



Domestic Homicide Review

Sasha

December 2023

Executive Summary

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Commissioned by: Kent & Medway Community Safety Partnerships

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Tribute

How can we convey in just a few words your life, who you were, and how life, agencies, and family let you down? You possessed resilience, strength, and a soul capable of tenderness and empathy for others, like Les the tramp who smelled awful, yet you always hugged, or the homeless person outside the local supermarket for whom you bought some beer, despite me suggesting a sandwich would be better, your response being, “not if you’re in his head.” You could sense others' grief, sadness, and loss of identity.

Sasha was failed by many, those who should have guided and supported her. I encourage you to reflect upon this - who holds accountability when individuals in supportive roles do not follow up, leading them to be lost in a system unprepared to aid? Sasha was abandoned, preyed upon by abusive and manipulative people, while her requests for help were ignored by the police, doctors, and counsellors. As I reflect on her cries for help, I feel ashamed, thinking I should have fought harder and raised my voice more, amidst widespread indifference from professionals. Please listen to our plea now and work to create a safer future for many others like Sasha, holding agencies responsible to the people they are meant to assist.

Sasha’s loss has deeply broken our hearts, taken away by a society and system that shirk responsibility due to claimed complexity, numerous issues, and lack of available beds. Sasha tragically succumbed to community COVID, which is particularly devastating because her death could have been prevented in the short term had a rehabilitation bed been found, and we could have had more precious time with her. She was a mother, a sister and my beloved daughter. She is now gone in body and mind but remains with us in spirit. Her kind soul is at rest, and we pray that her story inspires change to prevent others from experiencing a similar fate.

The panel overseeing this review would like to express their sincere condolences to Sasha’s family.

1. The Review Process

- 1.1. This summary outlines the process undertaken by the Kent and Medway Community Safety Partnership domestic homicide review panel in reviewing the death of Sasha who was a resident in their area. The review examined the involvement that organisations had with Sasha, a White British woman in her forties, and Latif a British Asian man in his fifties, between the start of their relationship in 2017 and Sasha's death.
- 1.2. Sasha is a pseudonym which was chosen by her mum. She was an intelligent, proud woman who loved animals and was always kind to those in need. Sadly, she struggled with the impact of childhood issues, abuse in relationships, poor mental health exacerbated by significant interpersonal trauma, addiction to alcohol, and later disability. Latif was an exploitative man who violently coerced and controlled Sasha, until she became disabled, when he severely neglected her, and she consequently died as a result of complex health needs.
- 1.3. The process began in March 2024 following a decision by the Kent & Medway Community Safety Partnerships' core group, once they had reviewed research received from partnership agencies. It was confirmed that the case met the criteria for conducting a DHR. That agreement was ratified by the Chair of the Partnership. All agencies that had contact with Sasha and Latif prior to the point of her death were contacted and asked to confirm whether they had any involvement with them.
- 1.4. In February 2024, the Home Office issued notice that in the future, Domestic Homicide Reviews would be called Domestic Abuse Related Death Reviews (DARDR) in recognition that not all victims die because of homicide but rather in the context of domestic abuse. Although Sasha's death occurred before this change, the Panel decided to adopt this naming convention considering the circumstances of her death. Consequently, the acronym DARDR was adopted for the remainder of the report.

- 1.5. A total of 33 agencies were asked to secure their records and contribute information to the review for the defined period. All agencies provided a return to the Panel's request, each return was evaluated, and a decision made whether a full account was required by way of an Individual Management Review (IMR) and chronology.

2. Contributors to the Review

- 2.1. Of the 33 organisations, 29 had pertinent information to share. 14 of those were asked to complete full IMRs, two were MARAC settings and were asked to submit minutes of all meetings and 13 were asked to contribute short reports.
- 2.2. All IMR authors were independent of direct or indirect contact with Sasha and/or Latif, either in person or via any management responsibility. The agencies that contributed information to the review were:

Agency/ Contributor	Nature of Contribution
Kent Police	IMR
Metropolitan Police Service (MPS)	IMR
Kent Fire and Rescue Service (KFRS)	Short Report
London Probation	Short Report
Kent MARAC	Meeting Minutes
London Borough B MARAC	Meeting Minutes
HMP Elmley	Short Report
HMP Belmarsh	Short Report
Kent Community Health NHS Foundation trust	IMR
Darent Valley Hospital	IMR
East Kent Hospitals University Foundation Trust (EKHUFT)	Short Report
Oxleas NHS Foundation Trust	IMR
Kent and Medway Partnership Trust (KMPT)	IMR
Kent GP 1	IMR
Kent GP 2	IMR

Agency/ Contributor	Nature of Contribution
Kent GP 3	Short Report
London Ambulance Service	Short Report
London Borough B GP	IMR
Southeast Coast Ambulance Service (SECAmb)	IMR
London Borough B Children's Social Care (CSC)	Short Report
Kent Adult Social Care (ASC)	IMR
Porchlight homeless service	Short Report
Solace Women's Aid	IMR
Choices DA Service	Short Report
Victim Support	Short Report
Rising Sun DVA Service	IMR
Town A Housing Team	Short Report
L&Q Housing	IMR
Forward Trust	IMR

3. The Review Panel Members

3.1. The Review Panel was made up of an Independent Chairperson and senior representatives of organisations that had relevant contact with Sasha and/ or Latif. It also included a senior member of the Kent Community Safety Team and two senior representatives from specialist domestic abuse services. Sasha lived with multiple disadvantages, consequently a range of agencies from across substance use, mental health, health and adult social care were integral to the panel.

3.2. A significant focus of this review was the management of perpetrator behaviour. Consequently, the panel decided to invite a specialist practitioner working with those who cause harm to advise the panel.

3.3. Agencies represented on the panel were:

Agency	Name	Job Title
N/A	Deborah Cartwright	Independent Chair
Kent County Council (KCC)	Kathleen Dardry	Community Safety Practice Development Officer
KCC	Georgia Head	Assistant Community Safety Officer
L&Q Housing	Lara Brading	Domestic Abuse Specialist Housing Specialisms
Rising Sun Domestic Violence and Abuse Service	Fran Ellis	Chief Executive
Solace Women's Aid	Jennifer Cirone	Director of Services
Kent Police	Stuart Norris	Detective Inspector, Public Protection Command
Kent and Medway ICB	Lisa Lane	Designated Nurse Safeguarding Adults
[Town A] Housing	Janine Hodges	Safeguarding Policy & Programme Officer/Resettlement Manager
	Ceil Newton (first meeting only)	Domestic Abuse Project Coordinator
The Forward Trust	Katy McGrath	Safeguarding Manager
Oxleas NHS Foundation Trust	Karen Laffar	Trust Wide Domestic Abuse Lead
Kent Community NHS Foundation Trust	Maureen Stephens / Annette Martin	Safeguarding Specialist Advisor (Adults) / Named Nurse for Safeguarding Adults
East Kent Hospitals University Foundation Trust	Louise Fortune	Named Nurse for Safeguarding Adults
Metropolitan Police	Sally Pattison	Review officer in the Specialist Crime Review Group (SCRG)
Kent and Medway Partnership Trust	Sarah Fowler	Specialist Safeguarding Advisor (Children, Adults and MCA)
KCC Adult Social Care	Catherine Collins	Adult Strategic Safeguarding Service Manager
Advisor on perpetrator accountability and management	Luke Kendall	Consultant

3.4. Sasha' mum and son were involved in the review. They were provided with Home Office leaflets and referred to AAFDA for support through the process. The chair met with them on various occasions to discuss the terms of

reference, their perspective on Sasha's experiences and to review information generally. Sasha's mum reviewed the report in its final draft form, expressing her ongoing distress that so much happened in relation to Sasha's situation without her ever being made safe. Sasha's son did not feel able to read the report, relaying via his partner that it was submitted to the Home Office without him doing so. His partner did review the report feeling it represented Sasha's experiences fully and with the hope that the lessons would be learned.

- 3.5. The panel discussed the possible interview of Latif for this review. It was initially understood that agencies did not have an address for him but also decided that the nature of the situation and the risks presented by him precluded his inclusion.

