reference were set by the panel in September 2022 and the review concluded in February 2024 after the family had read the report and made further additions and amendments with the independent chair. The panel met on five occasions, where they identified the key learnings, set the terms of reference, examined IMRs and agency information, and scrutinised the overview report and its recommendations. An action plan was developed and populated by panel members prior to Home Office submission.

3.5 Pseudonyms for both Safta and her husband Alexandru, have been used throughout this report to maintain anonymity. These pseudonyms were shared with and agreed by the family.

3.6 The Home Office were notified by the Community Safety Partnership (CSP) of their intention to carry out a Domestic Homicide Review (DHR) in June 2022 after the core group (comprised of statutory agencies) met and agreed that the case met the criteria for a DHR on the 16th May 2022. The coroner was also notified that a Domestic Homicide Review was taking place.

3.7 The coroner's inquest into Safta's and Alexandru's death had not taken place prior to the completion of this review however, the Police believed that the deaths of Safta and Alexandru were as a result of murder and suicide.

4. Confidentiality

4.1 The findings of the Domestic Homicide Review are confidential. At the beginning of the meetings of the review panel, attendees were reminded of the confidentiality agreement. The information supplied throughout the review process was only available to those participating in the review and their line managers until after the DHR was approved by the Home Office Quality Assurance Panel and published. Dissemination is addressed in section 12 below.

4.2 The deceased in this case was a white female of Romanian nationality. Safta was in her 30s at the time of her death. Her husband was a white male of Romanian nationality. Alexandru was in his 50s at the time of his and Safta's death. Safta and Alexandru had one child, child A, during their marriage and Alexandru had a daughter, Tanta, from a previous marriage.

Name	Gender	Relationship	Ethnic Origin
Safta	Female	Deceased	White Romanian
Alexandru	Male	Deceased (suicide)	White Romanian
Tanta	Female	Daughter of Alexandru	White Romanian
Child A		Child of Safta and Alexandru	White Romanian

5. Terms of Reference

The critical dates for this review have been designated by the panel as January 2020 to the date of Safta's death; however, the panel Chair has also asked the agencies providing IMRs to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report. These dates were felt to be the most relevant in the life of Safta as it was during this time that Tanta became aware of arguments taking place within the family home and it was identified by Safta that her relationship with Alexandru had gotten worse during the Covid-19 lockdown.

5.1 Specific Issues to be Addressed.

5.1.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR were:

5.1.1.1 Were practitioner's sensitive to the needs of Safta and Alexandru, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

5.1.1.2 Did the agency have policies and procedures for domestic abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those correctly used in the case of Safta? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

5.1.1.3 When, and in what way, were Safta's wishes, and feelings ascertained and considered? Is it reasonable to assume that the wishes of Safta should have been known? Was Safta informed of options/choices to make informed decisions? Were they signposted to other agencies?

5.1.1.4 Was anything known about Alexandru? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place? Were agencies aware of any abuse within previous relationships?

5.1.1.5 Had Safta disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

5.1.1.6 Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case? Were agencies aware of the 19-year age gap between Safta and Alexandru and whether this affected their relationship?

5.1.1.7 Were senior managers or other agencies and professionals involved at the appropriate points?

5.1.1.8 Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

5.1.1.9 Are there ways of working effectively that could be passed on to other organisations or individuals?

5.1.1.10 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Safta, Child A and promote their welfare, or the way it identifies, assesses, and

manages the risks posed by Alexandru? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources? Was the right level of support offered to Safta surrounding her impending court case and the impact this might have had on her? Were any stress indicators identified or reacted to regarding the impending court case?

5.1.1.11 Did any staff make use of available training?

5.1.1.12 Did any restructuring take place during the period under review likely to have had an impact on the quality of the service delivered?

5.1.2 **Key lines of enquiries**

5.1.2.1 How accessible were the services for Safta? Were there any issues regarding non-engagement of agencies either within Kent and Medway or across borders?

5.1.2.2 Safeguarding a victim whilst working and living together. This is specifically in relation to the non-molestation order and bail conditions. Alexandru was identified as possibly being Safta's boss; how did this affect the relationship?

5.1.2.3 Escalation of abuse during Covid-19 and access to support. Did Covid-19 cause a financial impact to the couple's business and if so, how did this affect their relationship?

5.1.2.4 Review the robustness of the non-molestation order and agencies awareness of the order.

5.1.2.5 Op Encompass and referral pathways following allegations of abuse.

5.1.2.6 Were agencies aware of any previous suicide attempts made by Alexandru or any suicide ideation? If so, was this dealt with appropriately?

5.1.2.7 Barriers for family members recognising abuse within the family and highlighting this abuse to professionals.

6. Methodology

6.1 The purpose of this Domestic Homicide Review overview report is to:

6.1.1 Ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case.

6.1.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.

6.1.3 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.

6.1.4 Apply these lessons to service responses including changes to policies and procedures as appropriate.

6.1.5 Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

6.1.6 Contribute to a better understanding of the nature of domestic violence and abuse; and

6.1.7 Highlight good practice.

6.2 This overview report has been compiled with reference to the comprehensive Independent Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. IMRs were signed off by a Senior Manager of that organisation before being submitted to the Domestic Homicide Review

Panel. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

6.3 The overview report author has also fulfilled a dual role and has Chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance, context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

6.4 The review author has also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard.

6.5 Some of the information within the report will not be, where possible, personally referenced, and the author has due regard for any confidentiality and sensitivities required. The author has also sought additional information outside of the date parameters and this has assisted in context to examine some background history.

6.6 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which is defined by the Domestic Abuse Act 2021 [1]as:

(1) 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.

(2) Behaviour is "abusive" if it consists of any of the following—

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

(d)economic abuse (see subsection (4));

(e)psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

[1] Domestic Abuse Act 2021 - https://www.legislation.gov.uk/ukpga/2021/17/section/1

(3) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b)obtain goods or services.

(4) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

6.7 One of the purposes of a Domestic Homicide Review is to give an accurate as possible account of what originally transpired in an agency's response to Safta, to evaluate it fairly, and if necessary, to identify any improvements for future practice.

7. Involvement of Family Members and Friends

7.1 Unexpected deaths are tragic, not just for the family, but for friends and work colleagues alike. The overwhelming effect that this has on those individuals can endure and their privacy must be respected and any willingness to assist agencies must be of their own volition. It is acknowledged by the review that they are survivors of this tragic episode, not least the family of the deceased, and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual and sometimes personal views, may identify intervention opportunities for agencies in future cases.

7.2 Safta's family members were contacted on behalf of the panel by their Victim Support Homicide Case Worker. Initial contact with the family included the Home Office DHR information leaflet and the Chair also informed the family of support available from Advocacy After Fatal Domestic Abuse (AAFDA). Contact was also made with Alexandru's daughter Tanta, who had a close relationship with Safta. Tanta contacted the chair of the review and agreed to speak to her about Safta and her father. The panel chair contacted Safta's family however although initially stating that they would like to be a part of the review made no further contact. Further contact has been made with Safta's family by the Homicide Case Worker and they have been advised that the door is always open should they wish to contribute to the review.

7.3 The Chair of the DHR spoke to Tanta and explained the review process and the panel membership and responsibilities. She was also asked whether she would like to meet the panel members, but this was declined. Tanta was also spoken to after panel meetings and addressed several queries identified by the panel. The overview report was shared with Tanta (in mid-February 2024) and Safta's family were also written to and informed that they could see a copy of the report.

7.4 The Chair explored the potential of meeting with Child A however both Tanta and Child A's school advised that Child A was not in sound mind to support any reviews. The panel and Chair agreed not to explore further for Child A's mental wellbeing. Safta's family who had taken over the care of Child A were contacted on two occasions in relation to talking to them about Safta and also raising the request to talk to Child A, sadly no contact was received back from Safta's family.

8. Contributors to the Review

8.1 The Independent Management Reviews (IMRs) were written by a member of staff from the organisation to which it relates. Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The IMRs were quality assured by supervisors and were signed off by management prior to being presented to the panel.

8.2 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
The Education People, Education Safeguarding	Independent Management Review
East Kent Hospitals University Foundation Trust	Independent Management Review

9. Review Panel Members

9.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Safta and/or Alexandru. They were independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The panel also included representatives from health, adult social care, a senior member of the Kent Community Safety Team, an independent domestic abuse specialist and a cultural advisor from the Kent Police Diversity Academy.

