

Domestic Homicide Review

Sasha

December 2023

Overview Report

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Commissioned by: Kent & Medway Community Safety Partnerships

Review completed: November 2025

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Tribute from Sasha's family

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.

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1. Introduction

- 1.1. This Domestic Homicide Review (DHR) examines agency responses and support given to Sasha, a resident of Town A, prior to her death in December 2023. On that day, having been in hospital for some time with health issues related to a previous stroke, cirrhosis of the liver and neglect, Sasha died of hospital acquired pneumonia.
- 1.2. 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.
- 1.3. 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.
- 1.4. This review 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 had been ratified by the Chair of the Partnership.
- 1.5. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, it was agreed that this review would be conducted using the DHR methodology. The Home Office was informed of the decision to review.

- 1.6. The review report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members.
- 1.7. 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 as a result 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.

2. Confidentiality

- 2.1. The findings of this DARDR are confidential. Information was available only to participating officers/professionals and their line managers, until after the DARDR had been approved by the Home Office Quality Assurance Panel and published.
- 2.2. Dissemination on publication is addressed in Section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Sasha's family.
- 2.3. Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Sasha	Female	Late forties	Deceased	White British
Latif	Male	Mid fifties	Perpetrator	Asian British

- 2.4. The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	Relation to deceased:	Relationship to perpetrator:
Son	Son	N/A
Mum	Mother	N/A

3. Timescales

- 3.1. This review began in March 2024 and was concluded on xxxx. The Home Office guidance recommends that a review is completed within six months. The timeframe was not achievable in this review due to the following circumstances:
- 3.2. Sasha's mother and son were engaged gradually in the review, and the panel determined to slow the process to accommodate their grief, and the extensive insights that they had into Sasha's history of domestic abuse and engagement with agencies.
- 3.3. The panel were required to analyse a significant volume of contacts across the scoping timeline; this took time outside of the norm to ensure that the report was meaningful in its assessment of lessons to be learned.

4. Methodology

- 4.1. The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Sasha and/ or Latif. An IMR is a written document, containing a series of key lines of enquiry to which the author must respond. The IMR should also include a full chronology of the organisation's involvement, which is submitted on a template.
- 4.2. IMR authors are members of staff from the organisation to which it relates. Each IMR submitted for this review was signed off by a Senior Manager of that organisation before being submitted to the DARD Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Sasha or Latif during the period covered by the review.
- 4.3. 33 agencies were scoped for the review with 29 agencies producing reports. The original chronology of information received amounted to almost 80 pages. In order to

ensure the report was meaningful the panel determined that non-essential information should be excluded, and some information should be summarised for brevity. This was undertaken in tandem with family meetings to ensure that theirs and Sasha's voices were not lost in this editing process.

5. Terms of Reference

- 5.1. The Review Panel first met in May 2024 to consider draft Terms of Reference, the scope of the DARDR and those organisations whose involvement would be examined in line with the purposes of a DARDR. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report. The key lines of enquiry are included in this section for ease of reference.
- 5.2. The review aimed to establish whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sasha. It also aimed to establish if such abuse took place and was not identified, consider why not, and how such abuse can be identified in future cases.
- 5.3. The full subjects of this review will be the victim, Sasha, and the alleged perpetrator, Latif.
- 5.4. The key lines of enquiry set out for the review were:
 - 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. Involvement of Family Members and Friends

- 6.1. The initial information identified that Sasha had a close relationship with her mother and son, and both were written to by the Community Safety Partnership followed shortly after by the panel chair at the start of the review. Both were provided with the Home Office DHR leaflet along with details about AAFDA.
- 6.2. Sasha's mother responded immediately and spoke with the chair, accepting the offer of a referral to AAFDA. Initially, Sasha's son did not wish to be involved. However, after some reflection he chose to be involved, and the panel slowed the process to accommodate further meetings and inclusion of his voice. Both were supported by a single AAFDA advocate.
- 6.3. Both Sasha's mother and son reviewed the terms of reference document to assist with review scoping. The document was left with them to afford adequate time for reflection. They provided detailed information regarding Sasha's experiences. They opted not to meet the review panel but did submit a picture and a tribute for the panel's review.
- 6.4. Prior to the draft report being finalised Sasha's mother and her son chose to withdraw from the process for their own wellbeing. They expressed their trust in the report author before doing so. However, it was agreed that the chair would remain in touch with the advocate, providing updates and that they could become involved again at any point. It was also agreed that the chair would advise Sasha's mum when the final draft report had been presented to the panel.
- 6.5. Sasha's mum and son did choose to read the report when it was finalised. The report was discussed with Sasha's mum and then sent to both following final panel approval for them to read it prior to Home Office submission. 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.

- 6.6. 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.

7. Contributing Organisations

- 7.1. 33 organisations were approached to contribute information to the review. Of those organisations, 29 had pertinent information to share. 14 of those were asked to complete full IMRs, 2 were MARAC settings and were asked to submit minutes of all meetings and 13 were asked to contribute short reports. The contributing agencies 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

Agency/ Contributor	Nature of Contribution
Oxleas NHS Foundation Trust	IMR
Kent and Medway Partnership Trust (KMPT)	IMR
Kent GP 1	IMR
Kent GP 2	IMR
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 (background information)
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

8. Review Panel Members

- 8.1. 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.
- 8.2. 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. All of these agencies were from agencies who had written IMRs, with all, except for the substance use service, having dual representation from Kent and a London borough.
- 8.3. 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.
- 8.4. The members of 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

Agency	Name	Job Title
	Ceil Newton (observer only)	Officer/Resettlement Manager 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

8.5. Panel members hold senior positions in their organisations and have not had contact or involvement with Sasha or Latif. Dual representation across many of the agencies enabled a cross agency critical review of practice. The panel met on four occasions during the DHR.

9. Independent Chair and Author

9.1. 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.

- 9.2. Deborah has developed a wide range of skills and techniques around the analysis of complex data, report writing, consultation, evaluation and learning review of practice systems. She undertook a research-based master's degree, graduating with distinction and has qualified with AAFDA as a Home Office accredited DHR/DARDR Chair. Deborah worked in Kent as Chief Executive of Oasis Domestic Abuse Service, leaving that role in 2023. Oasis was not involved in this review and Deborah is fully independent of practice in Kent today.

10. Other Reviews/Investigations

- 10.1. Despite the significant context of domestic abuse Sasha died in hospital of natural causes (noted on her death certificate as 'hospital-acquired pneumonia) and had a life limiting illness (cirrhosis of the liver). Consequently, there was no coronial investigation/ inquest held.
- 10.2. There were no other parallel reviews or investigations into Sasha's death.

11. Publication

- 11.1. This overview report will be published on the websites of Kent and Medway Community Safety Partnerships.
- 11.2. Family members will be consulted about publication dates, and any additional support they might require and will be provided with the website addresses and also offered hard copies of the report.
- 11.3. Further dissemination will include:

- a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Boards 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. Bexley Community Safety Partnership website and learning event
- e. Additional agencies and professionals will be identified who would benefit from having the learning shared with them.
- f. Briefings are offered to the local CSPs by Kent County Council's Community Safety Unit at the partnership meetings.
- g. A short briefing document highlighting key learning is circulated upon publication.
- h. Learning events held by Kent Community Safety Partnership.
- i. The Domestic Abuse Commissioner's Office

12. Equality and Diversity

The Panel considered the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, ethnicity, sex and sexual orientation) as prescribed in the Equality Act, 2010, seeking to establish if they were relevant to any aspect of this Review. The Panel also took an intersectional perspective in considering Sasha's access to services, specifically in relation to the multiple disadvantages that she experienced. The Panel considered whether access to services or the delivery of services were impacted by any of these features, and if any of them had in any way acted as a barrier. The Panel identified the following characteristics and intersectional issues that required consideration.

12.1 Sex

- 12.1.1 There is extensive research to support that in the context of domestic violence and abuse, females are at greater risk of being victimised and significantly harmed or dying because of this abuse. In fact, the term 'femicide' was coined in the 1970's in recognition of the extent of these violent deaths of women.¹

¹ South African feminist activist and scholar Diana Russell popularized the term to help rally activists to protect women. Russell's definition has since been refined to include only intimate partner crimes.

12.1.2 The third annual report from the national Domestic Homicide Project which works across England and Wales was published in March 2025. This report identified that, in line with wider literature on domestic homicide and suicide following domestic abuse, the majority of victims were female (73%, n=739/1012).²

12.1.3 Violence against women remains devastatingly pervasive with one in three women internationally subjected to physical and/ or sexual violence by an intimate/ non-intimate (in many instances of sexual violence) partner.³ Physical and/ or sexual violence is the leading cause of injury for women globally.⁴ The health consequences of this violence are far-reaching including physical injuries, chronic pain, gastrointestinal issues, increased risks of depression, anxiety and suicide attempts.⁵

12.1.5 Based on the panel's review of the information provided by agencies, Sasha was subject to patterns of abuse in both her intimate relationships and community that were acts of violence and exploitation on a gendered basis, enacted because she was female. The physical and sexual violence that she faced both within and outside of her home caused her significant mental and physical health problems.

12.2 Disability

12.2.1 Individuals are disabled under the Equality Act, 2010 if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities.

12.2.2 Sasha experienced persistent mental health issues throughout her adult life which resulted in her receiving a diagnosis of Emotionally Unstable Personality Disorder (EUPD). Her mental health issues caused "substantial, adverse, and long-term"

rally activists to protect women. Russell's definition has since been refined to include only intimate partner crimes.

² [Domestic homicides and suspected victim suicides 2020-2024 Year 4 report](#) [Accessed 21.10.25]

³ [World Health Organisation, 2021.](#)

⁴ [Un Women UK](#) (accessed 15.5.25)

⁵ [Violence Against Women – Key Facts, World Health Organisation](#) [Accessed 15.5.25]

impacts to her wellbeing and ability to function in society.⁶ Her mental health issues were compounded/ exacerbated by alcohol use which she used a coping strategy for the complex trauma that she experienced.

12.2.3 In the final two years of her life Sasha experienced physical disabilities related to both injury from violent assaults and a parietal haemorrhage (stroke) which although impossible to prove were likely to have been caused by repeat assaults to the head, one of which resulted in skull fractures and by repeated episodes of non-fatal strangulation.

12.2.4 For the purposes of the Equality Act definition, it was the view of the panel that Sasha should be considered a woman who lived with complex disabilities. Consequently, her ability to access services was significantly impacted by the disabilities themselves and then further compounded by the extreme violence and control that she lived with.

12.3 Race & ethnicity

12.3.1 Being White British would not usually create the barriers to support that those from Black and minoritised backgrounds might face. However, the panel wished to reflect that two specific issues may have exacerbated the barriers to help faced by Sasha. These are the failure to recognise her as a victim of modern slavery and the risk of her being stereotyped in a racist trope as a 'traveller'.

12.3.2 The concept of modern slavery goes hand in hand with human trafficking and ideas of forced servitude. These are often considered to be issues faced by migratory groups entering or living in the UK. However, it is important to note that the signs of modern slavery: appearing to be under someone's control, having few personal belongings, not able to move around freely, being reluctant to talk to strangers or officials, appearing frightened withdrawn or showing signs of physical or psychological abuse⁷ were all present for Sasha.

⁶ Equality Act, 2010

⁷ www.antislavery.org/slavery-today/spot-the-signs-of-slavery/ [Accessed: 30.7.25]

12.3.3 In tandem with Sasha's experience of gender-based violence, sexual exploitation and her disabilities it was the panel's view that this report should highlight the risks faced by women living with multiple disadvantages and the risks and barriers that they face if they are subject to economic exploitation by abusive men.

12.3.4 At one point in the chronology an agency recorded her a 'client from traveller community', this was written with no contextual analysis of how this might impact on her access to services. Travelling communities are subject to racism in the UK and a non-contextual statement such as this both stereotypes and consequently creates a barrier to help. The need for cultural humility in training and awareness terms has been addressed in both the London borough and Kent since this happened.

12.4 Intersectionality

12.4.1 Intersectionality is a sociological framework that assists in the analysis of how individuals' and groups' social and political identities result in unique combinations of privilege and discrimination. The protected characteristics, outlined above, contribute to this along with other factors, such as class, wealth and so on. Coined by Kimberle Crenshaw, the concept originated in considering the multiple and intersecting oppressions faced by Black women but is used today more broadly to consider power and oppression across society.⁸

12.4.2 Intersectionality is an important concept when considering members of society who face multiple disadvantages and consequently experience more structural inequalities. Women who experience multiple disadvantages⁹ are shown in research to be more likely to have experiences of abuse, violence and trauma.¹⁰ The co-existence of these issues and experiences creates intersecting barriers to help-seeking and accessing service provision including becoming 'stuck' in cycles of poverty, abuse and exploitation. There is a lack of holistic gender-responsive and

⁸ [Intersectionality 101: what is it and why is it important?](#)

⁹ Multiple disadvantages, also known as multiple needs or severe multiple disadvantage (SMD), refers to individuals experiencing a combination of two or more challenging life circumstances, such as homelessness, mental ill-health, substance misuse, and/or contact with the criminal justice system. These interconnected issues often stem from long-term poverty, trauma, abuse, and neglect.

¹⁰ [Agenda briefing: Women and girls facing multiple disadvantage](#), Agenda Alliance. 2020

trauma-informed services that can work with women with multiple vulnerabilities, with the available services being inaccessible based on resourcing and structural issues.

12.4.3 The panel found that Sasha's experience was congruent with these known experiences for women living with multiple disadvantages. Within the analysis section they sought to consider the multiple and intersecting barriers that she experienced that contributed to her becoming increasingly subject to the coercive control of a predatory, violent man.

13 Background Information

13.1. According to agency information 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.

13.2. 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.

13.3. 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.

13.4. 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.

- 13.5. 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.
- 13.6. Although Sasha died of natural causes the extent of the violence and abuse that she had experienced led to a Domestic Abuse Related Death Review referral and a subsequent decision to undertake this review.

14 Chronology

14.1 Summarising the chronology

- 14.1.1. As outlined in Section 4 there were 2,536 points of contact for Sasha across the collated chronology, 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, the chronology has been summarised in parts, and immaterial agency contacts have been excluded to maintain focus on the key lines of enquiry.

14.2 Pre-2016 - London

- 14.2.1. Sasha's family advised the author that she worked as a health and safety professional in the building industry as a young adult which enabled her to buy her own home. Sasha's mum advised of an ectopic pregnancy that was terminated when Sasha was very young and that this took a significant toll on Sasha's mental health. After the ectopic pregnancy, Sasha was told her chances of conceiving were reduced. Her Mum noted that after this Sasha was observant of pregnant women and babies describing her as 'seeing them everywhere.' Soon after she became pregnant with her only son. After he was born Sasha tried to juggle the demands of her career and caring for a young child. Sasha's mum also noted that alcohol was a significant part of her work culture, and over time this became unmanageable. Children's Services became involved and

advised her to leave her job, relinquish her property, and move into social housing; consequently, Sasha and her son moved to a deprived part of London.

14.2.2. Years later Sasha is known by agencies to have mental health difficulties and problematic alcohol consumption, and by 2014 Sasha's son, at age 14, had been removed from her care and placed with his maternal grandmother. He described a key insight from before the time he moved to his grandmother's home. He recalls Sasha having a week-long hospital admission relating to her mental health, and how rejuvenated she was when she was discharged.

14.2.3. According to health and IDVA records, as well as her family's recollections Sasha had been abused in relationships before and during this time, including an assault with a hammer in 2014. During support for this incident, she described to her GP that the boyfriend was 'her main carer'. As a result of her reporting this matter to the police she is harassed and assaulted (physically and sexually) by the perpetrators' friends. During these GP appointments, Sasha starts to disclose that on top of alcohol misuse she is misusing substances (diazepam) to cope with the fear and trauma she is experiencing.