4. Author of the Overview Report

- 4.1. The independent chair and report author for this review is Deborah Cartwright. Deborah has worked in the social sector for over 30 years, with experience in learning disabilities, mental health, and domestic abuse gained from roles ranging from frontline practice to executive leadership. The expanse of this career has allowed for the development of a broad knowledge and understanding of the multi-agency landscape in the social and public sectors, including many years of participation in a range of statutory review processes.

5. Terms of Reference for the Review

- 5.1. The key reasons for conducting a Domestic Homicide Review (DHR) are to:
- a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims.

- b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change.
- c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
- d) prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

5.2. The terms of reference for the review were initially agreed by the panel at their first meeting in May 2024. This included panel membership, the temporal scope and those agencies that would contribute information.

5.3. The panel understood, according to agency information, that Sasha lived in a London borough for many years, in social housing, before moving to another social housing property in a district of Kent. She lived in the Kent property for three years before her death in a Kent hospital in 2023. Sasha had a history of poor mental health and alcohol addiction, and this had led to her only son being removed from her care in 2014.

5.4. Sasha moved from London after four years of attempts/ requests to move to safety as she was subject to domestic and contextual violence, abuse and sexual exploitation in her home and community in London. In the first year of her desire to move she formed a relationship with Latif, by the time she did move she had been subject to extreme coercion and control by him for two years.

5.5. Latif moved to Kent with Sasha and continued to control and abuse her. Her family described the escalation of this control over time, often associated with

times when she contemplated change. Whilst living in Kent she was subjected to two serious assaults by Latif (of which agencies are aware). The first of these gave her significant head injuries, and the second damaged her kidneys for which she was hospitalised. Sasha regularly disclosed, from the start of the relationship, episodes of strangulation.

5.6. Between the two assaults described above she suffered a stroke and Latif presented himself as her carer. Based on her requests and a decision that Sasha had capacity to consent to his care she was discharged home.

5.7. Sasha was experiencing cirrhosis of the liver and was hospitalised for the second assault with poor kidney function. Her back was found to be covered in bruises and Latif told a health practitioner that she had been assaulted by her boyfriend for 12 hours, he then identified himself as the boyfriend. She was discharged home but was later re-admitted in a state of neglect, with serious health symptoms associated with her stroke and later died of hospital-acquired pneumonia.

5.8. Although Sasha died of natural causes the extent of the violence and abuse that she had experienced led to a Domestic Homicide Review referral and a subsequent decision to undertake this review. The panel determined the following key lines of enquiry:

- a) Were practitioner's sensitive to the needs of Sasha and Latif and knowledgeable about potential indicators of domestic 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?
- b) Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) and/ or DARA risk assessments and risk management for domestic abuse victims or perpetrators, and were those

assessments correctly used in the case of either party (as appropriate). Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sasha and/ or Latif subject to a MARAC or other multi-agency fora?

- c) Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?
- d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- e) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- f) When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- g) Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
- h) Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
- i) Was this information recorded and shared, where appropriate?
- j) Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability, including the impact of trauma and disability given as necessary? Were any of the other protected characteristics relevant in this case?
- k) Were senior managers or other agencies and professionals involved at the appropriate points?

- l) Are there ways of working effectively that could be passed on to other organisations or individuals?
- m) Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Sasha and promote their welfare, or the way it identified, assessed, and managed the risks posed by Latif? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?
- n) Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?
- o) How accessible were the services to Sasha and Latif (as applicable)?
- p) Were agencies sensitive to the impact of pet ownership, their emotional impact/ attachments and the use of these to enact abuse?

6. Summary Chronology

6.1. There were 2,536 points of contact for Sasha across the collated chronology in the full report, so the panel adopted an analytical process that enabled a robust review without overwhelming the final report with process detail that detracted from significant opportunities for learning. Consequently, that chronology was summarised in parts, and the chronology in this summary report is further summarised.

London

6.2. Prior to the scoping period Sasha had been a successful health and safety professional in the building industry. However, her family described a difficult relationship with her father which they believed set the scene for her emotional vulnerability in relationships whereby predatory individuals would exploit her. The emotional dysregulation she experienced also rendered her vulnerable to addiction and working in the building trade meant being amidst a drinking culture. Sasha had a son at a young age, was unable to continue working and

sadly concerns about her drinking and his welfare led to him living with his grandmother by the time he was a teenager.

6.3. Sasha and her son had ended up living in a socioeconomically deprived area as she had relinquished her mortgaged home after leaving her job on the advice of a social worker. Once her son went away, she became increasingly vulnerable to abusive and exploitative relationships. Just prior to her relationship with Latif, she was known to be in a violent relationship with a man who accrued drug debts in her name. She was subject to violence and sexual abuse in her relationships and by members of her community. She continuously described fear of drug gangs from 2017 and saw boyfriends as protective factors from the risk of multiple abusers.

6.4. Primary Care Services - Sasha regularly and consistently saw her London GP between 2017 and her move to Kent in 2020. For example, in 2019 she had 46 contacts with the practice. She saw her GP for mental and physical health concerns and routinely described mental distress and abuse at the hands of Latif and others.

6.5. Her GP regularly referred her to mental health services, and on one occasion noted, *'I have advised and counselled her'* in relation to her relationship disclosures. In 2018 she told her GP that, *'[Latif] takes her to jobs where she has sex with different males'* and that she was, *'regularly assaulted for no apparent reason.'* There were no onward referrals recorded by the GPs for domestic abuse services.

6.6. Mental Health Services – Sasha saw practitioners at Oxleas mental health service on multiple occasions whilst living in London, often struggling to make it to appointments. At one point they referred her to drug and alcohol services stating that she must address her alcoholism prior to any mental health intervention. Oxleas recognised Sasha's vulnerability to abuse and captured information relating to Sasha's experiences to support any possible criminal investigation.

6.7. The Metropolitan Police Service noted two reports of threats and an assault of Sasha by local drug gangs, but Sasha was too afraid to support prosecutions. However, a boyfriend prior to Latif was imprisoned for his abuse of her. Latif entered her life very quickly after this and at the first incident to which police were called was noted as appearing, *‘to care for her well’* despite his significant history of criminality and violence. However, thereafter it was recognised that Sasha was highly vulnerable and Latif was an abusive and exploitative man.

6.8. Notably MPS recorded following an incident at the end of 2017 that he had made *‘[threats to kill] and assault against [Sasha]. [he] had threatened to cut off her head with a saw.’* This was not progressed as the Crown Prosecution Service deemed there to be insufficient evidence to proceed. The IDVA noted in relation to this incident, *‘she was hit around the head 4 times. Risks identified: Escalation, Strangulation every day till point of passing out, Threats to kill and cut head off with a saw, Perpetrator protects client from travelling community¹, Multiple MARAC [referrals]’.*

6.9. Latif was arrested on several occasions for the abuse of Sasha, during one interview he described her as vulnerable to exploitation by males, positioning himself as someone who was protecting her because of this vulnerability and her addiction. Prosecutions were repeatedly not pursued due to a lack of evidence, Sasha could not support them due to the levels of fear she experienced, this was evidenced in her descriptions of that fear. On one occasion in 2020 police recorded, *‘Sasha was visibly upset and appeared very scared and anxious that [Latif] would get arrested. On [Latif]’s arrest Sasha became very upset shouting at officers and calling out it wasn’t her fault.’* Her fear of supporting prosecutions remained so for the rest of her life.

¹ The panel wished to note that this record exhibits a racist tone towards the travelling community which is unacceptable.