9.2 The members of the panel were:

Name	Organisation	Job Role
Elizabeth Hanlon		Independent Chair and Report Writer
Shafick Peerbux	Kent County Council, Community Safety	Head of Community Safety
Louise Murphy	Kent Police	Detective Inspector
Leigh Joyce	Clarion Housing Association and Domestic Abuse Service	Locality Business Manager (Southern Region) Independent Domestic Abuse expertise.
Martin Cripps	East Kent Hospitals University NHS Foundation Trust	Acting Mental Capacity Act/DoLS Clinical Lead
Claire Ray	During the review period titled 'The Education People, Education Safeguarding' now Kent County Council LADO and Education Safeguarding Advisory Service.	Head of Service, Education Safeguarding
Irina Mgebrisvili	Kent Police	Diversity Academy (expert panel member, cultural advisor)
Lisa Lane	Kent & Medway Integrated Care Board	Designated Nurse for Safeguarding Adults
Catherine Collins	Kent County Council, Adult Social Care	Strategic Safeguarding Manager

10. Chair and Overview Report Writer

10.1 The Independent Chair and report writer for this review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired eight years ago, in 2015. She has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership

Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire, and Essex County Council.

10.2 The Chair has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also has an enhanced knowledge of Domestic Abuse and attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the Chair of the Domestic Abuse Partnership Board in Hertfordshire to share learnings across boards. She is also the current Independent Chair for the Hertfordshire Safeguarding Adults Board.

11. Other Reviews/Investigations

11.1 Safta's death was identified as a 'death after police contact' and as such was the subject of a mandatory referral to the IOPC[2]. An internal investigation is still underway within Kent Police Professional Standards Department.

12. Equality and Diversity

The Panel considered the nine protected Characteristics under the Equality Act 2010, (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity). They sought to establish if they were applicable to the circumstances of the case and had any relevance in terms of the provision of services by agencies or had in any way acted as a barrier.

12.1 Sex

12.1.1 There is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured, or killed. In fact, the term "Femicide", which refers to the killing of women by men because they are women, was coined in the 1970s to raise awareness of the violent deaths of women.

12.1.2 Homicide represents the most extreme form of violence against women, a lethal act on a continuum of gender-based discrimination and abuse. As research shows, gender-related killings of women and

[2] Independent office for Police Conduct.

girls is a highlighted concern across the world, in countries rich and poor. Whilst most homicide victims are men, killed by strangers, women are far more likely to die at the hands of someone they know.

12.1.3 Women killed by intimate partners or family members account for 58% of all female homicide victims reported globally in 2017, and little progress has been made in preventing such murders, with a total of 87,000 women being killed across the world in 2017 alone. More than half of them (58%) were killed by intimate partners or family members, meaning that 137 women across the world are killed by a member of their own family every day. A third of these women (30,000) were killed by a current or former partner - someone they would normally expect to trust.[3]

12.1.4 Between 2009 and 2018, at least 1,425 women were killed by men in the UK, meaning a man killed a woman every three days on average. The above report shows that women are killed by their husbands, partners, and ex-partners, by sons, grandsons, and other male relatives, by acquaintances, colleagues, neighbours, and strangers. Unfortunately, but unsurprisingly, a huge number of women were killed in the context of intimate partner violence.[4] The link between domestic abuse and suicide is also a consideration within this review and is identified later within the report.

12.2 Race

12.2.1 In the Equalities Act (2010), the protected characteristic of race refers to a group of people defined by their race, colour, nationality (including citizenship), and ethnic or national origins.

12.2.2 Safta and Alexandru were both white of Romanian nationality. They moved to live in England around 2010 and both spoke good English. Both had British citizenship. Their child was born in Romania and only spoke English.

[3] https://www.unodc.org/documents/data-and-analysis/GSH2018/GSH18_Gender-related_killing_of_women_and_girls.pdf
[4] UK Femicides 2009-2018

12.2.3 The independent Panel expert identified that in Romania, the police are often very 'dismissive' of domestic abuse, seeing it more as a family problem or personal matter that they won't get involved in. Female victims are often still blamed for 'provoking' the abuse.

12.2.4 A person's cultural background or immigration status may make them more vulnerable to domestic abuse and create barriers to leaving an abusive partner[5]. Possible issues a victim may face include the fact that:

- they may not speak much English or know where to turn to for help.
- they may be reliant on their partner or partner's family for financial support and be isolated from people outside their immediate family or community.
- they may have an insecure immigration status and fear contact with the authorities.
- their right to remain may depend on their relationship with the abuser continuing.
- they may have been forced into marriage or be subjected to honour-based violence (HBV).
- certain forms of domestic abuse, for example, between husband and wife or father/uncle and daughter/niece, may be accepted in some families or households and cultural background may be a factor – if it is considered normal by the victim, perpetrator and their community, the victim may not seek help or be aware of what help is available.

12.2.5 In 2017, Romania was "criticised over its lack of commitment to tackling domestic violence in a ruling by the European Courts of Human Rights. The court fined the country after it failed to hold to account a man who attacked his wife eight times. Officials went as far as to accuse the victim of provoking the assaults, the court noted." The report from 2017 said that official statistics suggested most

[5] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/understanding-risk-and-vulnerability-context-domestic-abuse

Romanians think domestic violence is normal, and in certain circumstances, 60% of Romanians saw it as justified[6].

12.2.6 In 2022 an updated report[7] by the Council of Europe's GREVIO – the independent expert group that monitors implementation of the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) – acknowledged the steps taken by Romania to comply with the treaty but identified areas where progress was still needed. "Romania has made significant efforts towards building a legislative, policy and institutional framework to prevent and combat violence against women since it ratified the Istanbul Convention in 2016, in particular in respect of domestic violence".

12.2.7 It was however highlighted that the criminal justice mechanisms for combatting sexual violence, considered to be highly underreported, faced serious shortcomings. The definition of rape in the Criminal Code is not aligned with the Istanbul Convention and should be amended to fully incorporate the notion of the lack of freely given consent. In addition, the country lacks an adequate geographical distribution of fully established rape crisis or sexual violence referral centres.

12.3 Religion

12.3.1 Although identified as catholic Tanta stated that neither Safta or Alexandru were religious, and it was therefore felt that their religion did not have an impact within this review.

12.4 Age

12.4.1 At the time of their marriage Alexandru was in his 50s and Safta was in her 30s. There is research available which is detailed within this report (section 17.49) which shows a significant age gap in an intimate partner relationship can be a factor associated with domestic abuse, particularly coercive controlling behaviour. It is important to

[6] https://www.bbc.co.uk/news/world-europe-40010890
[7] https://www.coe.int/en/web/portal/-/romania-has-improved-protection-of-women-from-domestic-violence-but-progress-needed-on-definition-of-rape

note however, that the age gap within Alexandru and Safta's relationship does not appear to have been the reason that the relationship broke down, the breakdown followed the abuse that was inflicted upon Safta by Alexandru.

12.5 Marriage

12.5.1 Marriage and civil partnership is one of the protected characteristics. It was identified by Tanta that Alexandru had an 'old-fashioned' outlook on marriage and considered Safta to belong to him as his wife. He believed that as a male he was the head of the family and as such made the decisions. This impacted on their relationship as Alexandru wanted to be in charge and as such would restrict what Safta was allowed to do. Alexandru also believed that Safta's main responsibility was to look after their child and the house. Tanta identified that Safta enjoyed her work and also liked to go out so felt restricted by Alexandru on occasions.

13. Dissemination/Publication

13.1 The Panel shall, once it has agreed the final report, submit it to the Kent Community Safety Partnership for its consideration. The Partnership will be requested to consider content of the report, the recommendations, and the associated Action Plan. If the Partnership is satisfied with the report, it shall be requested to submit the report to the Home Office.

13.2 The overview report will be published on the website of Kent and Medway Community Safety Partnerships.

13.3 Family members will be provided with the website addresses and also offered hard copies of the report.

13.4 Further dissemination will include:

(a) The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Board and the Office of the Kent Police and Crime Commissioner amongst others

(b) The Kent and Medway Safeguarding Adults Board

(c) The Kent Safeguarding Children Multi-Agency Partnership

(d) Additional agencies and professionals identified who would benefit from having the learning shared with them.
(e) Briefings are offered to the local CSPs by KCC's Community Safety Unit at the partnership meetings.
(f) A short briefing document highlighting key learning is circulated upon publication.
(g) Learning events held by the KCSP.

13.5 In accordance with Home Office guidance all agencies and the family and friends of Safta are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues, if identified, will be shared with specific organisations, the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel.

13.6 The content of the overview report has been suitably anonymised to protect the identity of the female who died and relevant family members and friends. The overview report has been produced in a format that is suitable for publication with any suggested redactions before publication.

14. Background Information

14.1 Safta was born in Romania and was aged 18 years when she started a relationship with Alexandru. Alexandru was also born in Romania. There is a significant age gap between the two parties with Alexandru being 19 years older than Safta. Very soon after the relationship started Safta moved in with Alexandru. It was identified by Safta during her Achieving Best Evidence (ABE) interview with the police, undertaken in 2022, that Alexandru hit her early on in their relationship. He is said to have displayed jealous and controlling behaviours throughout their relationship.

14.2 The couple travelled to the UK to live in 2010 when their child was a new born. Both Safta and Alexandru set up a business together in the area they lived. They both worked together within the business.