14.3 – 2016 – London

14.3.1. Sasha had limited contact with services in 2015, notably with her GP and twice with mental health services. From the beginning of 2016 Sasha is increasingly in touch with services variously for her mental health, threats of and abuse by a local group (seemingly a drug gang), whom she refers to as '*travellers*'¹¹ and domestic abuse. There were 84 points of contact across this year with services.

14.3.2. Primary Care services – Sasha consistently and routinely saw her GP with records showing that she was on regular medication for her mental health and was open about her distress. Sasha was already discussing moving home for her safety and in one note

¹¹ 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.

the GP recorded that they had spoken with Adult Social Care (ASC) who advised they have supported her move, and she is on the list. Sasha saw her GP 10 times over the course of the year and continued to describe problematic substance use. Her GP referred her to mental health services routinely.

14.3.3. Mental health services – Sasha had five opportunities for contact with mental health services. In the first she had a review of her multiple medications and referrals out to Mind and counselling,¹² on the second, fourth and fifth occasion contact was not established, on the third she was referred to the ‘Freedom Project’¹³ via a Women’s Aid organisation. Sasha self-referred to mental health services on two of these occasions. The first time (February) she described experiencing *‘distress and social isolation.’*

14.3.4. Police services –there were seven records in relation to Sasha. Two related to a report of threats of abuse by *‘travellers’* and an assault by them. Five related to domestic abuse by a boyfriend which included two MARAC hearings that consider her generally at high risk of harm.

14.3.5. IDVA services – Sasha had 57 records relating to support from the local authority IDVA service with extensive work undertaken to support Sasha’s safety in this relationship, including safety planning, liaisons and safeguarding referrals. Her boyfriend at this time was imprisoned twice. Whilst he is on remand for the first incident, the IDVA recorded that Sasha stated she wanted to reconcile with him as *‘he will protect me from the travellers.’* She later describes that she will have *‘to sex work due to her partner leaving her with a large drug debt.’*

14.3.6. In August, the IDVA recorded contacts with ASC and *‘Mental Health’* who both stated that Sasha is not receiving any support from them. The IDVA recorded a plan to organise a professional’s meeting due to her risk status (there is no record of this meeting). By the end of August Sasha states to her housing officer that she, *‘wants to jump into a hole’* and states again that she is being abused and exploited by the local gang. Her IDVA records, *‘IDVA is sensitive to Sasha’s need not to be parted from*

¹² Due to the record keeping policies, in line with the Data Protection Act 2018, Mind did not maintain Sasha’s records, so these were not accessible to the review.

¹³ This is likely meant to be the Freedom Programme – a domestic abuse awareness course for women.

the dog, refuge and pet fostering were offered as options. Sasha does not wish to report the latest incident to the Police and wishes to move closer to her son in [Kent]. A fast-track housing application is undertaken which is subsequently denied due to *'no housing need - as it would take too long to successfully bid and the length of time survivor would be at risk in the current property.'* In a strategy meeting the housing officer offers to escort Sasha to Kent to make a homeless application. They begin the process online.

14.3.7. A housing strategy is noted as taking place in December. Sasha wishes to move to Kent and conversations begin again with a Kent housing authority. The IDVA contacts ASC in December to discuss Sasha's *'multiple support needs.'* Based on Sasha's experience of coercive control, the housing officer has her rent arrears of £3,000 removed.

14.3.8. Sasha's family described this period as being one where drug debts are being accrued in Sasha's name and local dealers/ her boyfriends are forcing her into prostitution to pay these debts and for financial exploitation generally. Her family are clear that, in line with Sasha's voice to agencies, she did not willingly engage in sex work/ survival sex and that this was sexual exploitation and she was frightened of reprisals. They were also clear that Sasha struggled so significantly emotionally that she found separation from her partners incredibly difficult even where there was such abuse taking place. They positioned themselves as carers, as Sasha herself was stating to agencies.

14.4 – 2017 – London

14.4.1. At the start of January 2017 Sasha was in a relationship which was abusive and was continuing the pattern of vulnerability and exploitation outlined above. He was imprisoned for assaulting Sasha early in 2017 and was released and re-imprisoned having assaulted her again. By the time he was released for the second time a new friend was helping Sasha, this later turned out to be Latif. She was known to be having a relationship with Latif by the autumn and was experiencing violent assaults and control from the beginning of their relationship. There were 82 points of contact with and between agencies in 2017 in relation to Sasha.

- 14.4.2. Primary Care services- Sasha saw or spoke to her GP surgery on 27 occasions throughout 2017. She was open about her needs and experiences with them and disclosed abuse and assaults on seven occasions. In the latter part of the year, when she is in a relationship with Latif, she told her GP that her new boyfriend had her benefits paid into his account which her Mum was helping her to sort out.
- 14.4.3. One of Sasha's disclosures to her GP (in November) was of an assault, it is noted that she was, *'strangled by boyfriend and flung around her room so hard it broke the bed frame. At that point, he stopped. Has pain in her neck and P+N [pins and needles] in both her hands. Police have been involved in past, and she says she wants to leave him but he's still hanging around... advised to stop all contact with boyfriend given alleged assault.'* There were no external liaisons recorded by the GP in relation to domestic abuse disclosures.
- 14.4.4. IDVA services – there were 36 points of contact noted during this year with 26 of those being information sharing and some casefile updates. There were 10 direct contacts between the IDVA and Sasha. Some were related to the former boyfriend and in the latter part of the year contact escalated as it became apparent that Latif was abusing Sasha. Between June and August, when Sasha's former boyfriend was in prison, her IDVA recorded, *'travellers have resumed sexual exploitation of her'*.
- 14.4.5. Housing – there were attempts to gain Sasha temporary housing whilst her former boyfriend was in prison, but accommodation that would accept pets was unavailable. By March Sasha was undertaking a housing application to move to Kent and was using the library to complete her forms. Her housing authority and Kent were liaising regarding a possible home swap, and she is advised by Kent that she will receive one direct offer from them which she is advised to accept, she agrees. There is no record of an offer being made.
- 14.4.6. Secondary mental health services - in early February Sasha's GP recorded an outcome letter from the psychiatry clinic at Oxleas, following Sasha's assessment. It stated that Sasha declined support from a substance misuse service and that they were unable to offer support due to unaddressed substance misuse.

- 14.4.7. Metropolitan Police Service (MPS) - in mid-September a *'friend'* contacted the emergency services to inform them that Sasha is expressing suicidal thoughts, later notes identified this friend to be Latif. MPS recorded that the *'DV Crisis Team'* were called to Sasha, who assured them she would not harm herself. In the run-up to this call, Sasha saw her GP stating she was unable to travel due to housing issues and no longer feels she can work to reduce her medication use due to stress and increased anxiety levels. She was advised to keep her Nexus¹⁴ appointment, and the GP recorded, *'needs a letter to support state her medical condition emotionally unstable personality disorder and manic depressive. Moods are all over the place.'*
- 14.4.8. In October Sasha did not attend an IDVA meeting, and they endeavoured with MPS to have a welfare check for Sasha, due to concerns that she could have resumed her former relationship. MPS undertook the check and found that she is with her new boyfriend, Latif, who *'appears to take care of her very well.'* Sasha stated to the police that her IDVA is hard to get hold of. A decision is taken to close her case by the IDVA, as she appears to be happy in a new relationship. At the end of October MPS received a non-crime report from Sasha as, *'Both parties decided to end the relationship, a verbal argument ensued.'* Sasha and Latif were spoken to separately, but neither would respond to DASH indicator questions.
- 14.4.9. The Metropolitan Police IMR author noted that Latif was known by MPS since adolescence, and for multiple offences, thereafter, including violent offences, one being grievous bodily harm and some for domestic abuse. MPS had over 100 contacts listed with him.
- 14.4.10. At the end of December police attended Sasha's home after a disconnected call and she disclosed threats to kill, being hit about the head and that Latif had been transferring her money into his account and was controlling her finances. She also stated that she relied on him as he protected her from the local gang – 'travellers' – who forced her into prostitution at a local park. She signed a short statement saying she had been assaulted but did not want to give a full statement. When arrested Latif denied the allegations but admitted that her money went into his account, stating he was helping her with her drug problem.

¹⁴ A support service for alcohol addiction.

14.4.11. MPS recorded, *'[Latif] was arrested for TTK [threats to kill] and assault against [Sasha]. [he] had threatened to cut off her head with a saw. Insufficient evidence to proceed – NFA [no further action] after CPS [Crown Prosecution Service] advice.'* MPS pursued a Domestic Violence Protection Notice (DVPN) with the order being agreed by a judge who, *'decided that the DVPO was necessary and granted the Order in the hope that Sasha may reconsider her stance and actively engage with both Police and the available support agencies during the next 28 days.'* Sasha was present at the hearing; she opposed the order and described Latif as her 'carer'.

14.4.12. The IDVA service received a new referral from MPS and the IDVA noting, *'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 community¹⁵, Multiple MARAC [referrals]'* The IDVA called Sasha on the same day who stated that he is a serial perpetrator of abuse, but he protected her from the 'travelling community', and she does not wish to support prosecution. The IDVA noted that Latif is known to the MARAC process for his behaviour and that a DVPN was authorised as Sasha was unable to support a prosecution. Latif was served with the DVPN, and Sasha reported to the IDVA that she was *'sad to be on her own'*, she refused temporary accommodation as she had a dog, two cats and a guinea pig. The DVPO was issued in early January for 28 days and in the run up to this the IDVA had maintained contact with Sasha undertaking safety planning with her.

14.5 – 2018 – London

14.5.1. In 2018 Sasha had 107 points of contact recorded by agencies relating to her own physical and mental health but predominantly related to the domestic abuse perpetrated by Latif. She was heard at MARAC four times in this year.

14.5.2. Primary Care – Sasha's GP had 31 records relating to her with 14 of these being direct contact. On nine occasions she disclosed physical violence and/ or controlling

¹⁵ The panel wished to note that this record exhibits a racist tone towards the travelling community which is unacceptable

behaviour by Latif. There were no external liaisons recorded in relation these disclosures.

- 14.5.3. Her GP worked to engage Sasha in mental health support recording in early January 2018 that the mental health team had prescribed Quetiapine.¹⁶ They also recorded in February that she had been allocated a care coordinator. By April she is noted as *'depressed and tearful'* by the GP and on the maximum dose of Sertraline¹⁷, with Quetiapine *'giving her nightmares'*. At this appointment, the GP noted that they had not mentioned the boyfriend in a letter to the mental health team, *'in case he reads it.'* In October she advised her GP that she could not engage with mental health services as Latif, *'made her change her number.'* She also stated she had stopped taking Quetiapine as it made her a *'zombie'*. The GP recorded, *'I have advised and counselled her'* in relation to her relationship disclosures.
- 14.5.4. Sasha's allocated mental health care coordinator was a student social worker from the ADAPT service. They contacted Sasha's IDVA in March asking which services are supporting Sasha, and they were advised that a professionals meeting was being planned. (On the following day the IDVA contacted the police to identify a date for a professionals meeting and recorded, *'Email from ADAPT Team - Sasha attended the service [mid-March] with bruising to her face. She was due to attend an appointment [the following week] but did not attend. Sasha states her boyfriend is responsible for these injuries and that he is a drug dealer. IDVA responds to this stating Sasha does not engage with services and she is in process of organising a professionals meeting.'*)
- 14.5.5. Secondary health services – in 2018 Sasha is seen in hospital twice, firstly in mid-January having overdosed on her prescribed medication. The local area Crisis Team recorded, *'Sasha was assessed [and] referred to Liaison Psychiatry (LPS). Sasha left the hospital prior to being seen by LPS. Patient notes were updated to state that Sasha should be offered a new LPS referral if she returned to A and E.'* This coincided with Latif being subject to the DVPO. She was seen in hospital again in the November following an assault and was referred to a Hospital Independent Domestic Violence

¹⁶ Quetiapine is a medicine that helps with mental health conditions such as schizophrenia, the mania symptoms of bipolar disorder, depression in bipolar disorder and depression (quetiapine is only used together with other medicines for depression)

¹⁷ An antidepressant medication

Advisor (HIDVA), but after initially accepting this support, she declined to work with them. She did talk to her GP about this incident who recorded her as, *'visibly shaken'* and that she was, *'regularly assaulted for no apparent reason.'*

- 14.5.6. At this November GP appointment Sasha also disclosed that Latif *'organised jobs'* for her but never told her what the job would be. He would say he would pay her and never did. *'Sasha disclosed that [Latif] takes her to jobs where she has sex with different males.'*
- 14.5.7. IDVA service – there were 59 records for the IDVA service across 2018. Of these, 14 were either interactions or attempts to contact Sasha, with three being initiated by Sasha. Of note, in January, Latif was subject to a DVPO and Sasha's IDVA recorded four case notes. One is information from the police, the second is eight days after the DVPO was issued, where Sasha declines temporary accommodation as she will not leave her pets. The third is an appointment that Sasha did not attend, and the fourth on the same day as that appointment stated, *'There is the very strong possibility that Sasha is a sex worker, I have come to this conclusion as she has been having sex/dogging¹⁸ activities up the heath now for a number of years, we recognize that sex workers are 5-10 x more likely to be homicide victims. Efforts to move her have failed so housing embarked upon a reciprocal to move her to [Kent]... Despite the continued ongoing efforts of the IDVA to reduce the risk, victim repeatedly refused/fails to attend appointments and doesn't answer her phone.'*
- 14.5.8. Her IDVA did not attempt to contact her in February (Sasha contacted her IDVA twice, advising she was *'okay'* and had been referred to a substance misuse service). In March there were four notes recorded by the IDVA regarding agency liaisons, and frustration at Sasha's *'engagement'*. Having convened a professionals' meeting the IDVA recorded, *'mental health service stated that Sasha had attended 1 appointment with a black eye and then not attended further appointments made. Was offered referrals to counselling at Women's Aid, alcohol treatment - both declined.'* In respect of alcohol services, it is recorded that Sasha stated, *'she needed the drink'*, and *'Support with rehousing including Dogs Trust was offered and declined. Stated that Sasha would not be offered any psychiatric services until she had addressed alcohol'*

¹⁸ A voluntary sexual activity whereby couples swap sexual partners in car parks.

use. IDVA stated that Sasha had not engaged much with IDVA and as mental health service were due to do a home visit next day to ask Sasha what services she would like and if she would like IDVA service. Purpose of visit is to close to service due to not attending appointments. IDVA asked worker to feedback on how meeting goes.'

14.5.9. There are limited contacts between Sasha and the IDVA service, other than relating to MARAC hearings through to the late summer of 2018. In one note the IDVA recorded that Sasha is '*agoraphobic*'. In September the IDVA recorded, '*last high-risk July 2018... close [case] September.*' They attempted to contact unsuccessfully to discuss closure. L&Q housing continued to progress housing options across this time for Sasha and endeavoured to work with the IDVA who advised the case was closed to them.

14.5.10. MARAC – there were four MARAC hearings related to Sasha and Latif in 2018. At the first (February) an MPS officer shares details of violent assaults, threats to kill and financial abuse that Sasha is subjected to routinely. They also shared, '*There is a history of client been sexually exploited by the travellers, where she would be forced to have sex with men on a nearby park common. The perpetrator was arrested but the case was [no further action]. A DVPO was issued to prevent the perpetrator from returning to the property, this has now expired.*' The IDVA noted a lack of response from Sasha in attempts to work with her via unreturned phone calls. It was also noted that she had recently attempted suicide and was open to the mental health service. A suggestion was made for Sasha to be referred to a specialist sex worker agency - (no record found of this referral). The IDVA was tasked with coordinating the above-mentioned professionals meeting and to liaise with mental health services.