- 6.10. MARAC – Sasha was heard at this multi-agency forum in London on numerous occasions (there were 11 MARAC meetings and 28 DASH risk indicator checklists² in total across London and Kent). She had been heard twice in relation to her previous boyfriend and was already noted to be generally high risk due to her vulnerability.
- 6.11. MARAC actions were focussed on her gaining a property move to Kent, to be closer to her family. The MARAC was aware of the significant risks and exploitation faced by Sasha, and of Latif's prolific, coercive and controlling exploitation of vulnerable women. Her IDVA described her '*lack of engagement*' as a barrier to helping her. She was noted by mental health services to have the capacity to make unwise decisions.
- 6.12. IDVA services – Sasha was supported by a local authority IDVA in her prior relationship and then during her relationship with Latif. Throughout these episodes of support, she described perceiving these boyfriends as '*caring*' for her, '*protecting*' her from the '*travellers*'³ and that she was having to sex work forcibly because of either drug debts accrued by her boyfriends or as a form of sexual exploitation by her boyfriends' for their financial gain.
- 6.13. The IDVA's support of Sasha became less proactive over time and she started to describe Sasha as failing to help herself, through non-engagement and/ or not changing; she also described Sasha as a sex worker (with the implication being that this was Sasha's choice). At one point she described her as '*dogging*'.⁴ There were examples of her describing non-engagement when there was no record of contact. This IDVA did not appear to have been supervised in her role.
- 6.14. A new IDVA took her place and came under the management of Solace Women's Aid. This practitioner endeavoured to gain Sasha the house move she

² A domestic abuse risk indicator checklist undertaken to ascertain the level of risk that a victim may face.

³ It should be noted here that these are Sasha's words. The ethnic origin of those that perpetrated abuse towards Sasha is unknown and it was the panel's view that given the cross-cultural existence of criminal gangs this should not be taken as a judgement of any single community.

⁴ A voluntary sexual activity whereby couples swap sexual partners in car parks.

desired for her safety proactively. She also advocated for evidence-led prosecutions with the Metropolitan Police. Sasha had a beloved dog, whom she could not be parted from consequently she would not consider temporary housing arrangements. In early 2019 Latif was on remand and her IDVA tried to get her a place in a residential detox through St Mungo's charity.

- 6.15. As well as this remand DVPOs were served against Latif. They were used as a standalone tool by officers, without multi-agency safety and support planning. Sasha would describe high levels of emotional and safety vulnerability when Latif was not present. These concerns were real as she repeatedly described sexual and physical violence and abuse and exploitation outside of her home.
- 6.16. Consequently, Sasha's mental health would often deteriorate in the context of separation from Latif. The extent of his control of her was such that she felt she could not cope without him. At the time of the referral to St Mungo's there was an incident where she was assaulted by someone who had gone to stay with her whilst Latif was on remand. The assault was committed by Latif's former cellmate and served to reinforce to her that she could not escape him. The narrative she had been coerced with was, *'[Latif] does a better job of protecting her than anyone else.'*
- 6.17. Housing services, in the form of her landlord, L&Q housing were proactive in supporting Sasha. She had significant rent arrears set aside on two occasions to enable her with a possible move and in recognition of her situation. They were also clear about their concerns regarding her vulnerability and the level of risk she faced at MARAC. The second IDVA and housing officer worked hard to move Sasha to Kent, they were inhibited largely by Kent's initial failure to recognise her as having a housing need – on the basis that she was too unsafe to wait. Sasha consistently described wanting to move away from the community threats and abuse that she faced.

6.18. In 2018 Sasha starts to be seen at hospital Emergency Departments because of injuries or overdoses. She was referred to Hospital based IDVAs (HIDVA) but did not wish to work with them generally. However, on one occasion in 2019 she spoke to the HIDVA describing strangulation and a MARAC referral was made. There were often attempts to have her seen by Liaison Psychiatry Service (LPS). She usually left hospital before being seen.

Kent

6.19. In 2020 Sasha moved to Kent and she continued to experience significant, high-volume assaults and coercive control as Latif moved with her. A MARAC-to-MARAC transfer took place disclosing all of the prior concerns and risks that she faced. Her final MARAC in London had discussed evidence-led prosecutions. She was also referred to a Kent IDVA service, Rising Sun, as an incident occurred days after the move.

6.20. Sasha denied being a victim of domestic abuse when Kent Police attended this first incident, and officers were proactive in establishing her background, making referrals and obtaining another DVPO. Sasha established a good relationship with her new IDVA who worked extensively to gain her support with her increasingly poor mental health.

6.21. By the end of this year Sasha was assaulted with a metal dog lead to the extent that she experienced significant facial and head injuries, and which her mum believes led her to ultimately have a stroke. She was supportive of the prosecution, but her family described her receiving an illicit phone call from Latif in prison and her visibly shrinking during the call. She withdrew her statement and became obsessive about the prosecution not taking place over the coming months.

6.22. Latif was refused charge for breaching his DVPO in early 2021 and, following a period of remand, Latif was bailed pending the assault investigation. He had

conditions not to contact Sasha (expiring initially in March and then extended indefinitely beyond this period).

6.23. In May Latif contacted the police stating he was concerned for Sasha's welfare, the officer in charge of the assault [Grievous Bodily Harm – GBH] enquiry, *'conducted a series of enquiries due to her concerns over Sasha which culminated in a forced entry and search of Sasha's property which resulted in Latif being found hiding in a wardrobe.'* He was placed before the court for breach of bail but was released on conditional bail with a GPS tag. Sasha's mental health deteriorated significantly which was observable through agencies recording suicide attempts and multiple disclosures of distress.

6.24. Sasha experienced anti-social behaviour during this period with drug users causing her to feel frightened and a brick being thrown through her window. Her mental health was poor, and she told her Housing Officer of her multiple suicide attempts. Sasha was also being medically examined for suspected cirrhosis of the liver at this time.

6.25. In 2021 alone Sasha had 328 points of contact with professionals. She continued to have high levels of contact with primary health, as she had in London, and with her Rising Sun IDVA. She also had contact with Forward Trust (for alcohol dependency), secondary health services and Adult Social Care. There were no MARAC referrals made despite incidents occurring.

6.26. Adult Social Care (ASC) provided some support to Sasha between 2021 and her death. By early 2021 she was noted to be self-neglecting and was living with poor home conditions. She was on a waiting list for a social care assessment. In May of 2021 KMPT⁵ referred to ASC as Sasha had been seen again at hospital by the LPS following a suicide attempt. ASC allocated her an adult social care mental health practitioner, a service that is no longer available.

⁵ Kent and Medway Partnership Trust (secondary mental health services)

- 6.27. At the end of November Sasha was visited by the ASC social worker for a planned assessment, they noted, *'flat was very cold as there was no heating, also no food or fridge noted; [Sasha] states "she is staying at mums as unable to cope alone". [Sasha] was expressing suicidal thoughts, taking her medication with alcohol. [Sasha] stated she was "missing her partner who was currently awaiting trial".'*
- 6.28. The assessing social worker made onward referrals for the Kent Enablement Service (KERS), the Forward Trust, and checked if Rising Sun were still supporting Sasha. They also notified her GP of the overdose risk and she was moved to weekly prescriptions. Sasha's IDVA requested a static social worker for consistency, but they were advised that this was not possible, but Sasha would receive regular welfare calls. On speaking with Sasha's mum it was noted that she was feeling hopeless to help her daughter.
- 6.29. Following the referral to KERS they noted that they would need to ascertain, *'if she is well enough to engage with enablement at this time.'* She was referred again to KERS towards the end of the year, and this was accepted. Forward Trust made a comprehensive assessment of Sasha, who expressed the desire to be abstinent, but they were then unable to contact her and closed her case.
- 6.30. The ASC mental health practitioner worked with Sasha's IDVA extensively over the coming months in attempts to support her. However, as 2021 went on Sasha had less contact with agencies as Latif was being maintained on a TAG awaiting trial. Consequently, the focus of Sasha's support was based on her mental and general wellbeing between July and December. There was no police activity during this pre-trial hiatus. The separation continued to have a significantly negative impact on Sasha's mental health. She spent more time with her mum, as she was lonely, and felt unsafe in her property. Her beloved dog had also died.
- 6.31. In 2022 there were 382 agency records in relation to Sasha. Latif was due to be tried for the GBH charge in February and Sasha continued to struggle with her

mental wellbeing; she was also still contending with the health consequences of the assault that Latif was due to be tried for. Her mum advised the panel that she did have a period of alcohol abstinence as she was frightened about her liver diagnosis but was unable to sustain it. She also advised that Latif went to great lengths to ensure she did remain dependent on alcohol, for example, he started drinking at home, despite not having done so previously. They also described his tactics of coercing her to drink, for example, when Sasha was prescribed lactulose, she told her mum that she caught him lacing it with surgical spirits. Based on her family's input the panel were made aware that Latif had maintained contact with Sasha in 2021.