14.3 In March 2022, Safta called the Police to report a domestic situation between herself and Alexandru. This was the first time that she had reported any DA

within their relationship to the police. During her interview, Safta reported to the Police a long history of sexual assaults and controlling coercive behaviour. Safta reported that the relationship between herself and Alexandru had gotten considerable worse during the Covid-19 lockdown. Safta identified to the Police that she had taken a non-molestation order out against Alexandru the previous month to prevent him from harassing, threatening, or using violence towards her. The order however, allowed Alexandru to still live in the family home that they shared with their child. Tanta identified that Safta had not requested that Alexandru moved out of the family home as she believed that that was best for their child.

14.4 Alexandru was arrested and interviewed by Police in relation to both physical and sexual assault against Safta and for breaching the non-molestation order. Alexandru denied all criminal behaviours and was released on conditional bail whilst the investigation continued.

14.5 In April 2022, Police were called to the business address of both Safta and Alexandru in relation to reports of a stabbing. Safta and Alexandru were both found deceased within the property. No other persons are suspected of being involved in their deaths, it is suspected Alexandru murdered Safta and then took his own life.

15. Chronology

15.1 This section of the report gives an overview of information about Safta and Alexandru provided by family members and professionals. It provides context of the dynamics of the relationship between Safta and Alexandru and a chronology of their contact with professionals.

15.2 Information from Alexandru's daughter

15.3 Alexandru's daughter Tanta spoke to the report writer in relation to her father and Safta's relationship. She identified that they had met in Romania when Safta was 18 years of age when Safta was working in a shop next to Alexandru's place of work. Tanta stated that Alexandru had previously been married to her mother but that they had separated and subsequently divorced, Tanta believed partly due to Alexandru being unfaithful to her mother but also believes that there was domestic abuse within the

relationship. Tanta stated that Safta was aware that she had spoken to her mother about their relationship and that she hadn't been comfortable with other people knowing what was going on. Alexandru and Safta had a child together, and shortly afterwards moved to live in England. Tanta stated that she followed a short while afterwards and lived with them all for some time, around two and a half years. She stated that Safta looked after her and made her feel part of the family. Tanta described moving to London to live with her mother, who had also moved to live in England.

15.4. Tanta described having a very close relationship with Safta as they were close in age and as such had a lot of the same interests. Tanta stated that after a while the relationship between Safta and Alexandru started to change, and she saw her father become controlling towards Safta. He started to restrict what she was allowed to do and who she was allowed to go out with. It became that Safta was unable to do anything or go anywhere without Alexandru and that he expected Safta to look after him and their child, clean the house and be a "good wife". Tanta identified that there was a power imbalance within their relationship which she put down to Alexandru, being the male, identifying as the head of the household and also the fact that Alexandru was a great deal older than Safta and as such tried to dominate her.

15.5. Tanta stated that Alexandru would spend a lot of money going out but didn't like Safta to go out and would take what money she did have off her. Tanta stated that although they worked together, he would do the good jobs and would get Safta to do those that he really didn't want to do. Tanta stated to the report writer that she now identifies Alexandru's behaviour to Safta as coercive and controlling but that she didn't really identify it as such at the time. Tanta identified areas where she believed that Alexandru would manipulate her and she stated that she found it difficult to tell him when she didn't want to do something that he wanted her to do i.e., act as the go between himself and Safta after he had been arrested and bailed.

15.6. Tanta stated that Alexandru started a relationship with another female that he had met near to where they worked. She said that the relationship had started eighteen months before the deaths and that the female was younger than her. Tanta described the fact that Alexandru would bring this female

around the house and made her the receptionist in the business. Tanta said that she told Safta not to put up with it and when the affair became obvious, she told Safta to leave her dad. Safta had started to make plans to leave Alexandru, firstly by making herself independent of him financially and by withdrawing physically as well. It is felt that the main reason that Safta continued to work in the business after Alexandru's arrest and against his bail conditions was so that she could continue to financially support herself and her child and to make plans for future independency. She said that Safta would sleep at a hotel quite a lot to get away from Alexandru. She described the tension increasing throughout the last year of their relationship and that she felt that she was in the middle of their relationship failing as both would tell her stuff about the other one, which she said she found very hard. The panel discussed whether Alexandru was acting in a coercive and controlling manner towards Tanta as well as Safta. Tanta stated that she believes that her father controlled her on some occasions and that she was aware that he was a manipulative person.

15.7 Tanta had encouraged Safta to take out a non-molestation order against Alexandru as he had started becoming more threatening and had started following her. She said that Safta felt that she had no choice than to get an order against him as he had started turning up at the hotels, she was staying in. He would leave flowers on her car when she was asleep which was worrying her. Tanta described an occasion where her father had said to her that if anything happened to both of them (Alexandru and Safta) that he wanted her to look after child A. She said that she felt weird at the conversation and had told him to stop.

15.8 Safta had told Alexandru about the application for the non-molestation order and that he was present during the court hearing as it was being conducted over video call due to Covid-19. Safta had described how Alexandru had kept coming into the room during the court hearing yelling and shouting and that the Judge had asked to speak to him but that he wouldn't speak to her. She believed that Alexandru was unhappy about the fact that Safta was taking out a non-molestation order against him.

15.9 Tanta stated that the relationship finally came to a head when Alexandru accused Safta of having an affair which she agreed with. Tanta said that

Safta had only said this to get rid of him as she thought he would leave her, but it had resulted in Alexandru going into Safta's bedroom and assaulting her. This is when Safta had called the police and made the report of domestic abuse, mainly because she was afraid of what Alexandru would do to her. She had told Tanta that she hadn't wanted to call the police, but she was worried as Alexandru had been acting strangely. Safta hadn't wanted to tell the police about everything that had happened within their relationship i.e. the sexual assaults but that the way they had questioned her had made certain things come out. Tanta stated that child A was mainly detached from the arguments that were taking place within the family and she would take them into her room if Safta and Alexandru started to argue so that they wouldn't know what was going on. Tanta stated that child A did ask their mother on one occasion why Alexandru was sleeping somewhere else, and she told them it was because he was 'having an affair with another woman'. This, Tanta said, was the only time that child A became involved in what was happening. Tanta identified that they were a child that kept very much to themself and was the happiest when they could play on their computer and felt better in their own company, not having to interact with people.

15.10 Tanta said that Safta had been really sorry that Tanta had become involved in the police investigation as she had had to give a witness statement against her father. She became the contact between Alexandru and Safta following his arrest as Alexandru had been given bail conditions not to contact Safta. Tanta said that she would often meet Alexandru where he would give her his dirty washing which she would give to Safta to wash before returning it to Alexandru. This is indicative of the control that Alexandru had over Safta and Tanta where he was still getting them to do things for him even after his arrest. It does not appear that agencies were aware of the full extent of the control that Alexandru was placing on Safta and Tanta. This is explored further during the analysis.

15.11 Tanta stated that she became more concerned about the relationship between Safta and Alexandru after he was arrested and that she spoke to the police to raise her concerns regarding Alexandru's mental health. She stated that she told the police that she was worried about what he would do to himself and that he was worried that he would go to prison. He made a comment to Tanta that "he would die before he went to prison". The police

have identified within Tanta's statement the fact that concerns were raised regarding Alexandru's mental health, but it does not appear that they were aware of the full extent of those concerns.

15.12 Tanta stated that Safta's mother had moved into the home address to help look after child A as she was scared to be on her own. Although Safta had told the police that she would not go to their place of work, she would attend to work but in a different area to Alexandru so that they didn't have to meet. She said that they both wanted to work as they needed the money due to having lost so much through the business being closed due to Covid-19.

15.13 Tanta stated that both herself and Safta carried out research on the internet and that she had also spoken to some of her school work colleagues about what to do in relation to domestic abuse taking place within the household (during Tanta's time working within a school). Tanta found and was given names of organisations that could offer help and support to Safta including help for females from a Romanian background. Safta had stated that she didn't want to move out of her house and that she didn't want to go to a hostel as she felt that that would scare child A. She said that Safta was happy when Alexandru was bailed not to live at their home address. This was identified by the panel as an example of the good training that takes place in schools in relation to highlighting domestic abuse and the support mechanisms available

15.14 Tanta was asked about the impact of being a Romanian national living in England and whether that had had any impact on Safta reporting any domestic abuse earlier. Tanta stated that Safta had faith in the police and the way they would support her and also in the courts which is why she took out the non-molestation order and also called the police to report the assault. She believed that Safta hadn't done any of these things any earlier as she had wanted to keep her family together and that they were private matters which she could cope with. She had only gone to the authorities when she had become scared.

15.15 Tanta felt that her father did not take domestic abuse seriously because "in Romania professionals do not take domestic abuse as seriously, as it is thought of more as a family matter". Alexandru did however start to take the

matter seriously after he was arrested for the assault on Safta and had expressed concerns that he felt that he would go to prison. The police panel member identified that a part of their processes when working with people from diverse backgrounds was to explain the UK legal system to all victims and perpetrators of DA and the impact of the legal system.