14.5.11. The second MARAC took place in May following a referral by the mental health worker (because of a March appointment when Sasha had attended with a black eye and Latif was in the waiting room). In this MARAC, Latif is noted as a prolific and controlling perpetrator of domestic abuse. The mental health service noted that she had '*capacity*' and the right to make poor decisions. Former concerns are recorded along with the risk of escalation of abuse. The planned action at this meeting is that the IDVA service will step her support down to a local outreach provider. This local women's aid service later contacted the IDVA stating that Sasha had contacted them, upset as her IDVA had not been in contact with her for a long time. The IDVA notes stated that Sasha

described herself [to the other service] as *'very frightened'* and that they were seeking address details so that they could support her with a lock change.

14.5.12. The third MARAC took place after the MPS referred Sasha, following Latif's arrest for Actual Bodily Harm (ABH) in June. In this incident Sasha had been seen walking down the street with blood running down her face by members of the public. It was recorded that Latif had *'punched and slapped her around her head and her whole body after she asked for money to pay her bills. He had locked her in the house, but she had escaped through a window.'* It was noted that there was *'insufficient evidence to proceed'* but a DVPN was served with the order being issued the next day. The GP received notice of the assault from the Emergency Department. The MARAC coordinator notified the IDVA to make immediate contact with Sasha. They made contact and Sasha stated that the police have *'no further actioned'* the incident as she did not support a prosecution, that Latif did not have keys and had conditions to stay away from her.

14.5.13. At the MARAC hearing the IDVA was recorded as stating, *'Client said that she will contact police if the perpetrator does try and contact her. Advised client to not let perp in the property if he does go to her property. Client admits to sex working. Client is from a travelling community. The client calls the police but then disengages.'* Other known issues were also mentioned. The Housing Officer is recorded as stating, *'Perpetrator is well known. Target hardening is vital. The perpetrator is capable of killing someone... He preys on vulnerable women who misuse alcohol and drugs.'* The actions at this meeting were to: *'Inform proactive unit of the perpetrator [policing initiative]; to put information on the briefing screen at the police station; to discuss tenancy with the client.'*

14.5.14. Between the summer and autumn of 2018 background work on Sasha's housing continued but she had limited contact with IDVA services. In November following another assault Latif was arrested for Coercive Controlling Behaviour, Grievous Bodily Harm (GBH) and causing a person to engage in sexual activity. He offered a prepared statement which stated (in response to the sexual activity):

'These males see Sasha as vulnerable due to her Bipolar and Personality disorder. An example of this is that they would lend her £10.00 and then later demand £50 in

return. Those males have also attended the cash point with her and her whatever they want this traveller group did previously murder Sasha's ex-partner and have not left her alone since. One of these males has raped Sasha and they always ask her for sexual favours'

- 14.5.15. The CPS were consulted stating that there was not sufficient evidence to charge Latif as Sasha did not wish to provide police with a statement; he was bailed with conditions not to contact Sasha. Police visited Sasha and spoke with her about providing a statement or a visually recorded interview (VRI). She was DASH assessed as high risk and referred back to MARAC, a MERLIN¹⁹ was created, and social services were contacted over the phone by police due to her vulnerability. She declined a panic alarm, special schemes on her address and an emergency house move.
- 14.5.16. Latif breached his bail conditions and assaulted Sasha again and was re-arrested. He was interviewed and shown Body Worn Video (BWV) of Sasha in a distressed state when the initial allegation was made. He made no comment. The officer in the case (OIC) obtained emergency charging advice from an inspector and charged Latif with two 'Assaults by beating' and a driving offence for which he was remanded in custody. The CPS later reviewed the incident and offered no evidence at court.
- 14.5.17. A week later, whilst on bail, police were called to Sasha's address after Latif allegedly threw a plate at Sasha cutting her chest. He denied the assault, stating he hadn't seen her but had contacted her to check on her wellbeing. The police IMR author noted that safeguarding in relation to the prior incident was ongoing, but in addition a MASH referral was made as there were concerns that Latif's daughter may have been witnessing these assaults. He was remanded in custody.
- 14.5.18. At the end of the year Sasha's IDVA suggested another housing application, as she wanted to pursue a transfer before Latif was released but would not be separated from her dog. The IDVA noted, *'this is closed case to IDVA and that it is unfortunate that a lot of help has been offered by agencies but there is no change in Sasha's situation.'*

¹⁹ Reports are recorded on Merlin to enable safeguarding teams to assess any risks or harm to individual children based on the report and any further relevant information. These reports are often shared with partner agencies to ensure a multi-agency approach can be taken to safeguarding. Merlin was a Metropolitan Police Service process/ system.

Following this period of incidents Sasha's local Housing Team advised that Sasha might be better off presenting as homeless in her Kent area of choice.

14.5.19. The fourth MARAC hearing took place in late-November it was noted the incidents that led to Latif's remand and her current housing situation, and that she has been suffering physical, mental, financial and sexual abuse during their relationship. They noted she did not want *'to get [him] in trouble and feels sorry for him.'* They noted that [Latif] had been charged with both assaults and ABH and remanded to court until [December] for a pre-trial hearing. The MARAC notes also recorded the IDVA stating that, *'There is information that travellers and various men were coming to her flat and she was performing sexual acts. Referred to MIND previously but did not engage. Sasha has a drink problem but refuses to stop. She would like to live closer to her mum and son who live in [Kent]. Sasha has been referred to SHINE for debt advice but also did not engage (it was later noted that Sasha was written to at the wrong address). L&Q [housing] have completed an eviction notice due to owing over 3K in rent arrears. Case now closed to housing officer due to non-engagement. Has been engaging with IDVA recently... is fearful of travellers in the area.'*

14.5.20. Sasha was identified to be facing the following risks: *'Escalation, Intimidation, Animal Cruelty, Sexual Abuse, Injuries, Jealous/ Controlling, Strangulation, Threats to Kill, Cultural, Previous DA, Financial Abuse, Substance Misuse, Separation, Criminal History, Housing, Isolation, Mental Health, Harassment, Violent History.'* The actions were *'MARAC support letter [for housing move] and continue to support the victim.'*

14.6 – 2019 – London

14.6.1. In 2019 there were 175 recorded agency contacts relating to Sasha. Early in the year she was assessed by a St Mungo's alcohol project, but her experiences of domestic abuse prevented this from progressing. In May, following further assaults by Latif she did accept a temporary accommodation project but eventually refused to move due to her concerns about the location.

14.6.2. Mental health services - In early January 2019 Sasha 's mental health was poor, and her GP referred her back to secondary mental health services, Oxleas, who made

counter-referrals to the drug and alcohol service. She had some sporadic engagement with both services during the year.

- 14.6.3. Primary Care Services – Sasha had 46 points of contact with her GP across 2019 and referred to abuse in her relationship and/ or injuries on nine occasions. There were no multiagency liaisons recorded, other than those with other health service providers. However, in June 2019 the GP noted awareness that Sasha had support from an IDVA. In this appointment she told the GP she was assaulted daily but didn't want to be on her own.
- 14.6.4. IDVA services – Following a complaint about the IDVA service by Sasha's mum in January - the local VAWG²⁰ lead sought an update from the IDVA that day and called Sasha exploring the dynamics of domestic abuse, seeking to understand what Sasha wants, and identifying the risks she was and had been facing. Sasha was allocated to a new IDVA.
- 14.6.5. Following this change of IDVA contact improved dramatically, with 94 contacts being recorded across the year and 28 of these being direct contacts between the IDVA and Sasha. They undertook proactive housing advocacy, spoke with the police regarding the possibility of evidence-led prosecutions, chased Sasha's mental health referrals, raised concerns about Latif contacting Sasha when on remand (January 2019) and pursued a St Mungo's residential detox referral. Sasha was already disheartened by agencies and stated early on her frustration that Latif *'does a better job of protecting her than anyone else.'* However, later in the year she, *'thanked the IDVA for everything she has done for her.'*
- 14.6.6. The pattern of support by the new IDVA continued as before albeit with more dedication. There were case closures and re-openings based on either Sasha's levels of engagement or incidents of abuse having happened. One such case closure in March was noted with an action of, *'step down and refer her to Pause'* ²¹

²⁰ Violence Against Women and Girls

²¹ A charity working to improve the lives of women who have had – or are at risk of having – more than one child removed from their care

- 14.6.7. There were multiple recorded assaults by Latif against Sasha across 2019. Namely in February, April, May, June, August and December. These resulted in four MARAC referrals which took place in January, May, July and August. MARAC discussions and actions continued along the 2018 pattern of discussing the multiple and significant risks faced by Sasha, and actions relating to continuing to support her, queries over DVPOs not being used and the suggestion of a Pause referral (which was declined). They also determined that Latif should be added to Operation Dauntless²² and a check should be made to see if Sasha/ Latif had a high-risk PNC marker with the police. In preparation for the August MARAC Sasha's IDVA asked her what she would like to get from the meeting. She said she would like to move away from the community threats that she faced.
- 14.6.8. In February Latif, who was still on remand for the assaults in late 2018, reported to MPS that Sasha had been sexually assaulted, a few days later Sasha confirmed this allegation with the police, but did not wish to take further action. Sasha's family advised the review chair that Latif had sent his cellmate to stay with Sasha and that this person had sexually assaulted Sasha, they believed that Latif organised the assault to maintain his narrative that she needed him to protect her from predators. Latif later described this to prison intelligence services from the perspective of himself as her protector. In October Sasha told the police that Latif had sent this man to 'look after her' and that he had tried to rape her, when she was advised that a report would need to be made, *'she became upset and was worried about the repercussions from Latif.'* They further recorded, *'Sasha did not wish to pursue the matter or provide the Police with a statement. As this was an historical allegation it was felt that arresting the suspect could cause serious safeguarding concerns for Sasha and without details of the incident from Sasha any prosecution would prove difficult.'*
- 14.6.9. Towards the end of April MPS recorded that Sasha had been the victim of ABH, with the suspected perpetrator being Latif. They DASH assessed her and referred her to MARAC and the IDVA service. However, they did not formally identify the perpetrator.

²² Operation Dauntless is a programme by the MPS that identifies individuals who have appeared as suspects or accused within a domestic abuse flagged crime report against three or more separately named individuals, in three or more London boroughs, over the last three years.

14.6.10. There were two incidents in May - one a '*non-crime*' domestic incident and another assault which she described as a '*beating*'. Sasha described to agencies the paramount threat to her being from community members. Sasha's IDVA offered temporary accommodation and refuge, but this was declined because she '*will not be separated from her dog*.' The IDVA told her that she would '*end up dead*' and offered her routine safety planning advice, Sasha ends the call saying he is returning from the shops, and she doesn't want to make him angry. A temporary accommodation was secured but Sasha refused this as it was on the second floor, and her dog needed access to the outdoors at night.

14.6.11. In June Sasha was seen at a Kent hospital Emergency department with a head injury, she did not wait for the final assessment. Her IDVA called her the next day, and Sasha asked if she was calling about '*what happened at the weekend*.' Sasha stated she accidentally hit her head getting into a car. MPS attended her property for another assault later in the month, she denied an incident happening [a neighbour had made the report] and officers note she is '*manipulated, controlled and abused*' by Latif and made a MARAC referral on professional judgement. The IDVA gained Sasha's permission to obtain a Domestic Violence Disclosure Scheme (DVDS),²³ which she agreed to, was requested, approved and was shared with Sasha in July 2019. She said she would need time to process the information she received about Latif. At the disclosure Sasha agreed to a DASH assessment scoring 19 of a possible 24 indicators of risk. There was a further assault for which Sasha attended hospital advising the Hospital Independent Domestic Violence Adviser (HIDVA) that she was strangled, and a MARAC referral was made.

14.6.12. In August there is a further incident, and she attends the Emergency Department but does not wait, she leaves a message for the IDVA the following day mentioning refuge. Through September Sasha and the IDVA attempted calls to one another, they spoke at one call, and she stated she could not talk much as Latif was present. In October the IDVA's Service Manager reviewed the case and agreed the IDVA should pursue Kent Housing who had agreed that the IDVA could make the application with Sasha's consent. Sasha had a period in hospital with a chest infection and her engagement with

²³ The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

services reduced after this time, consequently her file is marked for closure by the IDVA service in December.

- 14.6.13. In mid-December, she spoke to the GP nurse practitioner about medication and is distressed stating, *'partner came at her with a hammer. Broke a tooth. Has been called by L&Q [housing] and been offered a place in [Kent]. Will only go if can take her dog with her. Not sure if she can yet. Long chat. Left quickly as partner texting her to hurry up.'* Sasha's mother supported her to access further prescriptions over the Christmas and New Year period as she was going to stay with her, it was noted that she would have to have daily collections as she overused medication and had a high risk of suicide.

14.7 – 2020 – London/ Kent

- 14.7.1. Through 2020 agencies recorded 171 contacts relating to Sasha, as in prior years the majority of these were with her primary healthcare provider and the IDVA service. In October 2020 Sasha moved to Kent, closer to her family. High harm abuse continued to be recorded from Latif throughout the year.
- 14.7.2. Starting in March 2020 and lasting until July 2021 the UK experienced the COVID pandemic. This comprised of two full lockdowns of society (March 2020 – June 2020 and January 2021 – July 2021), and a series of tiered restrictions to society in between. Service provision was affected by this as the health service operated in a state of emergency contingency planning, and other services were unable to provide face to face services routinely.
- 14.7.3. Whilst still in London she was heard at MARAC on three occasions. The first hearing was in March. She had been referred by the Oxleas mental health service based on professional judgement. The mental health team noted that they were recording information relating to Sasha's domestic abuse to assist in any potential case building activity by the police. She had been deemed to have mental capacity at the time of the referral. She was also heard at MARAC in September, and in November when a MARAC-to-MARAC referral was made following her move to Kent. For the London MARACs all prior risks were discussed, along with it being noted that Latif had registered a car in her name (Sasha could not drive), and that she could not afford to buy a coat as he *'takes all of her money.'* There was a further conversation about

Operation Dauntless, and the police looking at evidence-led prosecutions for any future incidents. It was also noted for officers to attend her home in plain clothes amongst other routine safety actions. The added safety implications of the Coronavirus lockdown were also considered.

14.7.4. These MARAC referrals resulted from a range of (London) incidents across the year. In April, Latif was arrested for ABH and subject to a DVPO, (this was marked no further action as Sasha *'did not support'*) Sasha was determined as *'visible high-risk'*. Once the DVPO expired there was another incident that led to Sasha presenting at a North Kent hospital with injuries. Another incident was reported by Sasha's IDVA in September who had received a distressed (unintelligible) voicemail from Sasha, when the police made a welfare check she said that she was *'fine'*. In the same month she was arrested by MPS with drugs secreted in her bra, during the interview she stated that she was abused by Latif and wanted to *'break up with him.'*

14.7.5. For the first April incident the IMR author notes, *'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. DASH risk assessment was completed and Sasha answered 'no' to every question.'* The following note was made on the crime report:

14.7.6. *She was able to weigh up the risks of staying in the relationship and stated that she would prefer to be with him than be alone and she couldn't bear the thought of being alone or abandoned. She said she understood that he might cause her permanent injury or cause her death by his violent attacks on her, but that she still felt that it was better than being alone. She said she understood all this and appeared to be able to weigh up and evaluate the potential outcomes of her decision... Sasha expressed having extremely low self-esteem and stated that it must be her fault because she has always been in abusive relationships... She said that 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.'* A DVPN was authorised, and a MARAC referral made.

14.7.7. IDVA service – Sasha was less willing to work with this service stating to the IDVA (when referred for service because of the March MARAC) that, *'promised help never*

materialised.' She also described her abandonment issues, to the extent that she would end her life if she had to be separated from Latif (this was following an April DVPO having been made against Latif). The IDVA service did continue work on re-housing for Sasha having gained permission from her to take the lead with the application late in 2019 but had limited contact with her throughout the summer. The L&Q housing officer advised the IDVA of ongoing reports of shouting and screaming from Sasha's property throughout this time. When the IDVA eventually spoke to Sasha in August, she stated that she wanted nothing other than her housing to be *'hurried up.'* In October Kent made her a direct offer and she moved.