- 6.32. In early January Sasha was assaulted at a hotel, which included being strangled. Latif was arrested but evidential difficulties meant that the assault charge was not substantiated. The day after this Sasha overdosed and when seen by LPS she said that being unable to see her partner made her lonely. The HIDVA saw her, and recorded, *she is likely to say that injuries are accidents.* She was scheduled to see the CMHT in the middle of the month. Another hotel incident occurred in February which caused ASC, on notification from the ambulance service, to open a Section 42 enquiry. In February an Inquiry Officer was allocated, and KERS was initiated for Sasha.
- 6.33. Latif's hearing was scheduled for February, and a third party notified the police that they were concerned that Latif's father was intimidating Sasha into withdrawing her statement, saying that she, *'wouldn't survive without him.'* The assault investigating officer attempted a charge of witness intimidation which failed. Sasha was admitted to hospital having overdosed again, and as her statement was withdrawn the case against Latif was dismissed for *'no evidence'*.
- 6.34. The ASC mental health practitioner continued to advocate for secondary mental health service provision for Sasha. She underwent one assessment but was deemed not to, *'meet required thresholds'* and was referred variously over

this period to Forward Trust, Rising Sun, Livewell⁶ and social prescribing⁷ by the CMHT. Social prescribing deemed her needs to great for the service. She interacted with the CMHT again in May after failing to attend another referral appointment advising them, *'she had been unaware of the appointment as she had received no mail.'*

6.35. During a call in April the ASC mental health practitioner heard, *'A male in the background asked who she was speaking to... Sasha then asked if she could call me back.'* They spoke in mid-May but noted to the IDVA, *"almost impossible to discuss the safeguarding as partner still present.'* She had, *'declined to meet KCC ASC at a safe place but agreed to complete an assessment over the telephone. Plan: ASC to arrange a Case Conference with relevant agencies and invite Sasha.'*

6.36. Sasha's IDVA noted that Sasha was upbeat after the case was dismissed and *'that it's a challenge to support as she wants to resume the relationship, even taking into account the risks and potential threat of death, that [Latif] poses to her.'* They continued to support her. In relation to her response from the CMHT Sasha noted to her IDVA, *'Very disappointing, yet again referred back to gp , not really sure how they all justify their existence, if it wasn't so sad it would be laughable, thank you for all your efforts, Sasha... I don't want to "engage " with people that right you off, mental health is laughable, u take care speak next week.'*

6.37. Forward Trust did not have records between January and March when Sasha's GP re-referred her. Sasha had advised her GP that she had attempted to contact them with no response. The GP noted to Forward Trust that she had reconciled with Latif and was drinking 20 units of alcohol a day. In April the service noted no engagement with Sasha since January and determined that the recovery

⁶ Livewell is a Kent wellbeing service.

⁷ Social prescribing, also known as community referral, is a way for healthcare professionals to connect patients with non-medical support services in their community to improve their overall health and wellbeing. It addresses the social, emotional, and practical needs that can impact a person's health, moving beyond purely clinical treatments.

worker will follow the ‘re-engagement’ process. In late May they closed her case having not managed to engage her in support.

6.38. Between April and June of 2022 agencies had multiple points of contact with Sasha in relation to domestic abuse and her physical and mental wellbeing. During this time, she began to have anxiety/ panic attacks warranting ambulance calls, as well as allergic reactions⁸ for which she is given an EpiPen.⁹ At the start of this period Sasha makes abuse disclosures to her IDVA, and health services, and her mum makes effort to get her some help with her mental wellbeing stating on one occasion that she is, *‘in a bad way.’*

6.39. Sasha’s family noted that Latif bought Sasha a puppy at this time, it was an American Bull Dog which was too powerful for Sasha to walk – they saw this as a control mechanism knowing that Sasha would bond with the dog, despite Sasha having been thoughtful about the death of her prior dog, and was, at this point understanding that having a dog companion would prevent her from making changes. It is the family’s belief that, at this time, Sasha’s panic attacks and her ‘hypothetical conversations’ about options were signs that she was contemplating change – they felt that Latif saw this and escalated abuse and control of her.

6.40. Sasha did become more open about her experiences advising her IDVA that she experienced psychological abuse regarding her mental health, weight, intimidation and financial exploitation, being bitten in the face and having fairy liquid poured into her mouth whilst she was sleeping. The IDVA also recorded that Latif told her, *‘It’s your fault because you can’t shut your mouth’*. She also made some limited enquiries that spoke to consideration of change. These included enquiring about *‘domestic violence groups.’* The IDVA recorded conversations where she gently encouraged Sasha to understand the nature

⁸ These were considered to be as a result of her guinea pigs. However, her family note that she had always kept guinea pigs.

⁹ An EpiPen is an epinephrine auto-injector used to treat severe allergic reactions (anaphylaxis). It delivers a measured dose of epinephrine, which helps to counteract the symptoms of anaphylaxis such as difficulty breathing, swelling, and a drop in blood pressure.

of coercive control and on one occasion, they made a 'for' and 'against' list and Sasha stated, *'nothing is good'*. Following one incident they discussed place of safety options, but Sasha could not leave the puppy. When the IDVA spoke to her about Latif's isolation of her, Sasha said she no longer wanted support. A MARAC meeting took place, with the action for the IDVA to continue to support.

6.41. During this period there were nine ambulance call outs for Sasha she was noted during one to be, *'covered in bruises'*, in another she was distressed because she could not get hold of her, *'carer'* and in another she was having breathing difficulties and it was noted, *'boyfriend on scene keeping her calm.'* During one call the crew noted, *'Disclosed to crew that partner has been violently aggressive but has full capacity and does not wish for this to go further – no additional report made. Conveyed to [hospital].'*

6.42. Referrals to agencies, MARAC hearings and support from the IDVA, Forward Trust and ASC mental health continued through the summer. Sasha had ongoing health issues from her liver disease and from ongoing and persistent assaults. The case conference took place at the start of July, convened by ASC, with the CMHT, KERS and Sasha's IDVA in attendance. They noted all of the concerns and risks that Sasha faced and recorded, *'Safeguarding plan; for close joint working between KERS and ASC MH practitioner/KCC Safeguarding. Unannounced visit to be carried out face to face, if Sasha cancels planned visit, and to attempt to talk with Sasha alone to complete DASH. Follow up Safeguarding Case Conference [in two weeks].'* The unannounced visit was made to Sasha in the last week of July, ASC recorded, *'Sasha looked drained... it seems half of her face has slightly dropped which may be due to her jaw still being broken... stated partner is a 'control freak' and he got a new phone and number for her... and only "stays there on occasions". Sasha spoke about the dog being too much, but she now loves him and "doesn't want to go out anymore". ASC suggested going to a refuge, but Sasha declined.* Various actions were taken practically and the CMHT noted

that they would allocate a Community Psychiatric Nurse and psychiatrist. There was no record of contacts until the following spring.

- 6.43. Sasha's IDVA worked with the police at this time to endeavour to facilitate an arrest of some description. In August Sasha was admitted to hospital with abdominal pain and jaundice. She was diagnosed with Portal Vein Thrombosis (a blood clot in the liver). She refused to see the ASC Inquiry Officer in hospital and the Section 42 enquiry was later closed due to '*sporadic engagement*'. On discharge Sasha remained alcohol abstinent, and her mum and the Forward Trust noted an increase in her clarity regarding the abuse she was experiencing.
- 6.44. Latif stopped working and Sasha was readmitted to hospital with liver problems in September. It was noted that there were concerns that he was bringing alcohol to the hospital. Following discharge, she discussed with her alcohol recovery worker the requirement for her to have six months abstinence from alcohol to qualify for a liver transplant. At this meeting she said she didn't want to be with her partner but saw no way out.
- 6.45. In November Sasha was admitted to hospital with a stroke. Sasha's family advised the panel that following the stroke Sasha had significantly impaired memory and speech, had lost mobility, and her right arm was compromised. Latif wanted to take her home, representing himself as her carer and her mum was very unhappy about it. Latif was noted to be visiting daily, often at unsociable hours, and another patient had overheard him talking about being able to get a mobility car and blue badge because of Sasha's ill health. Sasha's mum expressed her concern to staff that he was seeking her bank cards and that he could be generating debt for Sasha as he was still at the property. Staff agreed to lock her bag away and Sasha's mum cancelled the bank cards. She also took photos of bruising to Sasha's back – expressing her concern that an assault had occurred prior to her stroke. They notified Kent Police who maintained contact with them, but the investigating officer was not able to see

Sasha at the times they attended the hospital, her speech therapist reported to the police that Sasha denied any assault.