15.16 Information from Alexandru's new partner.

15.17 The report writer also spoke to the receptionist of Alexandru's and Safta's business, who witnessed the death of Safta. She confirmed that she had been in a relationship with Alexandru and that they had been together for about 18 months. She stated that she believed that Safta knew that herself and Alexandru were in an intimate relationship although it wasn't spoken about and everyone acting as if everything was fine. She stated that she did not witness any aggression between Alexandru and Safta but described an underlying feeling of resentment. She was aware that Alexandru had been arrested on suspicion of assaulting Safta and that he was on bail not to contact her.

15.18. She stated that after Alexandru's arrest they spent a lot of time together in hotel rooms as he was not allowed to go back to the family home, which he resented. Alexandru was very upset at being arrested and stated that it was Safta trying to get back at him. He had described feeling very claustrophobic and that he couldn't take being locked up. The female stated that at no time did she feel scared or intimidated by Alexandru and that he never mentioned harming Safta or himself. She did identify that Alexandru had started drinking a lot of alcohol after the arrest which is something he hadn't previously done due to his diabetes. She said that she had encouraged Alexandru to leave the relationship if he wasn't happy and to find a way forward but that he told her that he was stuck in the relationship.

15.19. She described the fact that both Alexandru and Safta continued to work together but that they made sure that they weren't having any contact with each other due to Alexandru's bail conditions. She stated that if one of them came into a room the other one would leave and that they did not speak to each other. She stated that she believed that Alexandru feared being arrested again.

16. Agencies involvement

16.1 During the timeframe covered by the review Safta attended East Kent Hospital University Foundation Trust on four occasions in relation to chronic rhinosinusitis[8] with nasal polyps. She underwent surgery for septoplasty[9] and FESS[10]. Safta's medical condition related to severe allergies.

16.2 On the 16th February 2022 Safta was granted a non-molestation order, remotely, by the Deputy District Judge at the Family Court. The order was due to expire in February 2023. The application for an occupation order and a non-molestation order was listed for a face to face directions/ground rules hearing in the family court in September 2022.

16.3 On the 26th of March 2022 Safta contacted the Police stating that her ex-partner Alexandru, had entered her room where she was sleeping with her child and had woken her. He was threatening to take his own life and at the same time refusing to leave and was touching her. Safta identified to the Police allegations of physical and sexual abuse on her including coercive controlling behaviour, over several years.

16.4 Alexandru was arrested and interviewed but denied any offences. He was released from Police custody on conditional bail whilst the investigation continued. The bail conditions prevented Alexandru from going to the home address. The bail conditions did not restrict Alexandru from going to the work address as Safta stated that she would not go to the joint workplace to ensure that Alexandru wasn't prevented from working.

16.5 On the 26th March the school where child A was a pupil received an Operation Encompass[11] safeguarding notification from the Police in relation

[8] **Rhinosinusitis** (including nasal polyps) is an inflammatory condition of the nose and paranasal sinuses.

[9] Straightening of the nose bone and cartilage.

[10] Enlargement of the sinus.

[11] To facilitate the lawful exchange of information in order to comply with the statutory duty on chief police officers to safeguard children. This is a multi-agency procedure to identify and provide appropriate early intervention support to a child who has been involved in an incident that present a safeguarding concern to that child.

to an allegation of historical physical and sexual abuse against Safta by her partner Alexandru. The school records receiving the notification but there are no further notes detailing what action took place.

16.6 On the 1st April Safta provided an Achieving Best Evidence (ABE) interview during which she reported a lengthy history of sexual abuse, rape, physical assaults and coercive controlling behaviour taking place over several years. An Independent Sexual Violence Advisor (ISVA) referral was agreed, and a referral was made.

16.7 Later in April Police received a call from an employee of the business owned by Alexandru and Safta stating that her boss Alexandru had stabbed Safta and was still inside the premises. Officers attended to find both Alexandru and Safta deceased.

17. Overview of agencies involvement

17.1. Various health agencies were contacted prior to the commissioning of the review to establish their involvement. They had little to no involvement, hence only EKHUFT featuring in the review. However there was no pertinent learning to be found in their involvement. Paragraph 16.1 states ' During the timeframe covered by the review Safta attended East Kent Hospital University Foundation Trust on four occasions in relation to chronic rhinosinusitis with nasal polyps. She underwent surgery for septoplasty and FESS. Safta's medical condition related to severe allergies'. EKHUFT's contact with Safta was mainly due to her planned nasal operations surrounding severe allergies. It was discussed within the IMR as to whether professionals should have considered domestic abuse in relation to Safta's attendance at hospital for elective surgery however, it was identified through a letter received that Safta had been suffering from long term, serious allergies which was believed to be the cause.

17.2. EKHUFT had the following policies and procedures in place at the relevant time: Domestic Abuse During Pregnancy; Domestic Abuse Referral Pathways; and People at Risk Policy (Safeguarding Vulnerable Adults inc. Domestic Abuse). The Domestic Abuse During Pregnancy Policy included routine enquiry. There were two opportunities for professionals to consider

the use of professional curiosity where further explorations of potential domestic abuse could have been considered. There was the potential need to rule out the possibility of domestic abuse in relation to the nature of and circumstances of what may have caused the problems with Safta requiring interventions to resolve ongoing issues with her nose, where she was seeking corrective surgery for this in the form of septoplasty. With regards to Alexandru, he was cited on 2 occasions as being anxious and had taken more Metformin than prescribed resulting in him being unwell, and whether this would have been recognised as a form of self-harm and attempts to determine whether this had been deliberate or not determined.

17.3. EKHUFT now has a new Domestic Abuse Policy (Staff & Patients), published in 2023, which includes routine enquiry; a protocol of routinely asking (when safe to do so) questions related to Domestic Abuse e.g. out patients appointments, Accident & Emergency Attendance and to consider the use of professional curiosity and what this would look like for professionals. Hospital IDVAs are available at two of the trusts hospitals. They would have been available had there been a concern regarding DA.

17.4. **Kent Police**

17.5. Kent Police had one report from Safta of domestic abuse within their relationship.

17.6. On the night of Police involvement Safta reported that Alexandru had entered the bedroom where she had been sleeping with their child and was threatening to take his own life and at the same time refusing to leave the room and had started touching her. It was also identified that Safta had a non-molestation order in place against Alexandru which she had taken out a month earlier.

17.7. Police officers attending the home address completed a Domestic Abuse Risk Assessment (DARA). The assessment was recorded as medium risk. The risk level was discussed with an inspector who agreed that medium risk was appropriate.

17.8. In providing answers to the DARA risk assessment Safta stated that she was very frightened of Alexandru and stated that it was very likely that he would

seriously harm her. Safta reported that she had recently told Alexandru that she had been intimate with another man in an attempt to get him to understand that the relationship was over. She told officers that she hadn't been but that was the reason for telling Alexandru that lie.

17.9. Safta also disclosed to officers that early in their relationship Alexandru had told her that if he was ever arrested or entered into another relationship that he would cut her head off.

17.10. Although the risk surrounding Safta was assessed as medium it was identified that officers should have taken into consideration the fact that Alexandru had previously stated that he would cut her head off, had indicated suicide ideation, recent separation, and the recent non-molestation order. Safta was offered a referral to the ISVA service and Victim Support.

17.11. Alexandru was arrested by Officers on suspicion of both physical and sexual assault and breach of the non-molestation order. Upon being arrested Alexandru denied all allegations of both physical and sexual abuse and was released on conditional bail whilst the investigation continued. The bail conditions prevented Alexandru from going to his home address which it was identified that the non-molestation order had allowed him to do. It appears that the bail conditions were discussed with Safta who asked the Police not to place a condition on Alexandru to prevent him from attending the work address to ensure that Alexandru could continue to work. Safta informed the Police that she would stay away from the business during the investigation and whilst Alexandru was on police bail. However, this does not appear to have happened and Safta returned to work in the business. This was discussed by the panel in relation to the impact that continuing to work together might have had upon Safta and whether the level of risk was discussed with Safta. It was accepted that Safta wouldn't go into work however there does not appear to have been the discussion in relation to the economic impact that this might have had upon her. Was the question regarding financial dependency asked and was consideration given to the fact that Safta would need to work to continue to support herself and her child? Economic abuse is a highlighted form of domestic abuse and is often used by perpetrators to control their partners. Safta did identify to the police

that Alexandru would often deny her access to money and controlled what she could spend her money on.

17.12. Tanta identified that the pandemic had impacted on both of them financially as neither Alexandru nor Safta were able to work as their business had closed due to the restrictions. Tanta stated that Safta wanted Alexandru to continue working so that they could start earning money again for the family. Safta had recently started an additional add on to the business as a way to keep her removed from Alexandru and to bring in her own money. Tanta believed that her father needed Safta in the business more than she needed him. It appears that Safta did everything in the business, making the appointments, all the finances and had started up a new branch of the business which was financially stable. Tanta identified that after the separation Alexandru became more removed from the business, he wouldn't go into work as much, would take on less appointments and appears to have given up.