- 14.7.8. Primary care – Sasha continued to see her GP routinely, continuing her disclosures of abuse and distress. During the DVPO period she stated she felt like, *'jumping off a bridge'* and was advised to attend the Emergency Department if suicidal. In June it was recorded, *'Having a bad time with her partner at the moment still getting hit does not want to inform anyone. Cried, wanted Oxleas [for counselling]. Safety netted.'* In the middle of September, Sasha's GP recorded, *'Tel encounter with pt requesting appt for burn on breast. Adv A and E.'* No multiagency liaisons were recorded.
- 14.7.9. Sasha's family noted that Latif was a crack cocaine user and actively encouraged Sasha to take crack cocaine causing her to become dependent on it for a period. She stopped using it of her own accord but remained heavily dependent on alcohol. They further noted that when she made the move to her new town, she was surrounded by drug dealers, and social issues. Sasha did not feel safe there given her years long experience of abuse in her community. She had no means to travel and was placed in an isolated community. They believe that this made her more dependent on Latif. They stated that he moved in and took control of everything, her money, her bank card, where she went and who she saw, even when she saw her family. They stated that he was constantly on the phone getting her to go home when she visited them.
- 14.7.10. Following a MARAC-to-MARAC referral (from London to Kent) Sasha was referred to her local (Kent) domestic abuse charity, Rising Sun, who noted, *'Referral form notes [Sasha] had been heard at MARAC in Bexley 6 times between [May] 2019 and [September] 2020, most of the corresponding referral forms and MARAC minutes were attached.'* The Rising Sun IDVA immediately attempted to contact Sasha and

pursued alternative numbers as she was not able to get through. Rising Sun also pursued background information from Sasha's previous area of location.

14.7.11. Incidents did not pause following Sasha's move, within days of her move Kent Police received their first report from a neighbour. The police recorded the neighbour being told by Sasha *'[he] beats me day and night'*. She said she would not work with officers and had not moved due to domestic abuse, in a follow-up visit the next day she described the incident as an accident. Kent Police made further enquiries about Sasha's background. Based on the information discovered Sasha was assessed as high risk and referred to MARAC. Latif was arrested but was subsequently refused charge. Due to the high-risk nature of the situation and Sasha's denial of being a victim, a DVPO was successfully applied for which would expire in mid-December.

14.7.12. IDVA service – Sasha was contacted proactively by her new IDVA and spoke with her regularly stating honestly that she did not feel able to live in her new home alone for domestic and community safety reasons. She undertook extensive liaisons with the Vulnerability Incidents Team (VIT) at Kent Police, supporting her to register with a GP, mental health services, and liaised with her former IDVA. During a call when the DVPO was in place Sasha is recorded as saying, '*[She] hates being alone and said she's not the easiest person to live with, and it's not his fault. Asked about calling her when the order expires - she said he never checks her phone and bought it for her. Since he started work things had been good.*' Following later incidents Sasha's IDVA continued to work with her on safety planning.

14.7.13. The IDVA sought engagement by a secondary care mental health team who advised a self-referral. They encouraged Sasha to call the Single Point of Access (SPoA) that day. She was then sent these self-referral details by text, along with the Samaritans and Crisis Team. Sasha self-referred to the SPoA. As she had focussed on her practical needs during the call, they had not deemed her as needing their support but advised the IDVA that they could take self-referrals between 8am and midnight daily in future. Sasha's IDVA advised her to request a referral by the GP as Sasha found holding on the phone problematic.

- 14.7.14. Her first Kent MARAC meeting took place in November based on a professional judgement referral, with actions from that meeting including pursuit of insights to the mental health support Sasha had received in her previous area, housing actions and liaisons with the Central Safeguarding Unit at Kent Police. All agencies noted her high level of vulnerability and risk.
- 14.7.15. Despite the DVPO being in place two neighbour reported incidents happened at the end of November. At the first Sasha was crying and upset *'at how she had been treated previously and couldn't see her partner for 28 days.'* A few days later a neighbour reported, *'[Sasha] had come to her property bleeding from her mouth. [Sasha] had told the neighbour that [Latif] had hit her in the face with [a] dog lead. Latif was arrested for GBH and breach of DVPO.'* He was bailed at the hearing for the assault but remanded for the DVPO breach, and although initially supportive of a prosecution Sasha withdrew her statement and was noted over the coming weeks to go to great lengths to have the case dropped.
- 14.7.16. Sasha's family described Latif calling Sasha from prison after this incident, just as a police interview was ending, and that there was an immediate shift in her attitude towards the prosecution, which they said was observed by the police officer. They also stated that she was contacted and threatened by Latif's father. In their notes the police identified that she was in a state of *'self-neglect'* during this time. Initially, Sasha's mum agreed to a statement but withdrew as Sasha begged her not to do it. Fear of retaliation was also a consideration for the family. The family also advised the review chair that a forensic photographer took images of extensive injuries to Sasha's face and head. Sasha's IDVA recorded, *'He wrapped a metal dog lead round his hand and hit her round the face'*, that this had happened in a car and he had, *'then thrown her out of the car' and 'made her walk back.'* Sasha's IDVA spoke with her about the risk of grave harm, and she said, *'she had no one but her mum and needed to think about her son.'* Based on her family's comments, this statement could relate to her fear of her family being harmed.
- 14.7.17. The local Housing team, aware of the incident, proactively pursued any safety measures that they could and liaised with the officer in the case. As Sasha could not support a prosecution, and they were concerned about her not being able to stop

Latif from seeing her they referred her to the Tenancy Sustainment team. They offered support and advice to Sasha over the coming months, including referrals to mental health services.

14.8 – 2021 – Kent

- 14.8.1. Sasha remained in Kent through 2021, and agencies recorded 328 contacts in relation to her needs. She continued to have high levels of contact with primary health, as she had in London, and with her IDVA, now provided by Rising Sun. She also had contact with Forward Trust,²⁴ secondary health services and Adult Social Care. There were no MARAC referrals made in 2021.
- 14.8.2. Between January and March Latif was either on remand or subject to bail conditions following the assault of Sasha at the end of 2020. When he was released from the prison in January the Kent Police officer who was investigating the assault attempted a charge of witness intimidation and he was also facing a charge of breaching a DVPO. Ultimately, the CPS determined that these latter charges against Latif did not meet the necessary threshold. He remained on bail pending the investigation of the assault.
- 14.8.3. Throughout this time Sasha was in distress at being without Latif, to the extent that she took an overdose in January and contacted the police extensively attempting to have the investigation withdrawn. Sasha's IDVA spoke with her about the nature of coercive control and that agencies could not sit back and watch her be harmed. Sasha said that *'maybe she could do things differently, maybe she could change.'* The IDVA advised her that this was not her fault and that whatever Sasha did he would not change.
- 14.8.4. IDVA service – it is evident from the records that Sasha's IDVA worked tirelessly to support Sasha and in making liaisons with other agencies. In January Latif was released from prison with bail conditions not to contact Sasha (expiring initially in March and then extended indefinitely beyond this period). The IDVA discussed supporting Sasha to build a support network, which Sasha had said she would like to

²⁴ Drug and alcohol service

do. They also had discussions with agencies regarding the risk of Sasha withdrawing from support if Latif was able to re-establish control of her.

14.8.5. When Latif's bail was extended the IDVA and Kent Police decided to advise Sasha that the CPS had control of the case to protect their relationships with her, as she, *'just wants to speak with him. She said they are not protecting her from him. Sasha thinks the Police are trying to use her retracted statement. She said when she retracted it, she did state that it was true. She said her body can't take this; she has a rash all over her body. GP has stopped all her meds / she was threatening another OD. She then said she was not going to Detox - Sasha stated that she does not think she's worth anything and has to do things for Latif.'* In March Sasha asked her IDVA for solicitor information for Latif, this request was declined. She said she knew Latif might hurt her but *'all she wants is a hug.'* The IDVA continued to liaise with others, including the officer in the case (OIC) who felt it was likely that Latif and Sasha were spending time together. At the end of March Sasha text, *I'm truly blessed. Many thanks. I won't bother you again. You take care.'*

14.8.6. Tenancy Sustainment Team – Sasha had been referred to this housing service due to anti-social behaviour reports about her property. They undertook a needs assessment and worked proactively with Sasha, her IDVA and the police, becoming an integral part of her support for the period of their involvement. Sasha advised that she was frightened in January as a group of young people had *'smashed'* the communal front door and smoked Crack Cocaine in the stairwell. She was being reported for noise nuisance by her neighbours during February and was subject to anti-social behaviour when a brick was thrown through her window. At the end of February Sasha spoke with her tenancy officer, describing her love for Latif, and her grief without him, she disclosed five suicide attempts, with the officer endeavouring to encourage her to self-care. Sasha described wanting to live a *'normal life... be a mother to her son but struggling with alcohol and abandonment issues.'* She was referred by the officer to a drug and alcohol service in her local town for alcohol support and told the officer she was sorry for the noise nuisance. The tenancy team continued to monitor Sasha's anti-social behaviour, noting that this has lessened and determined not to send letters as this could be too heavy-handed given the decrease in anti-social behaviour and in recognition of Sasha's poor mental health.

- 14.8.7. GP – Sasha had a new Kent GP because of her move to the area, and they recorded her background and need for weekly prescriptions due to the risk of suicide; they also encouraged her to work with Forward Trust for her alcohol use and made a referral for secondary health investigations in relation to *‘liver concerns.’* They also requested that Sasha surrender a medication stockpile that she had disclosed. In February Sasha’s GP advised her that her liver scan results suggested that she had cirrhosis.²⁵
- 14.8.8. Kent Police – The Officer in the Case (OIC) made significant efforts to pursue charges against Latif, including considering the possibility of utilising Sasha’s withdrawn statement. The OIC was furnished with safety precautions due to concerns about Latif as cloaked threats were made through Sasha when she spoke with her. At the end of January Sasha was taken by police to hospital following a *‘drug and alcohol overdose.’* This incident caused Kent Police to seek permission from Sasha to make a referral to Adult Social Care which she agreed to. By February Sasha was not working with police officers in relation to the case against Latif, and in a discussion with Sasha’s IDVA it became apparent that Sasha was aware of the date that Latif’s bail conditions ended but had not been formally advised of this yet by any agency.
- 14.8.9. Following the attempted suicide Sasha was seen at hospital by the liaison psychiatry team (LPS) who made a referral to Rising Sun based on her disclosures of domestic abuse, during the assessment Sasha stated she was *‘desperate to have him back... she does not care about the violence as she is used to it... it is my fault I annoy him.’* They also noted, *‘Police have stated they have enough evidence to prosecute; her injuries were significant experiencing several skull fractures & will probably loose (sic) many of her upper teeth.’*
- 14.8.10. Adult Social Care – were asked to undertake a care needs assessment by KMPT in early February undertaking initial work based on the referral information, *‘agreed outcomes if [Sasha] is able to engage; KCC spoke to [Sasha]... referrals were made*

²⁵ Cirrhosis is a serious condition where the liver is severely damaged, and normal liver tissue is replaced by scar tissue. This scarring disrupts the liver’s ability to function properly.

for SPOA, KERS²⁶ referral for enablement support, Forward Trust Referral, Contact the GP regarding weekly medication pickups to be utilised, look at supplying a fridge freezer/oven.'

14.8.11. Forward Trust – undertook an assessment in February during which Sasha disclosed the history of her trauma and her recent suicide attempt. She disclosed drinking half a bottle of vodka and 2-4 cans of cider daily, and that she had been drinking daily since the age of 17, except for a one-year abstinence following a hospital detox eight years previously. She was advised of the risks of sudden alcohol withdrawal as she described herself as *'too unwell to drink'* and was sent a drink diary and other materials. Her action plan included a referral for an in-patient detox. Her GP was notified of the assessment and planned outcomes and supplied a medical summary.

14.8.12. As preparations for a residential detox got underway in March, Forward Trust recorded Sasha as being, *'preoccupied with partners potential return home.'* In mid-March Sasha advised her Forward Trust worker that her beloved dog had died. On a later call Forward Trust recorded, *'Discussion re. the alcohol pathway and attendance at group and Sasha advised she intended to attend* [Authors note: Sasha had told her IDVA that she could not afford the internet for online groups]. *She advised that she was due to find out whether the CPS intended to proceed with the case against her partner that week, and so she would find out whether or not he could return home.* Case notes included reflections that Sasha was *'entrenched'* in the relationship and, *'prioritises this above all else including her health, finding it hard to focus on anything other than her partner at that time.'* She did not attend the later recovery groups.

14.8.13. Community mental health team (CMHT) – this team contacted the Forward Trust during this period and advised of their imminent assessment of Sasha and their concerns about her alcohol consumption. They noted *'[Sasha] had taken an overdose following a physical attack by her partner. Police are involved and partner*

²⁶ Kent Enablement Recovery Service - this service provides short-term, free support to individuals experiencing mental health difficulties and who have unmet social care needs. KERS focuses on helping people achieve positive outcomes and maximize their wellbeing and quality of life. This is done through a process of enablement, where individuals are supported to develop or regain skills needed for daily living tasks.

is currently on bail and not allowed contact... [Sasha] was contacted today by telephone for 72 hr follow-up. [Sasha] was tearful and upset as feeling that she cannot cope on her own, she has damage to her teeth and jaw and slurred speech. She spoke of feeling stressed and low in mood due to not being able to speak to her partner as he is currently on bail. [Sasha] has dropped all charges, and she wants him to return home... [she] described feeling isolated and alone... and spoke of having some support from the local CMHT [prior to her move] but missed some appointments, so was discharged. She currently has no counselling or support. She is currently struggling with her everyday tasks and is isolating herself at home and not self-caring.' The outcome of the CMHT intervention was advice for her to contact Rising Sun and Forward Trust along with a referral to ASC.

14.8.14. Between April and June Sasha continued to have contact with a range of agencies and Latif was charged with the assault to her. She continued to experience poor mental health, and to feel unable to separate herself from Latif's control. She had less contact with the tenancy sustainment team, who continued to receive anti-social behaviour reports from her property, they closed her case in May following an inability to engage her. Her GP also requested that she register at another practice as they had become concerned about professional boundaries.²⁷

14.8.15. Forward Trust - during this time Sasha's contact with this service was, at times, erratic. They continued to encourage her engagement with online groups and during one call it was recorded that she was, *'currently drinking 1 bottle of vodka a day, and again presenting as very tearful, [stated] 'getting no help from CMHT'*. Given concerns about her mental state she was *'encouraged to consent to a Mental Health single point of access (SPOA) referral.'* She was asked and stated that she had no self-harm intentions. The Forward Trust continued liaisons with Sasha's IDVA. By May she described remaining abstinent from alcohol. In mid-June Sasha described drinking two cans of beer a week due to her concerns about her liver function, based on this description a decision is taken to close her case to the Forward Trust.

14.8.16. Kent Police – in early May Latif called Kent Police stating he was concerned for Sasha's welfare, the officer in charge of the assault [Grievous Bodily Harm – GBH]

²⁷ A separate matter and immaterial to the review regarding a conflict of interest.

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. Latif was arrested for breaching his bail, he was charged with the GBH offence that had occurred in November 2020 and placed before the court for a remand in custody. Sasha was very unhappy with the officer's actions and stated she had blackmailed Latif into coming to her home.'* Latif had appeared in court and was, *'Released from Court with conditional bail to have no contact with [Sasha] and [was] placed on a GPS tag.'*

14.8.17. In the first week of June, a Witness Care Officer (WCO) contacted Sasha to discuss the court process relating to Latif's GBH charge. The WCO was concerned about Sasha's level of distress and requested a welfare check. She was seen by officers and given advice and support. The attending officers requested an adult protection referral, but this was not sent following a decision by a supervisor that Sasha's needs had been catered for with signposting.