6.46. During this admission Sasha was subject to a Deprivation of Liberty Safeguard (DoLS), but by the time of her discharge was deemed to have the mental capacity to choose to go home. There were issues with where to discharge her to, her mum was not in a position to care for her, and she became distressed at the idea of going to a rehabilitation ward.

6.47. Latif despite having been aggressive on the ward initially started to do 'kind' things for Sasha, bringing her the food that she liked, telling her he would look after her, and she was noted to become very emotional following his visits. In January 2023 she was discharged home under his care. During the capacity assessment for discharge Sasha stated he had, *'not hit her for three years... and that he had been really good whilst she had been in [hospital]'* Sasha's mum was *'devastated'* that she had not been involved in this outcome, and that Sasha would be, *'be back in [the hospital] with injuries or in a body bag'*.

6.48. Between January and August 2023 Sasha was predominantly seen by Occupational and Speech and Language therapists. Latif initially described leaving his job to care for Sasha, but by the third appointment with an OT (Occupational Therapist) was noted to be at work. Sasha struggled with her recovery work, noting to the practitioners variously that her exercise sheets went missing, feeling unsure if Latif was giving her the correct medications, saying that she was not being provided with food, and also that Latif was asking her who had, *'power of attorney'* over her affairs.

6.49. There were ongoing safeguarding concerns generally as Sasha became increasingly gaunt, had a hand crush injury (which her mum believes resulted from Latif shutting her fingers in a car window intentionally), and she experienced regular falls. Her mobility, speech and language were poor generally.

6.50. The CMHT saw Sasha in March and reviewed her antidepressant and that the care coordinator would remain in touch later noting, *'There is no evidence of contact with the care coordinator prior to May and Sasha did not attend the May appointment. This was rebooked for early June. She was seen by the CMHT in the first week of June and they noted (which had been observed by the pharmacist) that Sasha had not stuck to the plan to change her antidepressant and the need for this was reiterated. She was to be followed up by the care coordinator and have a further out-patients appointment in 12 weeks.'* She spoke with them in July but was noted to be *'sleepy and incoherent'* so the meeting was rebooked for August.

6.51. In July Sasha was admitted to hospital as her legs were purple. She was deprived of her liberty temporarily, and a care package of support was discussed with her. She initially agreed but later said she would not let carers in. She was deemed to have capacity and was discharged.

6.52. Following discharge, it was noted by agencies that she continued to deteriorate and be in a state of neglect. Her Speech and Language Therapists noted hearing shouting and swearing as they approached Sasha's property in July and that, *'[Sasha]... unkempt in appearance - top was visibly and notably soiled / stained in several large areas. Her hair appeared unwashed and not groomed. The table littered with various items, [unopened] hospital letters on the floor, beer bottles on the floor in the kitchen, used pans and plates on work surfaces. The environment was felt to have numerous falls/trip hazards.'* Sasha described things as *'difficult'* with Latif swearing and getting angry with her. She said she couldn't leave her dog.

6.53. A Multi-Disciplinary Team Hub meeting took place with the actions of speaking with the IDVA and asking the GP for a medical review. They also asked for the matter to be escalated to Sasha's social worker, she didn't have one. In August the GP found evidence that she was suffering from acute kidney injury following blood tests and called an ambulance to Sasha's property. The crew noted that Latif was dismissive of concerns. When they arrived at hospital her mum noted

that she was preoccupied with food to the extent that the ambulance crew had gotten her a sandwich which she *'devoured.'*

6.54. On admission Sasha was noted to be covered in bruises and her mum advised the panel that Latif immediately went shopping, spending hundreds of pounds from her account. The day after Sasha was admitted to hospital the Community Dietitian went to see Sasha at home they wrote to the GP, who recorded, *'On arrival she was advised by a man coming out of her property that [Sasha] was in A&E. The man went on to tell the dietician that [Sasha] had been beaten for 12 hours by own boyfriend and was taken by ambulance to A&E. The dietician initially thought this man was a neighbour but on asking him who he was, he then told the dietician that he was the boyfriend.'*

6.55. Sasha was subject to a four-month DoLs, it was recorded, *'The purpose of authorising a deprivation of [Sasha's] liberty at the above location is so that she may continue to receive the supervision and care that is necessary to maintain her health, safety, and wellbeing. She has a mental disorder caused by acute confusional state on the background of stroke and alcoholic liver disease. As a result of the mental disorder, [her] ability to manage independent living is impaired. She requires interventions across a range of health needs and daily living activities such as receiving support with personal care and hygiene, nutrition and hydration, medication, personal safety, and psycho-social needs. Without the measures that give rise to a deprivation of [Sasha's] liberty, it is foreseeable that she would most likely encounter harm of a serious nature and degree.'*

6.56. A significant amount of work was undertaken by Sasha's IDVA, nursing staff and others to maintain Sasha's safety during this admission. At one point she is noted to have said, *'he owes her money, always shouting at her, saying she's stupid'* and *'Sasha's saying "take me home I'll sit quiet, I promise I'll sit quiet."* *She's going on about [Latif] constantly shouting and telling her to sit quiet.'* During one conversation with the HIDVA Sasha is noted to say that he had

called her on her phone, *'the other night and that he was calling her names and telling her she was useless. She doesn't understand why he hates her so much and why he has to say all the horrible things.'*

6.57. Sasha had fluctuating health and cognitive issues during the admission. She became increasingly distressed about the removal of her liberty and not being discharged home, at one point she left the hospital and was found a few hundred yards away. Kent Police had some involvement prior to and during the admission. They pursued actions through MARAC and opened an investigation recording, *"Limited contact was established with [Sasha] due to her medical condition, but she denied any assault by Latif. [Concerns were all outlined by mother as described above]. Latif had stated she had fallen a number of times which mum did not believe to be the cause of the bruising. Latif was arrested and interviewed. He denied all criminal allegations. Investigations continued but no evidence could be gathered to support a charge, the case was filed following investigation and review.'*

6.58. Latif was not allowed to visit Sasha; her neighbour visited with many of her favourite things as gifts. Sasha's mum noted that this was arranged by Latif as Sasha did not like the neighbour, and that this neighbour had been encouraged to spy on Sasha whilst Latif was at work. Sasha was highly distressed and under the care of the LPS, she maintained that she wanted to go home. Work was undertaken around discharge plans, but in December, having acquired hospital-pneumonia, Sasha died. Latif went to the ward and described himself as her executor in an attempt to gain her possessions. Sasha's mum had been granted power of attorney, the hospital declined.

7. Key Issues Arising from the Review

7.1. Sasha was a high-risk victim of domestic and contextual sexual violence and abuse for many years; her relationships were violent and exploitative and drug

dealers in her community also exploited her vulnerability. Latif is a prolific and anti-social perpetrator of extreme violence and coercion to Sasha and other vulnerable women. He exploited her vulnerability to coerce her into believing that she was safer with him than alone.

7.2. Domestic and sexual violence and abuse (DSVA) is an umbrella term that covers a range of differing interpersonal and family dynamics where abuse in different forms is acted out. Sasha experienced extremely violent coercive control which made her fearful and without psychological '*space for action.*'¹⁰ The responsibility for the position that Sasha found herself in lies solely with the perpetrator of her abuse and for agencies whose role it is to safeguard vulnerable members of society. The panel noted a clear example of her fear when Latif is arrested by MPS for an assault and she, '*became very upset shouting at officers and calling out it wasn't her fault.*' The panel believe that Sasha was consistently too scared to support a prosecution.