17.13. An ABE interview took place with Safta six days after Alexandru's arrest. During the ABE interview with Safta, Safta identified that she had been subjected to several years of both physical and sexual abuse at the hands of Alexandru. She also identified that she had been living in a controlling coercive relationship. The risk assessment was completed with Safta at the time that Alexandru was arrested however, the risk assessment was not re-assessed following the ABE. It is identified that if the risk assessment had been looked at again then the level of risk might have been raised as significant long-term abuse had been identified. The Detective Chief Inspector within the Victim Investigation Team identified that investigation officers within the unit should be assessing all new information that comes into their investigation for the impact upon risk and responding to that risk where appropriate. He identified that they do not re-run the DARA or follow up with a DASH[12] assessment. It is significant that the risk assessment was not reassessed after Safta completed her ABE interview as this may have led to the creation of an action plan and potentially adding further safety precautions for Safta and her family. The DASH is used by agencies to identify a shared understanding of risk in relation to domestic abuse, stalking and honour-based violence.

[12] Domestic Abuse Stalking and Honour Based Violence.

17.14. Tanta also provided police with a statement in relation to the night that Alexandru was arrested. After the ABE interview with Safta the police provided her with safeguarding advice and a referral was agreed for an ISVA. The ISVA contacted Safta and agreed an appointment five days later. It was identified that security measures were in place at that time. The ISVA contacted Safta at the agreed time and date but there was no answer, so a message was left for Safta to contact the ISVA. This was shortly before Safta's death. The panel raised concerns as to why a referral had not been made to the IDVA service at the time of Alexandru's arrest and it was identified by the police panel member that Safta was identified as medium risk and that a IDVA referral is only automatically made when the risk assessment identifies high risk. The officer attending can however make a referral if they feel it is appropriate.

17.15. It was identified that a Sexual Assault Referral Centre referral was not made by the police. Beech House SARC[13] offers a comprehensive service for adults and children in Kent and Medway who have experienced sexual violence or sexual abuse. Individuals will be offered support and guidance as well as medical assessments, treatment, a forensic examination, and the opportunity of aftercare referrals for support services. The panel discussed the reasons why a SARC referral might not have been made and believed it was because practitioners might think that the SARC was used for the gathering of forensic evidence and not to signpost for support and guidance. This was identified as a possible gap in knowledge.

17.16. **Education Safeguarding Service**

17.17. Safta was described by staff at child A's primary and secondary schools as a friendly and committed mother. Staff had contact with Safta and described child A as being Safta's 'number one priority'. She was seen to be very loving and attentive towards them.

17.18. Alexandru was also noted to be actively involved with child A, collecting them from school and would jointly attend in-person events at the school, such as school performances which they were a part of.

[13] https://www.nhs.uk/services/service-directory/beech-house-sexual-assault-referral-center-sarc/N10935090

17.19. Neither school attended by child A had any safeguarding concerns regarding them until the secondary school received an Operation Encompass notification from Kent Police. Although there are no recorded notes detailing the action taken by the school the Education Safeguarding Service's IMR identified from discussions with staff that they felt talking to child A in relation to the DA incident would be more disruptive as they were unclear what they knew about the DA within their parent's relationship. No behaviour concerns or changes were noted with their behaviour whilst they were in school. It was decided that the notification would be shared with the Designated Safeguarding Lead team to monitor child A. This was identified as a missed opportunity and may have resulted in stronger action being taken by the schools.

17.20. **East Kent Hospitals University Foundation Trust**

17.21. EKHUFT's contact with Safta was mainly due to her planned nasal operations surrounding severe allergies. It was discussed within the IMR as to whether professionals should have considered domestic abuse in relation to Safta's attendance at hospital for elective surgery however, it was identified through a letter received that Safta had been suffering from long term, serious allergies which was believed to be the cause.

17.22. Contact with Alexandru was in relation to him not taking the correct diabetic medication, his diet and blood sugars.

17.23. On two occasions, when Alexandru had attended hospital, he was identified as being anxious and had taken too much of his Diabetes medication than prescribed resulting in him being unwell. Practitioners did not consider whether this was in fact non-accidental, or a form of self-harm and questions were not asked.

17.24. It was discussed that at the time EKHUFT did have a DA policy however, it was only relevant to pregnant women. The new DA policy is now in place and covers all patients.

18. Analysis

18.1 This part of the review will examine how and why events occurred, information that was shared, decisions that were made and actions that were

(or were not) taken. It will consider whether different decisions or actions may have led to a different course of events.

18.2. Research and surveys of victims indicates that the risk of further violence and harm actually increases at the point at which a victim leaves a perpetrator[14]. A study of 200 women's experiences of domestic abuse commissioned by Women's Aid found that 76% of separated women had experienced post-separation verbal and emotional abuse and violence, including:

- 41% subjected to serious threats towards themselves or their children;
- 23% subjected to physical violence;
- 6% subjected to sexual violence; and
- 36% stated that this violence was ongoing.

18.3. For 60% of the women in the study, fears that they or their children would be killed by the perpetrator had motivated their decision to leave the abusive relationship. There is evidence that the risk of domestic homicide is increased post-separation.

18.4. A research project which took place by Liverpool John Moore University 2021[15] highlighted that 40% of victims of homicide had separated from their partner or were about to, with 24% experiencing stalking and harassment from the perpetrator. 11% of victims had begun a new intimate relationship. 25% of victims feared for their safety and 13% were actively seeking help at the time of the homicide. About 11% of perpetrators had contact with the criminal justice system, with 7% having recorded violations of court orders, 14% of perpetrators had harmed or threatened to harm others, and 12% had threatened suicide or were demonstrating suicidal thoughts.

18.5. In 76% of cases, services were involved with the victim and/or perpetrator at the time of the homicide. Most common were primary care services and the police. In 46% of cases, at least one of the services was aware of domestic

[14] https://www.leeds.gov.uk/docs/Domestic Violence - Risk at the point of separation.pdf
[15] https://researchonline.ljmu.ac.uk/id/eprint/16172/11/Risk factors for Intimate Partner Homicide in England and Wales.pdf

abuse in the relationship. In 28% of cases, family or friends of the victim were aware of the abuse. In 51 of the cases, a risk assessment was carried out for the victim, with the majority being classed as medium risk (39%), 13 (25%) as high risk, and 11 (22%) as standard. The classification of risk was not reported for 7 cases (14%). 24 of these cases (47%) were referred to Multi-Agency Risk Assessment Conferences (MARAC).

18.6. Coercive and control questions are within the DARA however, it appears that Officers didn't recognise the threats made to Safta during their relationship as being an indicator of a high-risk situation and did not identify the sudden shift in power within their relationship once Safta had reported the abuse. Alexandru being arrested was also not recognised as being high risk. Officers did not consider the impact that these changes might have had on Alexandru's behaviour and how he would possibly react to losing control over Safta.

18.7. The Police IMR writer identified within their report that the evidence gained during the investigation indicated that Alexandru believed that he had a 'right' to Safta as she was his wife and could not accept that the relationship had ended. The possibility of economic abuse within the relationship does not appear to have been taken into consideration nor the impact on Safta of not working. Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence, and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. 1 in 7 women in the UK has experienced economic abuse by a current or former partner[16]. The DARA risk assessment is designed and used by officers to try and identify risks which include the financial implications there might be for the victim of domestic abuse. Within the DARA risk assessment Safta identified that she was often denied access to money and that Alexandru controlled what she was allowed to spend her money on. Safta had agreed not to go to the workplace as she wished Alexandru to continue to work so that he could support the family. This should have been viewed as an area of control over Safta by Alexandru and further questions should have been asked of Safta. Consideration should have been given as to how Safta was going to be able

[16] https://survivingeconomicabuse.org/what-is-economic-abuse/

to support herself and her child and how this would impact upon their safety. The impact of Safta working closely with Alexandru and the loss of an income was not identified as a risk factor.

18.8. The panel discussed the appropriateness of the risk assessment following the information received from Safta. The police panel member identified that the DARA risk assessment is completed in the first instance but following the ABE interview completed by Safta a few days later, a second follow up DASH risk assessment has been identified as good practice. This might have heightened the level of risk identified by Safta as the Police would have been aware of the long history of abuse and coercive control behaviour by Alexandru. Having viewed the DARA risk assessment, the report writer believes that the risks identified by Safta to the officers at the time of Alexandru's arrest were not considered seriously enough. The DARA risk assessment identified that Safta was very scared of her husband and what he would do if she supported a police prosecution. This together with the fact that it was identified that he had made previous threats to take his own life and threatened to chop her head off should have raised significant concerns to the officer. The police need to consider the impact of both the DARA and DASH risk assessments to assure themselves that they are being used correctly and not just as a 'tick box exercise'.