14.8.18. Kent and Medway Partnership Trust (KMPT) SPOA - notified Sasha's GP that they had, *'assessed [Sasha] following a referral from Forward Trust. The Forward Trust had shared with KMPT SPoA that they were referring [Sasha] as reporting frequent crying, anxiety, poor sleep, and appetite.'* The letter advised that an urgent appointment was arranged with CMHT. KMPT recorded that there was *'consideration of providing a place of safety for Sasha at this time given her level of distress. However, Sasha declined support and denied suicidal ideation.'* Sasha did not attend several appointments with the CMHT, later stating that she had a broken foot. She stated to the team during a call that, *'Latif was on tag and was not supposed to contact her, yet he did from several different numbers. Sasha stated that he did not face any consequences for this.'* They note updating the KCC Adult Safeguarding Team about this disclosure.

14.8.19. On the day that Latif appeared in court for his remand hearing Sasha presented to the hospital with suicidal ideation and was discharged home. A few days after this Sasha's son called 999 as he was concerned about her mental health, she described having suicidal thoughts. The crew recorded that she mentioned her dog, feeling low and that she was due to see the crisis team the following day. She settled and did not

want to go to the hospital. Three days later she is taken to hospital by ambulance with chest pain and vomiting. The hospital made a MARAC notification based on her domestic abuse disclosures. At the end of May Latif's former partner contacted Kent Police concerned that Sasha had posted on social media that she had taken an overdose and stated, *'I'm going to die tonight'*. On contacting her she told the police officers that they had ruined her life as she wanted her boyfriend back, she was in and out of consciousness and the officers waited until the ambulance arrived and took her to the hospital.

14.8.20. As a result of this admission Sasha was seen by the LPS, and they recorded that, *'When assessed she advised that she had taken the overdose as she had been unable to see [Latif]... She was able to acknowledge the relationship was unhealthy and she felt controlled. On this occasion, she was referred to CRHTT (Crisis Resolution Home Treatment Team) and accepted onto the caseload.'*

14.8.21. CRHTT noted that safeguarding had not been considered so contacted the local authority to ascertain if there was still a safeguarding open. They were advised that Sasha was on the list for a social care assessment and that due to the safeguarding concerns, they would try to prioritise. THE CRHTT further noted, *'things settled, and she was discharged to the care of the CMHT [Community Mental Health Team] [in mid-June] ... and... with the plan to engage with Forward Trust.'* It was documented that she was also *'under social care.'*

14.8.22. Adult Social Care recorded because of the above, *'[Sasha] was placed on the waiting list held by the ASC [Town A] Mental Health Team, for specialist Mental Health Social Care support. Discussions also held at RED Board multi-disciplinary meeting held by KMPT and may have led to further related discussions in terms of support for [Sasha] which are not all recorded via the Mosaic system. ASC advised KMPT to raise a Safeguarding Concern if they felt there were any concerns for [Sasha].'*

14.8.23. IDVA service - Rising Sun noted that Sasha remained unhappy that, *'[Latif] is not coming home.'* They continued to support her throughout the period. Following the above incident the IDVA called Sasha who advised that she, *'begged him to come down, as she was going to end her life. [Latif] came down... the neighbours called*

Police, and he was arrested.' She sought the IDVA's legal help for Latif and was advised of the IDVA's role. The IDVA liaised with the witness care team and attempted to contact Sasha a few days later for an update on her crisis team appointment. She was not able to contact her but liaised with the Forward Trust and they discussed an adult social care referral due to self-neglect. They agreed that a home visit would be made to check the viability of this referral. Sasha confirmed in a later call with the IDVA that the Forward Trust and Crisis Team would be visiting her that week. Sasha's engagement with the IDVA service became increasingly erratic, however, they continued agency liaisons.

14.8.24. As Latif was being maintained on a TAG awaiting trial the focus of Sasha's support was based on her mental and general wellbeing between July and December, and overall, her support from agencies lessened. 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, at her home, as she was lonely, felt unsafe in her property and continued to grieve for her dog.

14.8.25. During this time Sasha was re-referred to the Tenancy Sustainment Team who supported her with anti-social behaviour that she was experiencing, offered emotional support and liaised with relevant agencies. On one occasion in August, they were concerned about not being able to contact Sasha as she had intimated suicide to them, they spoke with the ASC Operational Team who advised, in mid-August, that they refer to the KMPT SPOA and that they also notify Sasha's GP of their concerns. The SPOA had also been contacted by Sasha's mum in mid-July with concerns, they advised *'the criteria for intervention were not met, and the referral was closed. [Mum] was signposted to the GP.'*

14.8.26. CMHT – around the same time as Sasha's mum was reaching out to the SPOA the CMHT notified Sasha's GP that they had been unable to contact her and the GP recorded, *'she was subsequently referred back to the CMHT.'*

14.8.27. Shortly after the above welfare concern Sasha called 111 having overdosed on medication and vodka. They notified 999 who recorded, *'States she is struggling with her mental health, partner arrested for violent abuse against her... Is distressed as he*

will go to prison for this, so she is retracting her statement and is persuading her mother to do the same, but says Police are hounding and distressing her. Patient non-compliant with prescribed medication. Is missing her partner, not permitted contact with him but disclosed they are in contact and have been meeting up every other weekend. Police unaware this is happening – the mother is aware. Patient states she will not testify against her Partner and loves him as he has “nice episodes”. Conveyed to [East Kent hospital].’

14.8.28. Liaison Psychiatry Service – Following Sasha’s August overdose admission the LPS recorded that, *‘Despite the situation, she refused referral to crisis services, CMHT, or the Forward Trust. She was discharged home.’*

14.8.29. A pertinent note at the time of these concerns and admissions was recorded by Sasha’s tenancy sustainment officer. They spoke with the SPOA and recorded, *‘It was jointly felt that Sasha is at risk of fatality due to her alcohol addiction and taking her medication on top of this... We both agreed that this was mainly due to the lack of contact she has had with her ex-partner who is not able to come and see her. Sasha refused crisis assistance and [a] referral into CMHT. [She] also refused consultation with on duty Psychiatrist. All professionals are in a difficult position with regards supporting Sasha and it is hoped that she will engage with Forward Trust. I am also awaiting Social Care being looked at to see if that can help Sasha at the moment. I have spoken to [colleague] regarding the case, and it was agreed that there is little more we can do from a housing perspective.’* The SPOA noted the referral to them by the tenancy team recording, *‘it was identified that she required support from the Forward Trust. The plan was for Forward Trust to try and engage her.’*

14.8.30. IDVA service – she continued to have engagement with her IDVA on a less intensive basis, with the IDVA offering to maintain contact *‘if it helps.’* The IDVA had seven points of contact with Sasha. She was made aware of the admission to hospital by the HIDVA, but there are no notes relating to any ongoing contact between Sasha and Latif. In a call relating to her Forward Trust appointments (see below) she stated she could not engage with appointments on Zoom.²⁸ As Sasha was describing personal and social care difficulties her IDVA referred her to ASC in September, they also

²⁸ A virtual meeting platform

supported Sasha's enquiries about access to benefits (she was seeking to apply for higher rates given her health issues). They continued to speak through October and November with the IDVA discussing (variously) a Rape Crisis referral due to her former experiences of rape, liaising with the OIC, following up the ASC referral status and providing general support. Based on concerns raised by Sasha's mum in November her IDVA pursued mental health outcomes on her behalf.

14.8.31. Adult Social Care noted, *'[Sasha] has mobility, and health issues and requires support in relation to feelings of isolation. Operational team was notified.'* In the final week of November Sasha was contacted by ASC to undertake, *'a Mental Health Screening with her; [Sasha] requested another time due to ill health.* [She had been hospitalised with a chest infection]. *After further attempts with support of an IDVA, a phone-based screening was undertaken by ASC; outcome was for a face-to-face assessment to be completed.'*

14.8.32. At the end of November Sasha returned to her flat and was visited by the ASC social worker for the 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".* ASC duty plan - referrals completed: mental health SPOA, Forward Trust, Kent Enablement and Recovery Service (KERS) and GP. Although not allocated yet, the assessing ASC MH practitioner on duty continues to follow through plans and maintain relationship with [Sasha], with links with Rising Sun IDVA and other referrals to support [Sasha]. Sasha's GP also left her a voicemail advising that she would be moved to weekly prescriptions as advised by ASC due to overdose risks. Forward Trust also noted a referral from ASC, and the social worker noted a call to Rising Sun checking that they were still engaged with Sasha. Rising Sun confirmed that they still have contact in relation to Sasha's domestic abuse. Sasha's IDVA expressed the importance of Sasha having an allocated social worker for stability. The social worker advised that one would not be allocated but she had two staff numbers to call, and that they would make a welfare call the following week and that they felt, *'this would be a regular occurrence'*.

14.8.33. ASC also contacted Sasha's mother, within the same week, noting, *'Mother was very distressed and says she feels hopeless and does not know how to keep her daughter safe. ASC explained that we do not deal with medications and that is something to discuss with [Sasha]'s GP. I asked if they had tried to contact crisis team regarding some support and she stated that the hospital and crisis team just keep bouncing them back and forth from one another in the past. I reassured [Sasha]'s mother that I would contact the allocated SW and that they will be in touch either Thursday or Friday. I then explained that if she felt [Sasha] was at risk of herself or others then she should take her to the hospital to seek medical advice. I also suggested in the meantime to call crisis team for support if they require it. She thanked me for support and the call ended.'*

14.8.34. KERS had not progressed the earlier referral for Sasha in December, and having received this second referral noted, *'Also need to discuss any associated risks in working with [Sasha], and if she is well enough to engage with enablement at this time.'*

14.8.35. Forward Trust – based on a re-referral Sasha had an appointment with Forward Trust for a comprehensive review, she described overusing diazepam and zopiclone in addition to alcohol. She expressed a desire for alcohol abstinence and remained preoccupied with Latif's trial and their separation. They obtained a medical summary from her GP. At the end of October Forward Trust, despite repeated efforts had not been able to make contact with Sasha and issued a 'ten-day letter' regarding non-attendance and possible case closure. Her case was closed at the start of November.

14.8.36. Sasha's ultrasound, as recorded by her GP, showed 'diffuse liver disease'.²⁹ The results were communicated to the Forward Trust and in mid-December Sasha discussed them with her GP stating that she was only drinking two units of alcohol daily, and was advised to stop completely over the coming seven days. In the final week of December her ASC mental health practitioner re-referred Sasha to the Kent

²⁹ Diffuse liver disease is a condition that occurs when the cells of the liver are damaged, leading to a decline in liver function. It can be caused by a number of factors, including metabolic disorders, storage diseases, vascular diseases, neoplastic diseases, and drug toxicities

Enablement and Recovery Service (KERS), the referral was accepted. At this time the ASC mental health worker contacted Sasha's IDVA to request a joint visit for the purposes of assessing Sasha. The IDVA recorded that this could, *'lead to a care plan, and that she had been allocated a CPN (Community Psychiatric Nurse).'*

14.9 – 2022 – Kent

- 14.9.1. 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.
- 14.9.2. A report to Kent Police in early January recorded that Sasha and Latif had stayed in a hotel over new year where he had *'assaulted her including strangling her. Kent Officers liaised with Essex Police. Essex investigated but found Sasha would not engage and was consistently upset stating that Police were hounding her. She denied she was with [Latif] but was with another male. It was suspected this was untrue. An investigation continued but did not proceed to a charge due to evidential difficulties. Sasha's mother was liaised with to increase safeguarding around her. [Latif] was arrested for bail offences.'* The assault allegations were closed following investigation due to a lack of evidence. The day after this report Sasha overdosed on alcohol and diazepam and was hospitalised.
- 14.9.3. Liaison Psychiatry Service – the team saw Sasha after this overdose, and she told the LPS staff that she was distressed and lonely as she could not see her partner because the police were pursuing criminal charges despite her wish for that not to happen. The hospital referred her to Forward Trust and noted that she was due to meet the CMHT in mid-January.

- 14.9.4. There was a further report by a hotel receptionist in February of a similar incident. Latif was located *'and arrested later the same day. Assessed as high risk and a MARAC referral submitted.'* Sasha attended for a scan to see if her cheek was fractured. She said the injury was an accident and the HIDVA requested that a safeguarding alert be added to the hospital system to note Sasha as a high-risk victim of domestic abuse, with the additional note that she is *'likely to state injuries as accidents.'* As a result of the call from the hotel South-East Coast Ambulance Service (SECamb) raised a safeguarding concern, which caused Adult Social Care (ASC) to initiate a Section 42 Safeguarding Enquiry.
- 14.9.5. In mid-February a third party reported to Kent Police that Latif's father had been, *'trying to get Sasha to drop charges [against Latif]. Sasha was spoken to and denied the allegations.'* The police recorded, *'declined safeguarding options such as an IDVA and referral to MARAC.'* The day after this SECamb contacted the police to advise that, *'they had received a number of calls from [Sasha] and were now conveying her to hospital.'* The LPS recorded that, *'[Sasha] was brought to hospital by ambulance having been found unresponsive under the influence of alcohol and substance (sic). She was not seen by LPS as she self-discharged when she recovered.'*
- 14.9.6. Sasha's family stated that Sasha was not allowed to see Latif's family throughout the relationship. They said that Sasha told them that Latif's family thought the relationship was *'disgusting'* due to their differing cultural backgrounds and that Latif continuously told Sasha that she was lesser than them, he called her *'white trash'* and told her that she got what she deserved. His Dad phoned Sasha and told her she would *'not survive without him.'*
- 14.9.7. Sasha continued to have poor mental health and distress regarding the pending court date for Latif. Her ASC mental health practitioner was in contact with her regularly and variously had contact with Kent Police, the ambulance service and her IDVA. Safeguarding practices were utilised as necessitated by policy in relation to these contacts. The mental health practitioner endeavoured to support her on the court date offering flexible options for contact across the day. Their final call to Sasha

noted that she was with Latif following his release. Kent Police noted, 'case dismissed as no evidence offered.' The ASC mental health practitioner continued to pursue secondary mental health support for Sasha after the court date, these were deemed not to meet the required thresholds.

14.9.8. IDVA service - Sasha's IDVA remained in contact with her, in January they noted how upset she was about the situation, with the IDVA expressing, *'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.'* Her IDVA attended her January CMHT appointment and noted that Sasha stated she had not seen or heard from Latif for over a year. The records show that Sasha was becoming increasingly desperate to prevent Latif's trial from going ahead, she told her IDVA that she had written to the judge, and that she made Latif visit her by threatening suicide. After the case was dismissed in February Sasha was noted by the IDVA to be 'upbeat', and her case was scheduled for closure to that service in March.

14.9.9. CMHT – Sasha was seen for an appointment in January and assessed to require a medical review with the GP for a medication review, that she should engage with the Forward Trust and continue working with Rising Sun (IDVA service). The CMHT advised Sasha that if she were referred again, she must engage with them to make the service successful. Sasha's IDVA was advised to make a SPOA referral one week before the hearing date for Latif. In a text message exchange with her IDVA the day after this appointment Sasha stated, *'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.'* A few days later she sends another text message, *'Won't get fridge freezer or carpet, as [mental health team] have made that impossible, thanks'.*

14.9.10. In mid-February, Sasha's GP referred her back to the CMHT, who declined the referral because the previous advice had not been implemented, and advised that she should continue with Forward Trust and access support in the community via GP and Livewell.³⁰ Sasha had also been referred to the Clinical Nutrition and Dietetics

³⁰ Livewell is a Kent wellbeing service.