7.3. Sasha was a victim of gender-based violence which is described as disproportionately affecting women and includes sexual, physical, mental and economic harm inflicted in public or in private.¹¹ She faced physical and sexual violence and abuse in her home and from members of her community; she was subjected to extreme violence and forced prostitution by all of those parties.

7.4. In light of Sasha's story, the panel observed that her situation with Latif was viewed through a domestic abuse lens, with its associated practices being utilised in her support. However, they felt that Sasha was experiencing something more akin to 'cuckooing'¹² through the 'Loverboy'¹³ method. Latif's behaviour was exploitative and the chronology, makes it clear that his sole focus

¹⁰ Professor Liz Kelly, Domestic Violence Matters, 2010

¹¹ [UNHCR, Gender-based violence \(Accessed 8.4.25\)](#)

¹² Also known as 'home takeover' cuckooing is a form of criminal exploitation where individuals or organised crime groups (OCGs) take over the home of a vulnerable person to use the property for illegal activities.

¹³ Whereby someone presents as a boyfriend in order to gain access to the vulnerable person.

was on financial gain. The panel noted that Sasha would have scored high on the Cuckooing Risk Identification Checklist.

- 7.5. Sasha made clear that this exploitation was taking place, both from Latif, her former boyfriend and from drug gangs in her community. It is unknown whether these individuals colluded in their abuse of Sasha, but it is apparent that she was seen as a source of income for Latif cloaked in the guise of a loving relationship. They noted that she could have experienced safeguards as a vulnerable adult experiencing modern slavery.
- 7.6. They further noted the risk of her being stereotyped in a racist trope as a 'traveller' a label that was applied for not apparent analytical reason. Had Sasha been from the travelling community this knowledge should have been used to understand her. Rather, her 'lifestyle' and this appear to have both served to mask the risks which she faced. The areas in scope have attended to cultural humility in practice since this happened.
- 7.7. Some practitioners went above and beyond the limitations of their roles to try to support Sasha. However, the panel acknowledged that system design inhibited her from achieving any meaningful outcomes. Sasha routinely disclosed the abuse that she faced, the problem was not hidden. The panel were concerned that Sasha was so conditioned to abuse, that she was desensitised to its impact upon her, which is evident in her graphic descriptions of the abuse, and the impossible position of internal conflict she held as she, *'hated him for abusing and degrading her but also loved him and she understands that this seems irrational but it is how she feels.'* The coercion that she faced led her to self-blame for the abuse which in turn rendered her more vulnerable.
- 7.8. Given Sasha's experiences the panel reflected on the suitability and efficacy of risk assessment and management practice by agencies for Sasha. The currently accepted practices are DASH (Domestic Abuse, Stalking and Honour risk indicator checklist) and MARAC (Multi-Agency Risk Assessment Conference)

respectively. DASH is an incidental tool that uses an actuarial and structured professional judgement approach.

7.9. There were 28 mentions of DASH assessments in the chronology of agency records during the time that Sasha was in a relationship with Latif. There was only one instance where risk should have been identified as higher by MPS, and one where, based on Sasha's word, she was scored as medium risk by her IDVA; otherwise, no agency failed to identify the high level of risk that Sasha faced, and there was good practice when DASH assessments were undertaken on the basis of professional judgement when she was not able to answer the questions.

7.10. The follow-on mechanism for a 'high' classification of risk is the MARAC process, and the assignment of an Independent Domestic Violence Adviser (IDVA). In short, MARAC is a multi-agency meeting that can take place with or without the consent of the victim-survivor (where there is a high-risk score) whereby a group of professionals' pool intelligence, identify risks and engage in safety planning activities designed to reduce the risks faced by the individual. The panel noted that Sasha was heard at MARAC meetings 11 times across London and Kent in a six-year period.

7.11. SafeLives, in a recent MOPAC report, noted that, 'When implemented well, MARAC can be an effective model for managing and preventing risk of serious harm...' but that it can be impacted by, 'a lack of understanding about what a good outcome is for victims, survivors and families.' They further note that 'it is often process based rather than focussed on the outcome achieved for the victim-survivor.'

7.12. The panel noted that whilst Sasha remained in a relationship with Latif, she would remain high risk and that this risk level should have been consistently maintained without the need for assessment. They further noted that MARAC was not a suitable and/ or appropriately used safeguarding meeting for someone with Sasha's needs given its lack of outcomes and minimal action plans. It is not possible to say what would have been achieved had MARAC acted in a more

continuous and outcome-oriented way. However, for someone facing the levels of complexity and disadvantage that Sasha faced its form and structure was unhelpful.

7.13. The panel noted that Multi-Agency Risk Management (MARM) meetings could have been more helpful given Sasha's adult safeguarding needs. In whichever setting this essential multi-agency practice took place, it required curious and reflective thinking which was not evident in most of Sasha's support. Focussing on process over outcomes led to missed opportunities to help her to disconnect from Latif's control.

7.14. Sasha's family acknowledged the difficulties that agencies would have faced in establishing meaningful contact with her, given the complex adversity and control she faced. However, the panel observed that the use of the concept 'non-engagement' was often problematic and situated responsibility with Sasha who was largely unable to operate within the strict confines of service criteria. There were also examples in the chronology of agencies not recording any attempts to contact Sasha but describing her as not engaging. The barriers to support, in the view of the panel, sat predominantly with agency systems and failures to acknowledge whether she was being controlled away from support.

7.15. Sasha was a woman who lived with multiple disadvantages. The Making Every Adult Matter (MEAM) coalition describe multiple disadvantages as, 'People facing multiple disadvantage experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.'¹⁴ Sasha wasn't homeless but faced all of the other issues in this list, and as a woman shared a commonality with homeless women in that she was coerced to believe that she was better off with one perpetrator of abuse over many.

¹⁴ [MEAM Coalition website homepage \[Accessed 20.5.25\]](#)

7.16. In working with women who experience this level of disadvantage it is essential that practice focusses across their needs, seeing them as a whole person and working without silos. Despite some good cross-agency collaboration and coordination the panel observed that the practice silos still presented a hindrance to Sasha finding services accessible. It is also important that accessibility barriers are identified and addressed in service design to give the greatest chance of service access.

7.17. Service requirements are set out in a 2024 DLUHC (Department of Levelling Up, Housing and Communities) report¹⁵ which notes the barriers and challenges for women facing multiple disadvantages being overcome in the following ways:

- Improving service and practitioner capability and capacity to support women experiencing multiple disadvantages.
- Adapting or providing specialist housing-based interventions.
- Integration or co-ordination of domestic abuse services with support for multiple disadvantages.
- Providing tailored, relational recovery support in safe spaces.

7.18. In essence those facing multiple disadvantages require an enhanced coordinated community response¹⁶ that acknowledges the complex systemic barriers that they face. The failure to comprehensively coordinate services around Sasha served to entrench her further in Latif's control.

7.19. London today has a process called C:MARAC for those experiencing community abuse and exploitation and Sasha's situation would have triggered a referral into this process. Kent and Medway have MARM, as previously mentioned which is designed to support anyone *'working with an adult where there is a high level of risk of harm and the circumstances sit outside the statutory adult safeguarding*

¹⁵ [Understanding domestic abuse interventions for women experiencing multiple disadvantage: A rapid evidence assessment](#). Department for Levelling Up, Housing & Communities, April 2024

¹⁶ A CCR brings services together to ensure local systems truly keep survivors safe, hold abusers to account and prevent domestic abuse. [What is CCR? Standing Together](#) [Accessed: 20.4.25]

*framework, but where a multi-agency approach would be beneficial.'*¹⁷In order for MARM to take place it would be important for practitioners to acknowledge that MARAC was not working for Sasha as there is an inherent risk that representation at MARAC, whether or not it was working, would inhibit a MARM referral.

7.20. As a vulnerable adult many safeguarding concerns were raised by agencies with adult social care. In London these resulted in no action. In Kent the actions were complicated, the appointment of a mental health practitioner meant that Sasha had some longer-term consistent help, but Section 42 enquiries failed and she was not subject to any care needs assessments, even when experiencing significant physical disabilities. The panel noted that she could have been deemed to be 'refusing assessment' when a Section 42 enquiry took place which could have seen the enquiry proceed without her support. Overall, there were issues with the process for obtaining interventions, the thresholds for services and time delays in initiating help.