18.9. DARA risk assessments were introduced throughout Police Services in 2022. The DARA was developed by the College of Policing[17] and was implemented with a focus on making it easier for frontline responding officers to identify coercive control and to make better informed risk assessments. The review by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) identified that many officers focused on the current incident, especially physical violence, and injury, as opposed to identifying ongoing patterns of abuse. The College of Policing's published guidance for DARA identified that the DARA was designed and evaluated for use by first responders and that Specialist police officers and staff conducting secondary risk assessments are expected to continue by using the DASH risk assessment.

[17] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

18.10. Although the DARA risk assessment identified Safta as medium risk a referral to the ISVA or IDVA was not made at the time of the allegation but following the ABE interview which took place a short while later. An automatic IDVA referral will be made by the police on every high risk assessment, but it would only be made on medium if the attending officer thought that it was required. Safta was identified as a medium risk at this time. The ABE interview took place within an acceptable timeframe with safeguards having been put in place by the use of bail conditions to protect Safta. However, it was emphasised that referrals of medium risk individuals can be made to community outreach services which could have perhaps led to a DASH risk assessment being done quicker.

18.11. Research carried out by Dr Jane Monckton Smith looked at hundreds of cases of intimate partner homicide through interviews with bereaved families and public protection professionals. Through her study, published in the Violence Against Women Journal (VAW)[18], Dr Jane Monckton Smith, Senior Lecturer in Criminology at the University of Gloucestershire[19], found an emerging pattern that could be broken down into eight separate stages.

18.12. Information obtained throughout the review identified the significance of these stages and the level that these were reached throughout the relationship between Safta and Alexandru.

18.13. Stage one is a pre-relationship **history** of stalking or abuse by the perpetrator. Already identified by Tanta was the fact that the relationship between her mother and father (Alexandru) was a volatile relationship involving domestic abuse and the fact that Alexandru had affairs throughout their marriage.

18.14. Stage two is romance developing quickly into a serious relationship. This appears to have taken place within Safta and Alexandru's relationship. They met whilst Safta was working in a shop next to Alexandru's business in Romania. Shortly afterwards they started a relationship and Safta then went to live with Alexandru in his home.

[18] Launched in March 1995, *Violence Against Women* is a peer-reviewed, scholarly journal that focuses on gender-based violence against women in all forms and across cultural and national boundaries.
[19] https://eprints.glos.ac.uk/7797/1/Homicide.jpg

18.15. Stage three identifies that the relationship becomes dominated by coercive control. Safta painted a picture to the police during her ABE interview of a long history of sexual and physical abuse and a coercive controlling relationship. She was expected to carry out the 'duties of a wife' including looking after the house and their child. Tanta also identified that Safta was unable to go out on her own and that Alexandru restricted her movements and friendship circle. He controlled her by restricting the amount of money that she made and by taking money off her from her work. Another example of control was within the business where Alexandru would identify the clients that he wished to deal with and gave the least interesting work to Safta.

18.16. Within those stages, stage 4 is identified as the **trigger stage** when risk starts to increase. It is when something happens to challenge the control the perpetrator has or challenges their status. The most significant trigger noted internationally is separation or its threat. Perpetrators have been guarding against separation, and see it more as outrageous or unacceptable, than heart breaking.

18.17. The risk to Safta from Alexandru had escalated following the police report and his subsequent arrest. The information from Safta is that she had been subjected to both physical and sexual abuse at the hands of Alexandru throughout a great deal of their relationship and this had not previously been reported to professionals. The control that Alexandru had over Safta had suddenly been taken out of his hands and the relationship had changed which is an indicator of escalation of risk. Safta had also made the decision a short while earlier to report the abuse to a county Judge to obtain a Non-Molestation Order. This again would have reduced the level of control that Alexandru had over Safta as she was now taking action to withdraw from him. These actions highlight the risk to Safta and do not appear to have been considered in the risk assessment.

18.18. Stage Five of the Homicide Cycle is **escalation**. In this stage, the reduction in control prompts some perpetrators to seek to try to regain it. They may increase controlling patterns, or use violence, they may threaten suicide or homicide, and they may beg and cry. Some will switch between all of these. Threats at this stage should be taken very seriously. Even small

threats, when acted on, show a clear escalation in risk and threat. Alexandru is identified as having followed Safta when she stayed in hotels and leaving flowers on her car. He had also made threat of taking his own life to Safta.

18.19. Stage six is where the perpetrator has a **change in thinking**, where they choose to move on, either through revenge or homicide.

18.20. Following Alexandru's arrest Tanta identified that Alexandru's behaviour became more erratic and concerning. She stated that she would meet Alexandru and that they would go for a drive. She indicated that she became concerned about his behaviour and even envisaged that he would crash the car and kill himself. Tanta stated that she became terrified that Alexandru would do something to himself and possibly to others as well. Tanta stated that she had spoken about her concerns to her mother, who then tried to have a conversation with Alexandru over her concerns. Tanta identified that Alexandru was terrified that when he returned on police bail, they would lock him up and wouldn't let him out.

18.21. Stage seven is the **planning** stage where the perpetrator might buy weapons or seek opportunities to get the victim alone. It has not been established whether the knife used by Alexandru was specifically brought into the business for the sole purpose of killing Safta however, Alexandru knew the weapon was available and is believed to have placed it there for the purpose of killing Safta.

18.22. Stage eight is the ultimate **homicide.**

18.23. The Police receive a significant amount of training in relation to domestic abuse and coercive controlling behaviour. The training informs Police on how to identify abusive behaviour and the robust mechanisms that are in place to deal with any potential offences. The Police are also taught about appropriate safeguarding and the importance of IDVA/ISVA referrals, Victim Support and referrals to MARAC. What appears to be missing is the level of academic training that the police receive which highlight the significance of offender behaviours and the impact that these behaviours can have on the safety of the victim. The Police IMR writer identified that

the sudden shift in power in the relationship once Safta had reported the abuse and Alexandru was arrested was not recognised as being a potential indicator of a high-risk situation. The specific threat made by Alexandru to Safta early in their relationship was also not recognised as being an indication of a high-risk situation.

18.24. Within the Police's IMR they identify that in 2017 they introduced a new policing model which has a focus on delivering a quality of service placing vulnerability at the heart. This model introduced the Vulnerability Investigations Teams (VITs). The VITs provide specialist investigative response to domestic abuse, vulnerable children and vulnerable adults.

18.25. A new role of Domestic Abuse Liaison Officers (DALO) are looking to be introduced within the near future. These officers are being looked at to provide a more consistent and coordinated role to supporting and safeguarding victims of domestic abuse. The DALOs will carry out bespoke victim needs assessments and maintain contact in accordance with victim's needs and wishes. It is recommended that staff within the VITs are trained to a high standard in relation to the published research surrounding both victims and perpetrators of domestic abuse which can then enhance the level of risk assessments and support provided.

18.26. The Domestic Abuse Act 2021 came into force in April 2021. It is significant as it was amended to recognise children as victims of domestic abuse in their own right. The Act acknowledges the substantial impact on children, which includes '[harm] to emotional and psychological wellbeing as well as effects on education, relationships, risky and harmful behaviour and housing and accommodation' (Wedlock & Molina, 2020). A child is now considered a victim of domestic abuse when they witness, hear or experience the effects of domestic abuse and are related to the victim or perpetrator of the abuse. This is a positive step forward, as legal recognition of children as victims of domestic abuse should:

- give children greater protection through Domestic Abuse Protection Orders
- enable professionals to take action to protect children at risk of domestic abuse

- help authorities ensure there are specialist domestic abuse support services for children and young people.

18.27. The National Centre for Domestic Violence reported in 2020 that in 2019 there were 2.4 million adults who were victims of domestic abuse. (1.7 million women and 699,000 men). 20% or 1 in 5 children have lived with an adult perpetrating domestic abuse[20].

18.28 Research strongly suggests that the sort of response a family experiencing domestic abuse receives from professionals depends on the sector those professionals are working in. Marianne Hester (2011)[21] describes the areas of domestic abuse, child protection work and child contact work as 'three planets model'[22], each 'with their own separate histories, culture, laws, and populations (sets of professionals)'.

- the domestic violence planet, where domestic abuse is considered a crime. The perpetrator's behaviour is recognised by the police and other agencies as being abusive and action is taken against the perpetrator.
- the child protection planet, where victims and survivors are expected to remove themselves and their children from the perpetrator and keep them safe; and
- the child contact planet, where a victim or survivor who has tried to protect their child by calling the police and removing themselves and their child from the relationship, is now ordered to allow contact between the perpetrator and the child.