Service (CND) by her GP in recognition of observed malnourishment. Based on a request from the CMHT Sasha was referred, in mid-March, to social prescribing.³¹

14.9.11. Forward Trust - in January Sasha advised she was still drinking, they noted she *'remains preoccupied by her situation with her partner.'* The appointment resulted in *'targets set regarding completion of workbook sections.'* She later said she had not received these and agreed to support group attendance. There is no record of contact between Forward Trust and Sasha between the end of January and mid-March when they recorded an email referral for Sasha from her GP, *'reconciled with her partner, drinking about 20 units of alcohol a day'* and that she had, *'tried to get help from Forward Trust and had been leaving messages for them without getting call backs. Sasha told GP that she was under social services but had not heard from them. She also alleged that Rising Sun had told her that there was nothing they could do as she did not want to leave her partner.'*

14.9.12. The ASC mental health worker called Sasha in January, offering a face-to-face visit in February. The practitioner chased the SPOA referral (made in November 2021) and were advised Sasha had not met the threshold, they highlighted to the SPOA the extent of Sasha's self-harming behaviour. The SPOA contacted Sasha and recorded that she did not wish to engage with them, they advised that they would be contacting the CMHT due to her risk level (she had stated she would kill herself if Latif was imprisoned). During the period there are records of Sasha referring herself to the SPOA on one other occasion.

14.9.13. Adult Social Care advised Sasha's IDVA in February that they had allocated an IO (Inquiry Officer) in relation to the Section 42 enquiry and that KERS (Kent Enablement and Recovery Service) were becoming involved. As a result of this contact the IDVA became aware of recent incidents, contacted the Police for details and sought permission to share with relevant safeguarding professionals, which was agreed upon and actioned. The IDVA ascertained that the hotel assault had been refused

³¹ 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.

charge, but Latif was on remand for breaching prior court bail conditions. As a result of these liaisons, Sasha became upset with her IDVA leaving a voicemail to that effect.

14.9.14. Social prescribing service – after an assessment at the end of March this service referred Sasha to Rising Sun’s IDVA service and sought to secure her a dentist (she had lost her front teeth in the assault with a dog lead and wouldn’t go out without a mask). Two days after her first call with the social prescriber, Sasha had a second call with the records showing that the service was ended because, *‘her mental health needs were too great for social prescribing. [Decision made] after Sasha had sent abusive texts to the social prescriber. Sasha was upset when she was advised that the social prescriber was terminating further contacts with her.’*

14.9.15. 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 reactions³² for which she is given an EpiPen.³³ 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.’*

14.9.16. In May a second Kent MARAC was heard, based on a professional judgement referral, where a full history was shared and actions were noted for the IDVA to maintain contact with Sasha.

14.9.17. 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

³² These were considered to be as a result of her guinea pigs. However, her family note that she had always kept guinea pigs.

³³ 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.

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.

14.9.18. IDVA service – during this three-month period there were various contacts between Sasha and her IDVA. She was closed to the service but was re-opened as 'outreach' although a decision was taken to keep her support with the same IDVA for continuity. Sasha made disclosures of abuse, describing 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'*.

14.9.19. Sasha made these disclosures despite the IDVA having been asked to keep secret this information and declining that they could do so. 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 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. At one point she said she had split from Latif. Through case reflections and reviews the IDVA can be seen to be cautiously endeavouring to maintain contact with Sasha and is hopeful that this could be a turning point. On one occasion the IDVA spoke about his isolation of her and Sasha said she didn't want to *'move forward with support.'*

14.9.20. Sasha's mum was contacting the IDVA through this time, at one point she sent a text message, *'I'm so concerned re Sasha his behaviour is escalating and also controlling her money and when she can see me. This is so difficult as I have to promise her not to say anything, but this is spiralling out of control he's leaving her reliant on him financially but her money. What can I do?'* On calling Sasha's mum the IDVA noted, *'IDVA advised she was being supportive to Sasha, and it was difficult to take matters out of her hands, [He] is not using any of his money, just hers. She's isolated and unable to go out due to funds / he cancelled the mattress she ordered. [Latif] paid for his car insurance from her money.'* Shortly after this the IDVA spoke with Sasha and

told her she had spoken with her Mum and asked about financial abuse. Sasha said she had actually been okay.

14.9.21. In relation to safety planning the IDVA noted, *'At the last hearing the judge did state that if [Latif] appears in front of him again, he will serve a custodial sentence. This might add to the risk level as [Latif] will take further action to prevent Sasha from seeking help or reporting to the police.'* They looked at available safety planning but noted the limitations of this if Sasha might not call the police. Her address was flagged with Kent Police Op Info and noted the need to discuss with the ASC mental health practitioner.

14.9.22. Ambulance Service – There were nine ambulance call outs between April and June. In the first the ambulance was cancelled Sasha described being, *'covered in bruises'*, refusing to say who hurt her and that she was distressed because she could not get hold of her *'carer'*. The ambulance service contacted the police, but Sasha denied any issues. The second happened a day after Sasha had been open with her IDVA about the abuse she was experiencing, Sasha had breathing difficulties with the notes recording, *'patient very distressed, boyfriend on scene keeping her calm. Before ambulance arrival, call back stating patient now calm and asleep – ambulance cancelled.'*

14.9.23. The third ambulance call related to Sasha experiencing chest pain and high blood pressure. Latif was present, it was recorded, *'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].'* The fourth also resulted in a disclosure of abuse and was for chest pain, her ECG was fine, she was advised to attend hospital but declined. On the fifth call an ambulance took her to the Emergency Department with breathing difficulties, *'following an anaphylactic reaction to guinea pig.'* She was taken to hospital against her will as *'deemed to lack mental capacity because she was unable to understand and retain information... or make good choices.'* She was treated and discharged. Kent Community Health Foundation Trust (KCHFT) added a MARAC alert to Sasha's file at this time.

- 14.9.24. The sixth call related to an overdose and was reported by Sasha's mum. During the call Latif returned from London to find her slumped in the street. The hospital noted that she was treated and discharged to the Liaison Psychiatry Service (LPS). Sasha described to LPS that she *'just wanted some peace and had not intended to kill herself. She was annoyed as Latif had taken an ex-girlfriend to his sons' graduation. It was agreed she would be managed through the active review process.'* Shortly after Sasha's GP received notice from the CMHT stating that she was under their active review team.³⁴
- 14.9.25. The seventh call happened soon after the sixth. Sasha requested an EpiPen having experienced an allergic reaction. She was, *'managed and discharged.'* Three days later an eighth ambulance call saw her taken to hospital with *'pleuritic chest pain'*. The letter to the GP stated she had a hand injury. A few days later Latif made the ninth call stating that Sasha was having difficulty breathing. He took the dog out for a walk when they attended, and they noted, *'Today she has had an argument with her partner, has become very upset and feels like she is breathless and cannot breathe. Partner called 111 - 999. Sasha stated that she has an abusive partner. She reports both physical and mental abuse. She states that she stays with him because she does not want to be alone, and she loves him and despite the fact he is abusive she states that she makes her feel safe. However, she appeared very nervous, anxious and upset. Agreed to a [vulnerable adults] referral.* Kent Police sent plain clothes officers two days later and she advised she was happy to remain with Latif.
- 14.9.26. Forward Trust – in April the service noted no engagement with Sasha since January and determined that the recovery worker will follow the 're-engagement' process. In late May they closed her case having not managed to engage her in support.
- 14.9.27. Adult Social Care – Sasha was contacted by her ASC mental health practitioner at the end of April regarding the care needs assessment noting, *'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*

³⁴ A service that supports people through transition from assessment to treatment

arrange a Case Conference with relevant agencies and invite Sasha.' The IDVA advised, *'he has often been at work, so she has been able to talk [to the IDVA].'*

14.9.28. In early June the KERS service undertook an assessment face-to-face with Sasha, this had been delayed by her health issues. She described the significant injuries she had lived with since, *'Latif was swinging a heavy dog lead and accidentally hit her in the face.'* She discussed medication issues, her history of trauma, was asked if she had ever been counselled and becoming tearful stated, *'she just wanted to have a normal life, nice man, home and hates being me and she expects to die.'*

14.9.29. Single Point of Access (SPoA) and CMHT – following the incident in which Latif had bitten Sasha the SPoA contacted Sasha as the ASC practitioner had referred her, she declined a safeguarding referral. On receiving notice of this the GP referred her back to the CMHT and advised her to work with Forward Trust. She was planned for assessment by the CMHT in mid-May, she did not attend. They recorded, *'She was contacted and advised she had been unaware of the appointment as she had received no mail.* A CMHT appointment went ahead at the end of May. The worker noted that they had, *'emailed the KMPT HIDVA to see if there was any additional support that could be offered, and safety planning advice was given.'*

14.9.30. GP – During this period it was noted, *'[Sasha] was smelling of alcohol and had slurred speech as well as old and new bruises on her arms. Sasha was offered support for Domestic Abuse but declined. It must be noted that the partner was in the waiting room at that time. [Planned] to discuss with [GP name]- the practice safeguarding lead.'* There was no record of this discussion taking place.

14.9.31. MARAC – at the end of April a MARAC referral was made by Kent Police relating to the hotel incident in February. The IDVA chose not to mention this to Sasha as *'a lot had happened since then.'* In the May MARAC meeting Sasha's history was noted and the IDVA recorded asking *'If there's anyone within mental health agency that she can be referred to or who can support please do advise.'* The Forward Trust stated she was open to them, not engaging much and often started crying during sessions, other

services gave updates, and the action was for the ASC mental health practitioner and IDVA to maintain contact.

14.9.32. Between July and August Sasha had ongoing health issues, including being hospitalised with sepsis later in the period, and a planned safeguarding case conference with associated visits took place. 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].'*

14.9.33. A MARAC meeting took place in August, based on a professional judgement referral. A list of Sasha's health issues was shared, and actions were determined as liaisons with the HIDVA, another professional (for the purpose of joint working) and for the IDVA to continue support.

14.9.34. IDVA and Adult Social Care - Sasha's IDVA recorded on their case file system, *'advised [ASC Investigating Officer³⁵] to obtain MARAC minutes, [that despite risk of harm] is not ready to end the relationship. Sasha wanted rehab but no referral to alcohol services.'* She also disclosed the issue with the dog, isolation, financial exploitation, and that MARAC would be consulted about a MARAC on professional judgement.³⁶ The IDVA also noted being sent information about the strangulation issue as reported by Sasha to a professional, and recorded, *'he took hold of her throat and she was unsure if she passed out - victims do not remember if they were strangled. The research now shows Sasha is now 750% more likely to be killed by her partner and this goes up every time. Scans are to be recommended for all strangulation cases due to the risk of stroke, even years later, which are a direct result of a strangulation. (over 50% of strangled women under 45, go on to have a stroke as a direct result of strangulation(s)).'*

³⁵ This is the Adult Social care practitioner who was undertaking a Section 42 enquiry.

³⁶ This is based on knowledge of the risks without undertaking the full risk assessment, or where the assessment does not 'score' the risk as high, but it is apparent the risk is high.

14.9.35. 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. [On the same day Sasha did hypothetically discuss refuge with her IDVA. She also contacted the KERS worker around this time saying she needed to 'get out now'- [they did investigate options but on both occasions the dog was a hindrance]. ASC practitioner attempted to complete a DASH form however [Sasha] did not feel she was able to engage at that time. [Sasha] stated her Personal Independent Payment (PIP) was stopped but they have granted her an extension, as she had not replied to letters due to postal issues. Plan: DASH completed by ASC with current information, GP contacted re medication review (arranged). Contact [Town A] Council re Sasha's mail. Invite [Sasha] to Case Conference to ensure her views and wishes are captured.'*

14.9.36. A follow-on case conference was held three days later and the CMHT recorded, *'It was noted that Sasha had become more withdrawn'* and the action plan was noted as, *'KCC ASC practitioner and KERS worker to continue to visit Sasha regularly. Sasha to be discussed at MARAC (referral sent by ASC). Police to advise outcome re last DA incident. CMHT to allocate Sasha to a CPN and psychiatrist asap. Contact IDVA re safety planning and options for Sasha's dog.'*

14.9.37. MARAC - At the end of July, Sasha was referred to MARAC the referral contained all of the facts that had been discussed by the safeguarding conference. The KERS and ASC social worker made a second unannounced visit and noted, *'No recent abuse disclosed but significant bruising to her knees was observed by KCC ASC worker. Sasha said her partner closes windows/curtains when leaves for work and feels like a prison. Sasha agreed for ASC to keep in regular contact.'* A Kent Police Domestic Abuse Liaison Officer (DALO) spoke with the IDVA at this time stating, *'if Sasha calls in the middle of the night wanting to flee, a patrol will go immediately and take to a safe house.'* They requested information about Latif's car. The IDVA spoke to Sasha who *'said she was now in trouble with the "pikies" round here as Latif speaks with*

them, and that he is working away a lot.' The MARAC meeting took place in early August with a plan for the IDVA to continue support.

14.9.38. The DALO continued to liaise with the IDVA seeking to know more about Latif's car, incidents of strangulation and any other possible updates. The IDVA continued liaisons with agencies but could not always establish contact with Sasha. By mid-September Sasha advised that Latif was out of work and was at home all day drinking. Sasha had been abstinent for a few weeks by this point. The DALO and IDVA continued to share updates and consider reactive safety planning.

14.9.39. The day after the initial safeguarding case conference Sasha was taken to hospital suffering from abdominal pain and was discharged to be seen by gastroenterology. Five days after the hospital admission SECamb took Sasha to hospital again with, *'Possible anaphylaxis. Patient has been finding it difficult for the last few days to breath, increased thirst, reduced urine output, painful and distended abdomen. Pt has been given own epi pen, has not improved symptoms.'* Two days later Sasha was taken to hospital again with possible anaphylaxis, she disclosed domestic abuse requesting no disclosure of this information. She did not wait in the Emergency Department and was seen by an ambulance crew again the following day with an *'anxiety episode'*.

14.9.40. At the start of August, the Hospital IDVA received a MARAC alert as Sasha had been admitted with abdominal pain and jaundice, she had been sent in by a GP. She was noted to be admitted being *'treated for detox, septic screen and full liver screen.'* The ASC IO requested to visit her in hospital, but she declined. Her ASC mental health practitioner did visit her in the hospital and Sasha told them that she, *'feels mental health needs not listened to by ward staff.'* The hospital had identified that Sasha had a Portal Vein Thrombosis (liver clot) and was prescribed anticoagulants. She stated she had stopped drinking alcohol a few days previously.

14.9.41. The Forward Trust attempted to engage Sasha in the hospital via their hospital liaison team. By the end of August they recorded, *"Comprehensive assessment - Sasha reported 6 weeks abstinence from alcohol post detox in QEQM and remained in*

receipt of acamprosate prescription.³⁷ Reported more clarity around the abuse her partner had perpetrated against her since achieving abstinence. Sasha to attend abstinence group weekly and medical to be booked. At the start of September Sasha missed a Forward Trust abstinence group meeting but later attended a medical review with the Forward Trust Doctor and a plan was made to engage Sasha in detox and recovery work.

14.9.42. By mid-August Sasha's Section 42 safeguarding enquiry was closed due to, *'sporadic engagement with Sasha... It was agreed by ASC that the Safeguarding would be closed on the basis that ASC MH practitioner and KERS continued to work with [Sasha], as well as the IDVA. DSO shared post abuse plan [Sasha] and all agencies. If further safeguarding concerns arise, a re-referral to MARAC is needed, due to risk of domestic homicide in context of strangulation in the past.'* The KERS practitioner had not been able to see Sasha since her hospital stay as they had contracted COVID, and towards the end of August made attempts to re-establish contact. However, by the start of October KERS closed her case, *'having not been able to complete an enablement plan with [Sasha].'* They noted that they would re-open quickly given the *'exceptional circumstances.'*

14.9.43. In the first week of September the KERS and ASC MHP made a home visit and were told by Latif that, *'Sasha in (acute) hospital with liver; says Sasha free of alcohol 4 weeks and better.'* They were later contacted by Sasha who advised, *'partner not working, so harder to be in contact, [and] at mums and forgot appointment'*. Sasha had missed a CMHT appointment because of the hospital admission too, they booked her for a mid-October appointment.