7.21. Sasha had similar experiences with access to secondary mental health support. In London she was advised that she would need to address her substance misuse prior to mental health support, a practice that has changed today. In Kent she was often signposted and deemed not to meet service criteria. Sasha was a woman who was diagnosed with emotionally unstable personality disorder, and one panel member described the lack of services for those with this diagnosis as a national issue.

7.22. There was an incredible amount of activity around Sasha throughout the time period in scope. Despite some practitioners' best efforts, many of these continued the overall theme for Sasha of process being prioritised over outcomes.

7.23. The primary escape mechanism that Sasha was offered was refuge. The panel noted that this would have been unlikely, given Sasha's needs, to have been a

¹⁷ [Multi-Agency Risk Management Framework, KAMSAB \(Published 1.4.25\)](#)

successful outcome for her, and further unlikely that a refuge space suited to her needs would have been available.

7.24. The panel also discussed the complicated matter of Sasha's mental capacity in light of her alcohol consumption and the multiple and repeated episodes of non-fatal strangulation and head injuries that she experienced. Having mental capacity means that a person can make their own decisions. Practitioners should always start from the assumption that the person has the capacity to make the decision in question,¹⁸ and show that every effort has been made to encourage and support the person to make the decision themselves,¹⁹ whilst remembering that if a person makes a decision that the practitioner considers eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision.²⁰

7.25. In Sasha's situation there were two instances where her ability to have capacity could have been considered. The first is regarding whether her mind or brain was impaired, and the second is where the levels of coercive control are so high that her decision making may have been affected. It was the panel's view that in Sasha's case it is possible that both applied.

7.26. Head, neck and face injuries are common for women experiencing domestic abuse and those that experience these injuries are at, *'increased risk of experiencing both traumatic (following a serious head injury) and hypoxic (anoxia following non-fatal strangulation) brain injuries.'*²¹ Women who screen positively for these types of injuries are more likely to experience moderate to severe post-concussion symptoms, post-traumatic stress, cognitive, emotional and physical symptoms of brain injury. They are also more likely to experience health and social inequalities describing difficulties navigating health and care systems. Some of the identified issues for women, and especially prevalent those who had experienced both head injury and strangulation are headaches, noise sensitivity,

¹⁸ [Mental Capacity Act, 2005](#) – Principle 1 [Accessed 20.4.25]

²⁰ Ibid – Principle 3

²¹ [Too many to Count- Brain Injury in the Context of Domestic Abuse](#). Brainkind, 2023

sleep disturbance, fatigue, depression and tearfulness, frustration and impatience, forgetfulness, poor concentration, taking longer to think, panic attacks, anger/ rage, hopelessness, worries and fears, flashbacks and sadness. It was the panel's view that Sasha had a high probability of having acquired brain injury, and that there should be future consideration to the use of the Brainkinds' Brain Injury Screening Index when seeking to understand the possibility of this type of injury for those experiencing domestic violence.

7.27. Sasha could also have been experiencing alcohol related brain injury/ damage (ARBI/ D). In the previously cited report it is noted that *'...women who drink more than 28 standard drinks (a minimum of 28 units a week) for 5 years or longer are likely to experience some changes in their intellect, even though many will not be aware of it. Usually, the person's intellect will recover over a period of 3 months of complete alcohol abstinence. However, even when abstinent, a combination of long-term alcohol misuse-associated health problems and vitamin deficiency may well result in longer-standing intellectual problems, some of which may improve over a subsequent 2–3 years of abstinence.'*²²

7.28. In the second instance, there should be recognition that coercive and controlling behaviour can impact on decision making. The sociologist Gilbraith described coercive power as *'used to inflict unpleasant or painful consequences on a person acting on their own choices so that they "choose" to follow the preferences of the person inflicting harm rather than their own'*.²³ Sasha was living in a situation of coercion and control whereby her day-to-day life was subject to violence, rules, threats, intimidation, isolation and limited 'space for action' whereby she was not allowed to make independent decisions.

7.29. The panel also noted that Sasha experienced victim blaming through overtly judgemental attitudes towards her, which minimised the risks that she faced. Covert victim blaming also existed through concepts like 'non-engagement' and

²² [Alcohol and brain damage in adults](#). Royal College of Psychiatrists. 2014

²³ [Mental Capacity and Coercion](#). Research in Practice, 2016

expectations on her to change the relationship and to hold Latif to account for violent coercion. Some of this was historic and the panel hoped that the overt victim blaming would not take place today. However, other panel members felt realistically that it is still part of the landscape. It is imperative that the learning from this report is used to understand that blaming Sasha, a highly vulnerable woman, for the behaviour of Latif is both unacceptable and indicative of the misogyny inherent in gender-based violence.

7.30. Accountability mechanisms and the management of perpetrator's behaviour was a key focus of the panel and resulted in an expert on those who cause harm being engaged to participate. Panel members noted the striking lack of information and focus on Latif in the chronology overall, and specifically within the MARAC process, a disturbing representation of the ease with which he could hide his harmful behaviour. They noted that Latif should have been managed as a Potentially Dangerous Person²⁴ through police processes, noting that he is free today and likely behaving exploitatively with other women. Processes and developments have taken place since Sasha's death in London and Kent with further activity resulting from this review.

7.31. One mechanism that was used routinely was that of Domestic Violence Protection Orders (DVPOs). DVPOs are a civil order designed to fill a 'gap' in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. They can also be used alongside bail with conditions and other protective measures simultaneously to build up greater protection for the victim.

7.32. The Home Office note that, *'A DVPO... allows the victim a degree of breathing space to consider their options with the help of a support agency... Although the*

²⁴ A "potentially dangerous person" (PDP) is an informal term police use for an individual who has not been convicted of an offense but whose behaviour suggests they may cause serious harm.

power to issue a DVPN and subsequent application for a DVPO lies with the police..., the success of any such process will be reliant on the partnership work with other agencies and organisations including those that contribute to Multi-Agency Risk Assessment Conferences...Engagement with the victim and the agencies referred to above at the earliest opportunity, is crucial to the success of the DVPN/ DVPO process.'

7.33. However, the Home Office description of success being reliant on partnership work through engagement with the victim and agencies did not take place and presented missed opportunities (on five occasions) to intervene in a coordinated way in Latif's control. Rather, they were put in place without a coordinated safety plan; Sasha was left to cope alone for the 28-day period of the orders.

7.34. The panel acknowledged that there were some attempts to hold Latif accountable. However, there were missed opportunities to achieve this, with the primary issue being in the investigation and undertaking of evidence-led prosecutions. The CPS identifies three key types of ELP with which officers need to be familiar prosecutions based on either hearsay, those featuring 'hostile' victims, or those based on circumstantial evidence.

7.35. The panel considered evidence-led prosecutions via the significant assault that Sasha experienced in November 2020 with the case making it to court as a charge of Grievous Bodily Harm, but being dismissed for a lack of evidence, because Sasha could not support the prosecution. Treating Sasha as a hostile witness would have been an option but would have implications for her safety. However, it was noted by the panel and the family that it seems unlikely that there was not other evidence that could have been gathered through investigation and presented to the court, from practitioners/ agencies, the forensic evidence and including overwhelming evidence of Latif's bad character.

7.36. The panel also considered the broader matter of a charge of Coercive and Controlling Behaviour which became an offence in 2015. In the 12 months to March 2024 - 44,212 CCB offences were recorded by the police with only 9% of

them reaching a first hearing at Magistrates Court. This speaks to a general issue with attrition rates for this crime.²⁵ Low charge rates are likely to be indicative of how proving patterns of abusive behaviour requires evidence of a course of conduct over time which takes time to investigate and gather. It was the panel's view that evidence of a course of conduct was available in this situation, but it did depend on the ability of officers to build an evidence-led case. Attempts were made unsuccessfully to engage the CPS in the review.

7.37. Latif's behaviour presented as sociopathic with an obvious disregard for who was hurt and when, which caused a climate of fear for Sasha, and her family and presented risks for professionals. In gathering evidence consideration must be given to practitioner safety. However, when Sasha was released from hospital following her stroke the Occupational Therapy team recognised that it was unsafe for them to visit her alone. This was an important safeguard, but it is important to note that it was disturbing for her family to know this whilst she remained trapped in the relationship, alone.