18.29. What this means is that each "planet" looks at the problem in a different way, and in turn their responses differ from one another's. Hester describes 'how, bouncing between these planets, are women and children who find inconsistency and contradictions; just the type of environment in

[20] https://www.ncdv.org.uk/domestic-abuse-statistics-uk/ - :~:text=20%25 or 1 in 5 children have lived,to experience DA than at any other age.
[21] http://www.bristol.ac.uk/news/2009/6703.html
[22] https://www.scie-socialcareonline.org.uk/the-three-planet-model-towards-an-understanding-of-contradictions-in-approaches-to-women-and-childrens-safety-in-contexts-of-domestic-violence/r/a1CG0000000GYCGMA4

which perpetrators can hide and abuse'. According to Hester, stopping families falling into this 'black hole' between planets requires much closer and coherent practices across the three areas of work, with understanding of professional assumptions and practices and those of other professional groups. For children's services, it means taking into account not just that work on domestic violence requires intervention with victims, children and perpetrators, but that the most effective way of doing this is to team up with practitioners on the 'domestic violence planet', who have extensive experience of work with both victims and perpetrators, and with practitioners on the 'child contact planet' to integrate further a common response to women's and children's safety as well as understanding the implications of domestic abuse on contact arrangements.

18.30. Adverse Childhood Experiences (ACEs) are traumatic events that occur during childhood and can have lasting impacts on an individual's physical and mental health, as well as their general well-being. Examples of ACEs include physical, emotional, or sexual abuse, neglect, parental divorce, living with someone who abuses drugs or alcohol, exposure to domestic violence, and losing a parent through divorce, death, or abandonment.

18.31. According to research[23] ACEs can cause toxic stress that can change brain development and affect how the body responds to stress. ACEs can increase the risk of certain health problems in adulthood, such as cancer and heart disease, as well as increasing the risk of mental health difficulties, violence, and becoming a victim of violence. It is important to note that experiencing ACEs does not guarantee an individual will develop health problems or engage in risky behaviours. However, it is essential to recognise the impact of ACEs on individuals and provide them with appropriate support and resources to help them overcome these experiences. The impact of domestic abuse taking place within the household on child A was not considered by agencies and the appropriate support was not put in place. It would be beneficial for professional to receive training on ACEs and how experiences can be impactive on them.

[23] https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

18.32 Non-molestation Order

18.33 The fact that Safta applied and received a non-molestation order from the Courts was discussed within the Panel meetings and whether Covid-19 had impacted on Safta obtaining the order. This does not appear to have been the case and it was highlighted that the Family Court had made good use of technology during the Covid-19 restrictions and had continued conducting their hearings remotely. This was identified by the panel as good practice. The non-molestation order was made against Alexandru on the 16th February 2022 ordering Alexandru to not use or threaten violence against Safta or encourage or in any way suggest that any other person should do so. Alexandru must not intimidate, harass, or pester Safta and must not go to, enter or attempt to enter any property, apart from their home address, where he believes or knows that Safta will be staying for a period of one night or more, and must not go within 10 metres of it. Two face to face hearings were also set for the 13th September 2022 and the 25th October 2022. It was identified that Safta petitioned the court for the order herself and not through a solicitor.

18.34 Tanta stated that during the Family Court hearing for the non-molestation order Alexandru refused to talk to the Judge and although Safta had initially asked for the order to be for six months the Judge had extended it to twelve months due to Alexandru's behaviour. No agencies were aware of the fact that Safta had been awarded a non-molestation order by the Family Court and the Panel discussed whether it would have made any difference to agencies had they been aware of this fact. The Panel felt that this would not have impacted on agencies responses as they would have treated any allegation of DA as serious. The panel felt that once aware of DA within the relationship the knowledge of a non-molestation order would have been significant as it would have provided them with more information and for the police more powers to deal with Alexandru as a perpetrator. The police identified that they were made aware of the non-molestation order and its breach upon arriving at the family home by Safta.

18.35 Operation Encompass

18.36 The Operation Encompass notification received by the school noted that child A was 'present' during the domestic abuse incident but that they had

not witnessed it. The Designated Safeguarding Lead (DSL) for the school shared the notification with the DSL team to monitor child A and filed the information. The school had no identified safeguarding concerns for them at this time.

18.37 The IMR author viewed that the school lacked professional curiosity in exploring the DA issues further with Safta. Best practice identified would have been to make direct contact with Safta to offer support and guidance and to signpost to appropriate support services. However, within the Operation Encompass notification is contained the statement that "All safeguarding will have been completed with the family and child/ren by Police and partner agencies. If you have any concerns for the child, please follow your usual safeguarding procedures'.

18.38 Schools' records must be reflective of the decisions made in relation to pupils within their schools and as such all records must accurately reflect not only any action taken, but also the decision-making process for either taking or not taking any action and how this has been assessed. The IMR author has identified this within their internal recommendations.

18.39 In relation to not discussing the domestic abuse incident with child A, it is the IMR authors view that not speaking to them did not allow for any concerns that they may have had to be explored further and was a missed opportunity for appropriate advice and support to be offered.

18.40 Highlighted within the IMR was the lack of detail in Operation Encompass training and guidance for schools in respect of actions they should take when they receive a notification. It would be beneficial for the guidance to schools surrounding Operation Encompass to clarify that schools must continue to follow their usual safeguarding procedures upon receipt of a notification. The panel discussed the training behind Op Encompass and agreed that all agencies would benefit from up-to-date awareness training surrounding their responsibilities.

18.41 Services for EU Nationals who are victims of domestic abuse

18.42 The Kent Police have published a YouTube video[24] in relation to the support available for victims of domestic abuse and advice on how to access that support. This video is also accompanied with subtitles in several languages, including Romanian, and is a good means of providing advice and support to victims of domestic abuse.

18.43 Although it was identified that support is available for victims of domestic abuse from several arenas within the County of Kent and Medway there is limited specific support targeting those from a non-British background. One example is work taking place in Canterbury by 'emic'[25] (Ethnic Minorities in Canterbury) who offer support and advise across a variety of issues including domestic abuse. Emic were involved in a raising awareness campaign in relation to domestic abuse in 2022 highlighting areas of available support and also encouraged communities to become domestic abuse champions and highlighting the 16 Days of Action against Domestic Abuse campaign. This is encouraging but again is limited to people searching and accessing the website for support and advice.

18.44 The Independent report writer highlights that more targeted work is required to raise awareness of domestic abuse within those hard-to-reach communities to highlight what domestic abuse is and areas where support is available. Agencies should consider various methods to provide outreach in their communities and to provide the information, help and support needed in the appropriate format.

18.45 Identified within the EKHUFT IMR was the fact that Alexandru attended the hospital on four occasions in relation to his diabetes and his non-management of medication. Details were recorded which identified language barriers and Alexandru presenting as being 'confused.' On occasions it was identified that Alexandru had attended with Safta and that Safta had provided support with language issues, which is not recommended practice. Provisions are available for patients to use the translation service available by the hospital. A single agency recommendation has been identified within the EKHUFT IMR.

[24] https://www.youtube.com/watch?v=QPN0ci0l2E4&list=PLcvqogtWXwi-eAE3YxwMbVfOXPcUuHW9H&index=7
[25] https://emic.org.uk/

18.46 **The impact of age on domestic abuse.**

18.47 In the context of Alexandru and Safta's relationship, there was a 19-year age difference, which may have been a factor. There is limited research available on this subject, but a study in 2004[26] revealed that there was a heightened risk of intimate partner homicide where there was an extreme age difference. It is however, identified that an age gap between partners in a relationship is not the cause of the domestic abuse taking place. The age gap between Alexandru and Safta appears to have been used by Alexandra as an imbalance of power and intimidation.

18.48 Tanta described an imbalance in power within Alexandru and Safta's relationship. She put a part of this down to Alexandru believing that he was the head of the household the 'dominant male' but also partly due to the age gap between them. It was felt that Alexandru believed that as the elder he had the right to make the decisions. Alexandru's diagnosis of diabetes might also have impacted upon their relationship due to the fact that Alexandru became limited in the amount of alcohol he could drink and as such restricted the amount he went out. However, Safta still wanted to go out and have a good time which was frowned upon by Alexandru.

18.49 Homicide and suicide

18.50 There is limited research into homicide followed by suicide. Figures published in 2022[27] identified 16 incidents in England and Wales. Most perpetrators are male, most victims are female, usually a partner or ex-partner. Homicide-suicide is less than 1% of all suicides.

18.51 An article published in April 2016[28] showed that the incidents of homicide-suicide were commonly preceded by relationship breakdown and separation. 62% of the perpetrators had mental health problems. A quarter of the perpetrators visited a GP for emotional distress within a month of the incident and self-harm and domestic abuse were common.

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26 https://www.researchgate.net/publication/8100312_Couple_Age_Discrepancy_and_Risk_of_Intimate_Partner_Homicide

27 https://sites.manchester.ac.uk/ncish/reports/

28 https://link.springer.com/article/10.1007/s00127-016-1209-4

18.52 Explanations as to why people commit these acts includes jealousy and revenge following real or perceived infidelity and relationship breakdowns, altruism or mercy killing, financial problems and mental disorder. The most common circumstances were the loss of a close personal relationship either through imminent separation or divorce. Most offenders had previously exhibited difficulty coping with emotional distress, resulting in violence and aggression or self-harm.