14.9.44. Sasha remained in hospital for the first half of October, Her IDVA liaised with professionals and her mum. There were concerns that Latif was bringing alcohol into the hospital when he visited her. She was discharged in the middle of the month. Sasha did not attend her Forward Trust appointments in October but did see her recovery worker at the start of November where they discussed the requirement for

³⁷ Acamprosate is essentially an anti-craving medication that helps to reduce the desire for alcohol

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.

14.9.45. Sasha's family noted to the panel that she was abstinent at this time, that she knew the cirrhosis would kill her and wanted to be able to have a transplant. She was thinking more clearly, and Latif could see this. They stated that she was contemplating change, and the family could see that this increased his controlling behaviour. They said she was motivated by the praise of the substance use team and regular testing.

14.9.46. In the first week of November, Sasha was re-admitted to hospital with a parietal haemorrhage (stroke). She refused treatment and food and was referred to the Liaison Psychiatry Service (LPS). She was assessed regularly for mental capacity. It was noted that Latif was abusive to staff on the ward, and the IDVA checked whether he was banned, recording, '*...[they] said Sasha does want her partner to visit, as well as her mother... advised they have agreed as a team that when any visitors come, we will observe within the bay.*' During her admission the Hospital-based IDVA (HIDVA) provided on-site support to Sasha along with her usual IDVA.

14.9.47. 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 Sasha's 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.

14.9.48. Sasha's ASC mental health practitioner contacted Sasha's mum, and was updated regarding the situation, they noted, '*Sasha doesn't have capacity, so mum is making decisions re Sasha's finances... offered to provide support with homing Sasha's dog and removing Sasha's partner from the property as he is not a named tenant.*' A decision was taken that Sasha would remain open to this worker, and the HIDVA supported with conversations regarding the tenancy issue, contacting the housing officer immediately. Sasha's IDVA advocated with professionals generally regarding Sasha's desire to end the relationship in the run up to the stroke. They made a MARAC referral and noted to discuss with the hospital safeguarding team the need to block discharge from the hospital without appropriate safety planning. During Sasha's stay she told the HIDVA that Latif was being nice to her and would leave his job to be her full-time carer.

14.9.49. The MARAC meeting took place noting that Sasha was held under DoLS (Deprivation of Liberty Safeguards).³⁸ Actions were hospital safety planning related, along with obtaining a DVDS.

14.9.50. At the start of December Sasha had regained some mobility, and there were discussions regarding the possibility of her being discharged to the care of her mum. This was unrealistic given her mum's age and the size of her home. There were further discussions about discharge to a rehabilitation ward. Over the course of the admission Sasha's attitude towards her mum changed, she became angry, blaming her for her situation. It was noted that Latif's conversations with her were unknown. He was bringing takeaway food to her regularly and she started to express the desire to go home with him.

14.9.51. Concerns about Sasha discharging herself led to a mental capacity assessment, and a decision that a nurse should be present in the bay when Sasha was visited by Latif. She was subject to deprivation of liberty safeguards (DoLS). During this time Kent

36. Deprivation of Liberty Safeguards (DoLS) are a set of legal procedures within the Mental Capacity Act 2005 that protect the rights of individuals who lack the mental capacity to consent to their care arrangements in hospitals or care homes, and whose care arrangements involve restricting their freedom. Essentially, DoLS ensures that if a person is being deprived of their liberty for their own safety, it's done legally and with appropriate safeguards

Police sent an officer to see if Sasha would disclose any abuse, the speech therapist supported this in principle but was mindful of losing Sasha's trust, so the meeting was delayed until January. Sasha increasingly spoke about her anger towards her mum for doing things without her consent and that she was, *'in the wrong mindset about Latif.'* The speech therapist and IDVA continued to raise the nursing staffs' awareness of Latif affecting her thoughts and feelings towards her family.

14.9.52. At the end of December, the transfer coordinator noted the plan to transfer Sasha to a rehabilitation ward and that, *'It is documented that due to ongoing safeguarding concerns, Sasha's partner had not been made aware of discharge planning.... Sasha was subject to a Deprivation of Liberty safeguard... It is documented that Sasha was known to MARAC and the Community Mental Health Team. Sasha was heard at MARAC the previous week and deemed as "high risk". However, her partner was still permitted to visit outside visiting hours, it was noted that Sasha became very emotional following his visits.'*

14.9.53. Sasha saw the HIDVA and was *'upset and angry'* as she had been advised of the move to a rehabilitation ward, stating, *'I am not doing it.'* The HIDVA spoke with the OT and ward matron. The OT stated that the rehabilitation ward was the only and best option for Sasha and that they considered it better for Sasha's mental health as she was not currently, *'being supported [with her mental state] due to a lack of staff.'* The matron expressed that ward staff were not prepared to restrain Sasha for the move and wanted her to be re-assessed for capacity as they felt she had it. The HIDVA tried to encourage Sasha to see the move as positive for her strength and recovery, they noted, *'Sasha became extremely agitated and upset... shouting "this is f***ed up and unfair".'* The matron then advised the HIDVA that Sasha continued to be unhappy when her mum was around, and that Latif, *'has been in everyday and bringing takeaways in like kfc and pizza and Sasha is the happiest she has been in here'. [Matron] also advised that he is saying he can look after Sasha, and he is happy to come and pick her up to 'take her home.'* HIDVA advised *[the matron] it is not safe with this man and why Sasha wanted to leave the relationship. [Matron] advised he is 'pleasant, nice and she is happy'. HIDVA advised he is a perpetrator of abuse.'* The matron, OT and HIDVA decided to try and encourage Sasha via a friendship she had formed with another patient who would also be transferring to the same ward.

14.10 – 2023 – Kent

- 14.10.1. At the start of 2023 Sasha was still in hospital with considerations of how and where her discharge should happen. She was discharged home to the care of Latif by the end of January, following a re-assessment of her mental capacity. Throughout the year there were 374 agency records in relation to domestic abuse across a range of agencies. She had been significantly disabled by the stroke that she had experienced. Consequently, she had speech and occupational therapy services along with other health appointments. She continued to have the support of her IDVA and others.
- 14.10.2. The lead into Sasha's discharge from the hospital commenced with another mental capacity assessment, it was decided this would contain a discussion regarding her relationship with Latif and whether she understood the risks she faced. She described positive relationships with her ASC mental health practitioner, had a supportive neighbour and the HIDVA recorded, *'...she said he has not physically hit her for 3 years now, he can get angry, but he now tends to leave to calm down. She said that her drinking had been a large part of the problem but that now she is teetotal and has been for about 11 months... She did not feel she was at risk from him and that he had been really good whilst she had been in, I asked about the fact she was leaving him before she came into hospital, and she denied this. She said her Mum does not like him, always jumps to conclusions if she sees any sort of bruise and she gave the impression the leaving had come from her Mum not her.'* Sasha's family raised concerns that Sasha's responses to mental capacity assessments were taken at face value and that she knew what answers to give to 'pass' them.
- 14.10.3. Sasha wished to return home and it was deemed that she had mental capacity. It was determined that she would be discharged a few days later and the hospital trust recorded discussing her care needs with her partner, and that she would have occupational therapy (OT) follow-up in the community. They also notified Sasha's GP of the status of her situation and associated safeguarding concerns.
- 14.10.4. A week later the ASC mental health practitioner noted a supervisory discussion that resulted in a plan to complete a *'Positive Risk Assessment'* for Sasha and then to close her case file. They noted, *'The Risk Assessment highlighted the concerns of DA,*

but recognised that there was ongoing support from the OT due to Sasha's cognitive function support, and this provided an ongoing professional presence with Sasha. They were unable to contact Sasha between then and the following month, her case was closed. The CMHT noted in mid-January that Sasha had a medication review whilst still in hospital and, 'was stable and should carry on with current meds.'

- 14.10.5. Sasha's mum contacted the IDVA service saying she, *'couldn't get past this'* and that Sasha was not speaking with her or her son now, and that it was unusual for this to be the case with her son. Her mum described herself as *'devastated'* that she was being discharged to the care of Latif and that she would, *'be back in [the hospital] with injuries or in a body bag'*. The IDVA advised Sasha's mum that Latif would be collecting her that day. Sasha's mum asked why, as next of kin, she hadn't known about the second mental capacity assessment, telling the IDVA that she couldn't talk to them anymore and that, *'she would never be allowed to see her daughter again now that he has all of the control.'*
- 14.10.6. Between Sasha's discharge and the end of March she was seen by her occupational therapist team (they had been instructed to attend her property in twos for safety reasons). She also had contact with her IDVA and had one psychiatric appointment.
- 14.10.7. Occupational therapy – in the period the team saw Sasha four times at her property, with a fifth scheduled but cancelled by Sasha as she *'felt too upset to see anyone.'* At the first visit Sasha stated difficulty using the stairs at her property, speech and memory problems. Sasha's mum asked to be notified of appointments due to the memory issue, which they did. They noted, *'Partner was present but took dog out for a walk towards end of assessment... It was noted that her partner spoke over her during the session and he stated he was not working so he could look after her. When he went out the OT asked if she was ok and Sasha reported that she was but found it difficult with him at home all the time. It was documented that it was challenging to explore fully Sasha's thoughts due to her expressive communication difficulties. Sasha confirmed that she did not drink alcohol and had been sober for months.'*
- 14.10.8. At the second visit the OT made a physiotherapy referral and noted, *'the reality of being back at home much more challenging in terms of her recovery than she thought*

it would. She appeared much more emotional at the second visit. Her partner... stayed in the bedroom and did not engage at all. Sasha appeared to have low self-confidence and lack of confidence in decision making processes.' The OT contacted the KCHFT safeguarding advisor with concerns that Sasha needed intensive rehabilitation and that the home environment was not suitable for her, they also noted concerns about her partner being present which prevented opportunities for Sasha to disclose abuse and were advised to be honest with Sasha regarding concerns.

14.10.9. At the third visit Latif was at work and the OT recorded, *'During visit Sasha reported that she thought her partner was getting rid of things that help her to get better - the putty (used for hand exercises) and written hand exercises could not be found. Sasha indicated that she was unsure if he was giving her the wrong medication on purpose, that he would explain, for example, how to use television remote and then get cross when she couldn't repeat the actions. Referrals to domestic violence support and safeguarding were offered but Sasha declined.'* They requested medication be issued in a Dossett³⁹ box.

14.10.10. At the fourth visit the OT recorded, *'Sasha said she hadn't eaten much that day, she showed OT her fridge, there were a variety of ready meals and food which Sasha stated she did not like and was her partners [Authors note: Sasha was a lifelong vegetarian – her family advised that Latif would stock the fridge with meat based meals so Sasha could not eat]. She became upset and stated that her partner would become angry around this subject and at times she would go without food.'* Sasha said at this visit that she did not want to move from her own home to more suitable accommodation but would have therapy sessions at her mum's house. Sasha told the OT that she was in contact with the domestic violence service and was also in contact with social services. She declined permission for the OT to contact either of these services. The OT then requested advice from the safeguarding specialist regarding Sasha's lack of consent for her to be in touch with other professionals, advising that they should do this anyway along with reiterating to Sasha the information sharing protocols when concerns arise.

³⁹ A daily medication organiser

- 14.10.11. Sasha wasn't at her mums for the fifth appointment, but her mum reiterated concerns about medication tampering and a lack of care and support for Sasha in her home. The OT followed up with the GP regarding a Dossett box.
- 14.10.12. IDVA service – Sasha's IDVA attempted to maintain contact with Sasha although this was limited by Sasha's health, memory and the presence of Latif. Consequently, despite several attempts, there were only limited interactions during the period. Early on she said Latif was *'being okay'* and wanted to know who had *'power of attorney'* for her affairs. She spoke to Sasha's mum who continued to express safety and wellbeing concerns for Sasha and advised that the ASC mental health practitioner was closing Sasha's case. In the final week of March Sasha's IDVA reviewed her practice and noted, *'[Latif] is currently the carer for Sasha so this is a risk as Sasha's family can't go around there if he is there. He has recently stated that he is getting fed up looking after her. [Latif] works so [communication is cautious]. Sasha is becoming more open about her situation.'*
- 14.10.13. Community Mental Health Team - Sasha was taken to a psychiatry appointment in mid-March by her mum. Sasha's medication was reviewed and the antidepressant changed. She reported struggling physically at home. The plan was for her to be followed up by her care co-ordinator.
- 14.10.14. Between April and June Sasha was seen by 9 separate agencies. Her health deteriorated and at the end of June she was back in hospital. Her GP had seen her once at the start of the period when she had presented with a crush injury to her right finger, and later in the period regarding concerns about falls and her, *'feet and her knees going purple.'* The latter is addressed below, for the hand injury Sasha required surgery. She described catching it accidentally in a car window. Sasha's mum advised the report author that Latif had shut her hand in the car window on purpose, this set her hand mobility recovery back. Sasha was also contacted by a dietitian later in the period due to concerns about eating. They noted, *'she had little support with food shopping and cooking.'* It was planned to commence dietary supplementation.
- 14.10.15. Occupational therapy – they recorded that Sasha's mum *'suspected that Sasha's partner had caused the injury by shutting her hand in the car window. The incident*

had not been reported to the police as Sasha's mum said it could not be proven. Mum said Sasha was very low and crying all the time.' The OT responded that they would be happy to speak to Sasha and make a safeguarding referral if Sasha consented but that the IDVA and Police would be most suited to helping with her current situation. They were advised in a safeguarding consultation to, *'have a conversation with Sasha to establish her views and wishes and what she would like to happen, to offer to raise a safeguarding concern with her consent and/or share details of domestic abuse services with her.'*

14.10.16. The OT continued to liaise regarding a Dossett box which was variously hindered by an incorrect referral pathway, a disagreement about Sasha's needs and culminated in the idea being rejected, the hospital stroke team intervened requesting an urgent assessment which resulted in a medication recording card being issued. However, by June they were being issued in weekly boxes.

14.10.17. By the end of April the OT, having found it difficult to maintain treatment at Sasha's mums' home (due to their disagreements about Latif), determined to continue this at Sasha's home. In the third week of May Sasha was not available for her OT appointment and they sent a text message to her mum advising that they would discharge her as her engagement was limited. Her mum responded that she had not had much contact either, and would check with Sasha if she wanted to continue speech therapy.

14.10.18. Speech and Language Therapy – Sasha was seen by this service from June and said she did want help from the OT as she felt her balance was getting worse. She said she was getting along better with her mum and would like these appointments to be at her mum's address. The SLT planned to liaise with the OT for joint visits. The SLT contacted Sasha's mum to discuss appointments, they recorded, *'she was very concerned about Sasha now - she is now looking increasingly gaunt/ill, constantly tired, changes to her speech, Sasha was falling regularly, bruising to legs thought to be due to falls. Discussed that Sasha's life was complex and chaotic, that she struggled to look after herself and her cognition was impacting on taking her medications regularly. It was agreed that SLT would liaise with the Clinical Team Lead for advice and a joint visit.'* This was agreed for the end of June.