8. Conclusions

8.1. Sasha was a vulnerable woman who experienced multiple disadvantages including violence and abuse from members of her community and predatory males seeking to exploit her financially.

8.2. She lived with multiple disadvantages and extreme coercion and control causing her to find services impossible to access. The extent of the coercion, systemic barriers and limitations within existing safeguarding structures rendered her and agencies providing her support helpless.

8.3. The perpetrator of her coercion was able to continue to violently abuse, exploit and control her because agencies did not successfully intervene to safeguard her.

²⁵ [Shifting the Scales](#). Domestic Abuse Commissioner, 2025

8.4. Consequently, she became increasingly unwell and disabled until she died in hospital.

8.5. The review identified many attempts at good practice, and many agencies who tried to support Sasha within the confines of their policy and practice.

9. Lessons to be Learned

9.1 Professionals dealing with victims of domestic abuse must consider the impact of coercively controlling behaviour and childhood trauma on the victims' ability to leave a relationship.

- This is necessary to ensure that vulnerable victims are not held accountable and blamed for the behaviour of a perpetrator of domestic abuse.
- Consideration should be given to the ways in which the perpetrator can be disrupted and diverted from the abuse and held accountable for abusive behaviour.
- Options to maintain a high-risk status for a vulnerable victim should be explored to reduce the dependence on risk assessments.
- Services should organise themselves around a vulnerable victim in order to afford the best chance of the victim developing the sense of safety (both actual and psychological) and resources that they may need to leave.
- Professionals must be curious regarding the dynamics of domestic abuse and its impact on the victims' space for action.

9.2 Agencies must be informed about adult safeguarding pathways and opportunities to escalate concerns.

- This is necessary to ensure that policy and process barriers do not inhibit access to support for vulnerable individuals.
- Consideration should be given to the use of informal and formal opportunities to bring professionals together to create protective plans for vulnerable people.
- Professionals and agencies should utilise creative and curious multiagency practice to ensure that resources are utilised as effectively as possible.

9.3 Investigations and interventions in relation domestic abuse related offences/ offenders must take place with a view to evidencing crimes without the statements of the victim in line with best practice.

- This is because high harm perpetrators of abuse must be held to account for their behaviour and to avoid further harm to other vulnerable victims.
- Evidence led policing must be developed in line with policy and case-building best practice to ensure that this happens.
- Investment into perpetrator programmes for high harm antisocial perpetrators should be routinely available.

9.4 When undertaking multi-agency processes practitioners must be curious about the intersection of risks.

- This is to ensure that cross-issue thinking takes place, in this example, the intersection of cuckooing type behaviour and domestic abuse.
- Agencies must be curious about the lived experience of vulnerable victims ensuring that they pay attention to their voices and do not fail to identify risks and needs.
- Communication and consideration of risks should be used to form a whole picture ensuring that key risk indicators are not lost.

10. Recommendations from the Review

	Recommendation	Organisation
1.	Kent and Medway and Bexley DA Partnership Boards should raise awareness of the potential intersection of domestic abuse and cuckooing for vulnerable women, including the availability of the Cuckooing Risk Identification Tool.	Kent and Medway/ Bexley DA Strategy Groups
2.	Kent and Medway agencies should ensure their policy, guidance and training in relation to modern slavery is not solely focussed on migrant communities and raises awareness of the potential for sexual exploitation of individual women living with multiple disadvantages and include guidance where required on the Duty to Notify referral to the NRM.	Kent Police KCHFT KMPT Kent ICB
3.	Kent and Medway agencies should ensure their policy, guidance and training in relation to cuckooing to ensure that it is not solely focussed on drug-gang related activity and includes the potential for sexual exploitation of individual women living with multiple disadvantages in line with the new Crime and Policing Bill (Ch.2, 57(4/5))	Kent Police KCHFT KMPT Kent ICB
4.	MARAC should be reviewed to include a permanent high-risk status and pathway for those who remain in a relationship where risk levels are unlikely to change and/ or experience multiple disadvantage. This should trigger additional professionals' meetings in line with	MARAC Operational Group - Kent

	Recommendation	Organisation
	the MOP. The activation of this marker and process should be communicated across agencies. Consideration should be given nationally to the development of pathways for those who remain high risk of harm and experience multiple disadvantages through pathway development	Standing Together Against Domestic Abuse Standing Together Against Domestic Abuse
5.	The Kent and Medway DA Strategic Group should use the learning from this review in its current review of the new MARAC case management system to maintain oversight and achievement of outcomes for victims of domestic abuse.	KMDASG
6.	Public Health to update the Co-occurring conditions policy with reference to the prevalence and impact of domestic abuse on the lives of those served by this policy. Public Health to confirm whether a 'Co-occurring conditions guidance panel' or other function is operational for any necessary amendment to be made to the Additional Barriers Framework. Public Health to update the Co-occurring conditions policy with reference to MARM as an available process for the management of risk (in the absence of any other approach).	Public Health
7.	KMPT should use the learning from this review to undertake reflective practice with Mental Health	KMPT

	Recommendation	Organisation
	Together teams with a view to considering what pathways and services are available for those in this situation today and producing action plans or recommendations for any necessary developments.	
8.	Adult Social Care should raise awareness of how coercive control can impact on people's ability to engage with assessment and highlight where Section 11 assessment may apply.	Kent Adult Social Care
9.	Adult Social Care Strategic Safeguarding to utilise the learning from this review to develop a resource to share with the domestic abuse champions network through reflective practice.	Kent Adult Social Care
10.	Adult Social Care to undertake an awareness campaign across practitioner meetings and ASC intranet of the impact of coercive control and interpersonal violence trauma on people with the appearance of care and support needs, and the need for timely intervention.	Kent Adult Social Care
11.	Kent and Medway DA Strategy Group should develop awareness of brain injury and non-fatal strangulation for victims of domestic abuse, including the intersection with mental capacity and Brainkind's Brain Injury Screening Index. This should be incorporated into the Additional Barriers Framework.	KMDASG Oxleas
12.	Agencies involved in this review to propose that the KMSAB Mental Capacity Resource Pack, currently under development, gives consideration to including guidance on mental capacity in the context of domestic	KMSAB Policy Procedures Working Group Oxleas

	Recommendation	Organisation
	abuse and coercive control, drawing on nationally available resources.	
13.	A briefing on brain injury prevalence and the availability of the Brain Injury Screening Index should be produced by the partnership group, disseminated as part of the review briefing, included in the relevant policies, promoted by KMSAB and posted to their website. The <i>'Multi Agency Protocol to safeguard adults with Care and Support needs who are impacted by Domestic Abuse'</i> should be reviewed to include the impact and prevalence of brain injury and possible use of Brainkinds' BISI tool.	Kent Community Safety Partnership Supported by KMSAB Policy Procedures Working Group Oxleas
14.	MARAC Chairs and domestic abuse organisations should be trained or introduced to the MARM Framework for use with those with entrenched domestic abuse and multiple disadvantages.	KMDASG
15.	Kent Police should use the learning from this review to ensure a cohesive approach between investigative teams (Rape and High-Risk DA/ PVT) and the MATAC/ MARAC processes.	Kent Police
16.	Kent Police should develop the domestic abuse scrutiny panels to look at cases that do not progress at court due to victim retraction, seeking to understand whether dependence on the victim's testimony could have been avoided through case building.	Kent Police
17.	Kent Police to propose to the Kent and Medway DA Strategy Group that a tasking group is developed seeking to develop multiagency guidance on domestic abuse evidence led prosecutions and how a	Kent Police

	Recommendation	Organisation
	coordinated case building response can be developed that would support policing practice whilst maintaining practitioner safety and victim engagement.	
18.	PVTs should work with DA Agencies using the learning from this review to inform the development of a safety/ engagement plan at the point of issuing a DVPO.	Kent Police
19.	EKHUFT should consider the learning from this review in the context of their visitors' policy, ensuring that it is rigorous in its ability for nursing staff to remove and ban visitors who are known to be harmful to patients.	EKHUFT