18.53 The study found that the majority of perpetrators of homicide-suicide were middle-aged white males, who had recently experienced a relationship breakdown. Domestic abuse was found to be an important factor of the cases, with over a third of offenders having previously assaulted a partner.

19. Conclusion

19.1 Safta was a hard-working mother who was sadly murdered by her husband who then took his own life. The was a significant change in the relationship between Alexandru and Safta eighteen months before the murder and during that time Safta had taken steps to start to remove herself from Alexandru. She had started a new business so that she could have her own income and would be able to have more control over the work that she did. It was identified by Tanta that Alexandru was in charge of the business and as such he would pick and choose the jobs he wanted to do and would give the lesser jobs to Safta and other staff members. Tanta did however identify that over time Alexandru became reliant on Safta for the smooth running of the business as she was in charge of the majority of the activities within the business.

19.2 Tanta identified that Alexandru presented as the dominant one and as such others felt that they had to do what he said. This was felt to be partly due to Alexandru's age but also due to the fact that culturally he was identified as being in charge. Although Safta identified to the Police that she had been the subject of domestic abuse and coercive controlling behaviours over several years it appears that the problems escalated rapidly when Safta started to withdraw from their relationship and take control of her own life.

19.3 Alexandru had started an affair with another female and had put her into the business as the receptionist. This had caused a significant breakdown in Alexandru and Safta's relationship which she identified as being something she could not come back from. There are significant events throughout the last few months of Safta's life which highlight the shift in power and ultimately the heightened risk within the relationship. Safta had removed herself from the martial bed and was sleeping in the spare bedroom. She had started a new business, had taken out a non-molestation order and ultimately reported Alexandru to the Police, resulting in his arrest. These changes in circumstances in the context of domestic abuse highlight escalation points and stages which ultimately lead to Safta's murder and Alexandru's subsequent suicide. These stages link into the 8 step timeline highlighted by Dr Jane Monckton Smith[29].

20. Lessons and Recommendations

20.1 Police

20.2 It appears throughout the review that the police dealt with the allegation of assault and breach of the non-molestation order by Alexandru robustly. A DARA risk assessment was completed, and referrals were made to relevant support organisations. It is believed that the significance of some of the answers given by Safta were not fully understood and as such this impacted on the medium grading being given. The ABE interview with Safta has been highlighted as good practice resulting in Safta telling the police about her history of assaults and coercive controlling relationship.

20.3 Any risk assessment is a continuing and dynamic process and should be subject to frequent review to ensure it reflects any change in circumstances. Forces should be clear who is responsible at all times for the continuing assessment of risk. Identified as future learnings for the police is the need to refresh risk assessments upon the receipt of further significant information. The DARA risk assessment in this case was graded as a medium risk however this was following the initial information supplied by Safta at the time of Alexandru's arrest. The subsequent ABE interview provided a history of significant physical and sexual abuse over several years and a coercive controlling relationship. If a follow up risk DASH risk

[29] https://core.ac.uk/download/210991723.pdf

assessment had been completed this might have raised the risk to high. It must be recognised however, that Safta's death occurred a very short while after Alexandru's arrest and bail and therefore even if the risk to Safta had been escalated to high it is not thought that this would have had an impact on the outcome.

20.4 The DARA risk assessment was identified as being used by front line officers to help them identify coercive controlling behaviour and to help officers look at the bigger picture and not a snapshot of time. What needs to happen is that officers and their supervisors need to be aware of the significance of the answers provided by victims of DA. Further risk assessments, such as DASH risk assessments should also take place following receipt of all relevant information. DASH risk assessments usually take place by more specialist officers or other agencies.

20.5 Specialist staff would benefit significantly by receiving training accompanied by academic research which would enhance their role. This would highlight the risk factors identified within this review to reflect the impact that these risks have on intimate partner relationships.

	Recommendations for Kent Police	
1.	Kent Police to update their DARA risk assessment training to make sure that the training incudes the significance of the risk assessment questions and the impact that the identified risks have on victims. Referral pathways including non-commissioned services are to be highlighted to frontline staff so that they can provide suitable information at the initial stages of their involvement.	**Kent police**
2.	Initial DARA risk assessments must be updated or followed up by secondary DASH risk assessments following each stage of an investigation to make sure that the risk assessment accurately reflects the most appropriate risk. Dip samples must take place by Kent police to identify their staff are being compliant with the above recommendation.	**Kent Police**
3.	Specialist staff investigating domestic abuse, coercive controlling behaviour are to be provided with awareness raising on the risk factors identified through academic research and the impact that these risk factors have on a relationship including the link to homicide.	**Kent Police**

20.6 **Education Safeguarding Service**

20.7 Child A's schools received an Operation Encompass notification from the police in relation to a reported domestic abuse incident that had taken place at their home address. Within the report it indicated that they had been present in the house at the time of the incident but that they had not witnessed it.

20.8 The school made the decision not to speak to child A or Safta regarding the reported incident, instead deciding to monitor the child for any safeguarding concerns. The reasons for the decision making in the case was not recorded appropriately.

20.9 The emphasis of Operation Encompass is set out within the guidance that all schools received. It is in place to ensure that timely notifications of domestic abuse incidents are provided to school safeguarding leads and deputies. These notifications enable schools to provide appropriate support for children impacted by domestic abuse and to increase safeguarding for children by enhanced information sharing between schools and police.

20.10 The purpose of Operation Encompass is to assist in reducing the impact by supporting children affected by domestic abuse at school. The schools are advised not to be evidence gatherers or ask about the incident but simply be there for the children and provide support. Identified within the panel meetings was the fact that the Op Encompass training had taken place some time ago and that agencies would benefit from some refresher training in relation their responsibilities. This would include schools and certain Heath specialisms i.e., Health Visitors.

20.11 As there were no highlighted safeguarding concerns in relation to child A the report writer feels that the decision made to not speak to them or Safta was the right decision. Recorded within the Operation Encompass referral is a statement which identifies that safeguarding precautions had been put in place.

	Recommendations for Education Safeguarding Service and Op Encompass	

4.	Designated Safeguarding staff within schools to be advised that decision making processes must be recorded and the reasons for making the decision highlighted and shared appropriately.	**Education Safeguarding Services**
5.	Updated training to be provided to agencies including the Education Health Safeguarding Service and Health Visitors in relation to the responsibilities surrounding Op Encompass.	**Kent Police**

20.12 Domestic Abuse Strategic Board

20.13 There were highlighted areas of good practice in relation to support being offered to victims of domestic abuse. IDVAs are now based in hospitals which has significantly increased the referral rate for support and the timings of initial contact taking place.

20.14 The Kent and Medway Domestic Abuse Strategy was also highlighted as good practice where training has been provided to Judges within Family Courts surrounding domestic abuse and legal support is available for victims of domestic abuse within the family court. IDVAs are also being placed within Family Court to offer advice and support where required and to make sure that victims have not fallen through the net.

20.15 SATEDA[30] is a recognised charity that do targeted work throughout Kent and Medway offering support to victims of domestic abuse. The have developed a 'support to court' programme which is currently running and will be rolled out throughout Kent in this financial year.

20.16 Although it was identified that there are services available throughout Kent and Medway for Romanian Nationals there appears to be a gap in a more targeted approach. It is identified as good practice for counties to carry out a County Wide Strategic Needs assessment in relation to the different nationalities within their county and then to carry out gap analysis on the services being offered to EU residents. Targeted support can then be identified and tailored to meet the needs of the individual communities without expecting them to reach out themselves.

[30] https://sateda.org/

	Recommendations regarding EU Nationals resident in Kent and Medway	
6	The Kent and Medway Domestic Abuse and Sexual Violence Board to complete targeted work in relation to highlighting domestic abuse and signposting the support available for all residents of Kent, including those where English is not their first language.	**Kent and Medway Domestic Abuse and Sexual Violence Board**
7	When commissioning domestic abuse services, Commissioners to ensure the service specifications include the requirement for • services and information on services, to be accessible to all, including marginalised communities and (but not limited to) those from Eastern European communities. • delivery of appropriate, tailored support to meet the needs of minority groups, including, but not limited to those from Eastern European communities, including the provision of safe accommodation as required.	**KCC Commissioning, Medway Commissioning and PCC**

20.17 **Recommendations for all agencies**

	Recommendations for all agencies	
8	All agencies are to receive a briefing in relation to ACEs and the impact that adverse childhood experiences can have upon a child who is subjected to or present when domestic abuse to taking place within a household. Agencies to also have training in place on ACEs.	**Kent Safeguarding Children Multi-Agency Partnership, Medway Safeguarding Multi-Agency Partnership and the Kent and Medway Adults Board.**
9	A communication campaign to take place to highlight the services within the SARC in Kent and Medway to all frontline practitioners who may have contact with victims of sexual assaults, to reinforce the pathways of support available.	**Kent and Medway Domestic Abuse and Sexual Violence Board.**