- 14.10.19. Community Mental Health Team – this agency recorded, *‘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.’*
- 14.10.20. IDVA Service – Following the hand injury Sasha’s IDVA spoke with Sasha’s mum and secured the details of Latif’s car, which Sasha’s mum described as being paid for by Sasha. She told the IDVA the injury was intentional and described to the report author that punishments were routine for Sasha. She further described this happening outside her home while Latif’s adolescent daughter laughed in the back seat of the car. On speaking with the OT, the IDVA was advised that Sasha will be referred to the MDT HUB for agency discussion. She also contacted the police and gave details of Latif’s car to them. The IDVA continued to attempt contact through April and May with limited success but stayed in touch with Sasha’s mum.
- 14.10.21. When Sasha spoke with her GP practice regarding her purple knees and legs, they spoke with the specialist stroke nurse who advised that she attend the Emergency Department due to further stroke risks. Consequently, in late June, a 999 call was made, and she was taken to an East Kent hospital with stroke symptoms. The caller (unknown) described her having fallen down some stairs. The IDVA ensured that the HIDVA saw Sasha. All agencies liaised to share information and ensure hospital staff were aware of Sasha’s circumstances. The hospital staff made an urgent Deprivation of Liberty Safeguard (DoLS) request, and the HIDVA advised staff not to allow Sasha’s curtains to be closed by visitors, or to allow Latif out-of-hours visits. She saw Sasha’s son who said he felt that something had been done for Sasha and was advised to call the police.
- 14.10.22. In early July Sasha attempted to leave the hospital with her belongings. She was saying that Latif was in prison but when spoken to on the phone by Sasha’s mum he said he was at his mother’s. It was noted that Sasha had not suffered a further stroke

but presented with *'decompensation of old stroke... Sasha wanted to go home, but she was assessed as lacking capacity to make this decision. However, she made progress during the admission, and a repeat capacity assessment deemed her to have capacity to make this decision. Initially Sasha agreed to have a package of care, lifeline and key safe but within 24 hours she wanted to leave the ward and go home, and it is reported that she told the ward staff that she no longer wanted carers and wouldn't let them in.'* In a handover referral between the hospital and community SLT it was noted, *'that Sasha's speech, cognition and mobility were significantly worse than when she was discharged in January. Sasha was encouraged to engage with therapy on her return home.'* She was discharged.

14.10.23. Sasha was at home for a little under six weeks following this discharge. She continued to be seen by a range of agencies, but on a limited basis. At the end of July, a Multi-Disciplinary Team (MDT) review took place due to concerns for her and based on her continued deterioration and state of neglect Kent Police became involved again. By mid-August Sasha was back in hospital where she would remain until her death.

14.10.24. Speech and Language Therapy (SLT) – a visit was made to Sasha in July and the practitioners heard raised voices and swearing as they approached the flat. Latif left with the dog at the start of the visit. The SLT recorded a significant amount of concerning information following this visit. Key notes included, *'[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.'*

14.10.25. Sasha also reported that she was not coping and that, *'Things are difficult with [Latif] due to her difficulties... he swears / gets angry, e.g. at times when he cannot understand her, or when she falls and is unable to get up. Sasha reported experiencing a high degree of back pain, she declined to let SLT/OT check her back but did consent to it being flagged to her GP for review.'* She described Latif being *'in control'* of her medication and that, *'She acknowledged that she felt sad but said 'it*

is what it is' and felt her situation was unlikely to change... she felt unable to leave as didn't want to leave her dog. When [Latif] returned Sasha appeared to become more emotional and distressed. He sat next to her, stroking her back and offering reassurance. He stated that he prompts Sasha to 'calm down' and 'relax' when her speech is difficult to understand. Sasha challenged this saying that he may swear at her at these times. As he spoke it appeared as if she disengaged, turning away and becoming quiet. [He] stated he had resigned from work as needed time off to care for Sasha. A notable deterioration to Sasha's speech, language and communication compared to last visit. Plan was to contact GP regarding back pain, liaise with community mental health team, refer to Hub for MDT discussion and management, contact Trust safeguarding team to discuss concerns.'

14.10.26. The MDT HUB meeting took place at the end of July who noted, *'Action for SLT was to liaise with Rising Sun Domestic Violence and Abuse service to discuss any current involvement with Sasha and flag the current concerns Contacted the service and was advised that Sasha is open to them, keyworker details shared and email to keyworker to request they contact SLT to discuss Sasha. Action for social services representative - to feedback to the Hub before next meeting. For GP review of back pain and medication review in view of partner having control of these. Sasha to remain open to the MDT Hub.'* In mid-August the Hub asked for concerns to be escalated to Sasha's social worker. Three days later the SLT was advised by Adult Social Care that Sasha did not have a social worker and that there had been no referral for a care needs assessment. They agreed to contact Sasha and discuss care needs.

14.10.27. Sasha's GP sent a text message advising her of a telephone appointment, she did not respond. However, she attended her GP with Latif in late July and was given an increase to her anti-depressant medication and some diazepam for anxiety.

14.10.28. In early August Sasha's mum contacted the SLT who recorded, *'Concerns raised - Sasha's hair not washed/brushed/ pale, sallow skin/difficulties with dressing/large, bruised area on Sasha's hip and below her knee/Sasha said she was hungry/long toenails curling into her feet. [Mum] wanting to get help for Sasha and asking for support from SLT. Reply sent to advise that team would follow up. SLT flagged*

concerns to Clinical Lead as out of office the following day, suggested that information was shared with the Hub.’ The Hub discussed Sasha again, recording, ‘still awaiting feedback from CMHT and social services. HSCC to email CMHT to request urgent update. To keep open to Hub.’

14.10.29. Community Mental Health Team – the team visited Sasha at the end of July, noting Latif’s presence and concerns that she might not be honest about her safety. They planned to review her medication in mid-August. In early August, having not heard from the CMHT, the SLT sought an update, none was given. When the time came for Sasha’s mid-August appointment they noted, *‘When contacted by telephone for the appointment could not go ahead as she seemed sleepy and her responses to questions were incoherent. The doctor asked for the appointment to be rebooked.’*

14.10.30. Kent Police - Sasha’s mum called the police in early August who recorded, *‘Mother saw her around 5 days previously and was concerned... dishevelled, bruised and was hungry. Latif had stated that he was not coping looking after [Sasha] as she kept falling. Patrols attended early the following morning to undertake a welfare visit but could not get a response. Officers finally attended [a few days later] and spoke to both and [Sasha] privately [who stated] she did not need any help. They both explained been to the doctors the previous day and referrals for physio and occupational health were being submitted.’* They later contacted Sasha’s IDVA. They had ascertained that there was an open Section 42 enquiry due to be completed at the end of August [Author’s note: this was related to a non-domestic abuse matter that happened on Sasha’s last hospital stay]. A further police welfare check was requested by Sasha’s IDVA after her mum advised concerns following a phone call with Sasha.

14.10.31. IDVA Service – Sasha’s IDVA continued to attempt to stay in contact with Sasha, which was limited by Latif’s presence, although in one July note they recorded, *‘She said Latif had been working every day and she was lonely. He should've been picking her up for an appointment at 11:15 but wasn't with her yet. She was getting upset and frustrated on the phone. Sasha then said he was coming and said bye.’* They continued to liaise with the SLT and Sasha’s mum who raised ongoing concerns throughout the period about Sasha’s state of neglect, including extreme hunger. One

note stated, *'She'd been hungry so [mum] took her to Asda, and she ate Jaffa cakes and biscuits...'* She also advised the IDVA that Latif had a *'very nosey'* friend downstairs from Sasha, who appeared to be monitoring her when Latif was not there.

14.10.32. Following the involvement of Kent Police the IDVA recorded the need to, *'consider a Hidden Harm check.'* It was further noted, following a call with Kent Police, to consider adding her to *'Op Pelican'*.⁴⁰ Latif's car details which were shared with the police along with information about the neighbour.

14.10.33. The GP was asked by the MDT Hub, in mid-August to review Sasha's back pain. Sasha saw her GP in mid-August who ordered blood tests, the following day these came back identifying *'acute kidney injury'*. Having not been able to get hold of Sasha they called an ambulance. The ambulance crew recorded, *'creatinine levels increased from 49, to 202. Whilst on scene patient's partner seemed dismissive when crews were asking questions and seemed uninterested in the patient's general well-being. Patient disclosed to crew she hasn't eaten for the last 48hrs when asked why, she said she didn't know.... Patient asked crew not to mention the domestic violence and said he often asks her if she's been quiet or kept her mouth shut when she's got to hospital, she also disclosed she's worried about going home but is scared to be on her own. Patient has been falling a lot more than normal, spatial awareness has been worse and has been getting unexplained bruises. Patient conveyed to [hospital]. Safeguarding concern raised by attending clinicians due to disclosures during contact. Shared with Police and Adult Social Care, without consent, having first confirmed Sasha is open to their services.'* ASC later recorded receipt of this referral.

14.10.34. Sasha's mum advised the panel that when she met the ambulance at the hospital Sasha was saying how hungry she was, and the crew got her a cheese sandwich which she *'devoured'*. When she was admitted, she was discovered to have bruises all over her back, a police officer came out and took photos and advised that she would be back after a period of leave, but the family did not see them again. Sasha told the nurses that he had been beating her. Sasha's mum also noted that within a few days of the admission Latif was spending hundreds of pounds on Sasha's bank card at Bluewater shopping centre and supermarkets. They also shared that later in

⁴⁰ A Kent Police programme

the admission a nurse, who later attended Sasha's funeral, raised concerns that Latif would lie across Sasha's bed whispering in her ear, and that Sasha began to wet herself after his visits.

14.10.35. 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 she was in A&E. The man went on to tell the dietitian that [Sasha] had been beaten for 12 hours by own boyfriend and was taken by ambulance to A&E. The dietitian initially thought this man was a neighbour but on asking him who he was, he then told the dietitian that he was the boyfriend. The dietitian then had a safeguarding consultation with the KCHFT team and informed GP, and the ward where [Sasha] was admitted.'*

14.10.36. A Kent MARAC was heard at the end of August based on Sasha's 'visible high risk' and the actions determined were to obtain a DVDS, make an animal welfare referral, review safeguarding plan, flag lone working issues, and liaise with the LPS.

14.10.37. During this admission a DoLS authorisation was granted for four months with the DoLS stating, *'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.'*

14.10.38. Sasha's HIDVA undertook liaisons to prevent Sasha from being discharged without warning. They noted Sasha self-blaming for the abuse from Latif, admitting that he had caused the bruising to her, observations of her 'squirrelling' food away and the need to involve Adult Social Care. Sasha's mum advised that a friend had looked at her mobile and found a tracker installed. Adult Social Care noted this information

along with, *'a S42 Enquiry was progressed; ASC Adult Safeguarding IO visited [Sasha] on ward. [Sasha] stated she "loves partner and wants to go home". IO liaises with Police and other agencies.'* The IDVA also advised the police of information as it arose. Liaisons between agencies continued throughout her admission.

14.10.39. Sasha was very unwell whilst on the ward. Her eyes were yellow, and her behaviour was erratic. She was observed to be extremely constipated with the consultant noting that her Lactulose medication had likely not been taken for a long time. During periods of distress, she was noted to disclose abusive behaviours, for example, *'Sunday, she told [mum and son] that Latif owes her £2000, 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.'*

14.10.40. In September she was told she was medically fit for discharge but could not go home, she became upset about this and was asking to go home. She was being aggressive to staff and was referred for a psychiatric review. Sasha was seen by the LPS with medication reviews and options for psychological services discussed. LPS continued to see Sasha every other day until November noting her agitation, aggression and attempts to leave the ward, they recorded, *'Advice regarding medication and management was given. Sasha continued to express her wish to return home to Latif.'*

14.10.41. Sasha's state of mind did not improve, the LPS recorded, *"post stroke behavioural changes. The working diagnosis is end-stage liver disease, Wernicke's encephalopathy and ongoing confusion - secondary to post stroke syndrome.'* The LPS later noted that she might abscond from the hospital and soon after Latif contacted Sasha's mum to advise her that Sasha was outside a local shop having walked from the ward to that place. Sasha's mum reported to her IDVA that *'the nurse questioned [Mum] about the DoLS stating she thought it was for a few days, and said they were short staffed. [Latif] has a new number, and [Mum] will send to IDVA to pass on to relevant Police Officers.'*

14.10.42. MARAC meeting – Kent Police had made this referral, and the meeting took place soon after Sasha’s admission to hospital with the IDVA recording actions as, ‘*Send minutes to OIC- Review Bail / RSPCA looking to remove animal so [Latif could] be at his own address. Professionals meeting to review safeguarding plan. Flag lone working issue for colleagues. Liaise with psychiatry team to make sure they’re aware- discharge meeting with IDVA required. Pass consultant details to [initials] from victim’s mum.*’ The day after this the IDVA recorded a conversation with the police Acting Detective Inspector (ADI), noting, ‘*[ADI] advised she authorised bail on this case as there is clearly a lot more to this case and a lot of investigation required. [Also] advised she forwarded the email on to the supervising Sgt and asked them to conduct a review and set appropriate actions.*’

14.10.43. In relation to the charges against Latif Kent Police recorded, ‘*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 [October 2023]. He was bailed during this time to Sasha’s flat because he had argued that he needed to care for the dog with condition not to have direct or indirect contact with Sasha.*

14.10.44. At the end of September Kent Police recorded, ‘*Latif was stopped driving his vehicle and reported for driving whilst disqualified and no insurance. He appeared before the Court in December 2023 and received a community order, work requirement and costs including 18 months disqualification from driving.*’ Sasha’s family advised the panel that Sasha had numerous parking and speeding fines, because Latif put everything in her name – Sasha didn’t have a driving licence.

14.10.45. Whilst Latif was on bail a neighbour came to visit Sasha. Her mum notified the IDVA of her concerns about this as they were not friends with Sasha and had brought many of the things that she liked. This was reported to the police who advised hospital staff to listen to conversations with this visitor. In October Sasha’s mum went to Sasha’s

property as Latif had advised of a build-up of post. He handed her two packets of refreshers (sweets) to give to Sasha; she found a letter from the Department of Work and Pensions relating to a carers allowance application by Latif. She did not give Sasha the sweets.

14.10.46. Adult Social Care (ASC) – In October the short-term pathway team undertook an assessment, following which a best interest's decision was made. Consequently, the KCHFT Rapid Transfer Coordinator recorded, '*a best interest's decision was for Sasha to be discharged to a pathway 3 bed for a period of assessment.*'⁴¹ In a later note the LPS recorded, '*attended a discharge planning meeting on... ward [start of October]. It was agreed that Sasha was likely to require more specialised placement than a pathway three bed and a plan was made to request an assessment by the rapid transfer dementia service (RTDS).*' RTDS later recommended a '*specialist facility.*' Unfortunately, as Sasha was too young for this type of placement it was difficult for an appropriate setting to be located which caused delays to her transfer.

14.10.47. In November an ASC social worker called the IDVA for an update. In the same week they recorded a further safeguarding concern, '*... partner recently visited [twice], and they noted a deterioration in [Sasha's] mental health presentation; incontinent and asking to leave since his visit/s; family feel it is not in [Sasha's] best interest for him to visit.*' Referral states DoLS baseline means partner can now visit, and ASC are not able to prevent someone visiting, however the person could be spoken to and an arrangement mutually agreed for further visits. Information added to open S42 Safeguarding Enquiry.' The ward manager called Latif and advised he should not be coming to the ward. He had started to visit after his bail conditions ended following the discontinuation of charges against him in October.

14.10.48. Housing – Sasha's IDVA liaised with housing regarding alternative accommodation for her at the point of any discharge. In October the housing officer spoke with the

⁴¹ In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement co-ordinated through the care transfer hub, including:

- care home placement for assessment of long-term or ongoing needs and facilitation of patient choice in relation to the permanent placement
- long-term care and support in a care home following a period of intermediate care in the community [Source: [Hospital Discharge and Community Support Guidance](#)]

IDVA who recorded, *'IDVA advised about [Latif] still in property - enforcement can remove if necessary.'* The IDVA service noted to ascertain if the dog had been removed from the property. In a follow-up regarding enforcement of Latif's eviction the housing team requested details of the police officer in the case from the IDVA to progress this matter. The IDVA advised housing that there would be no need to secure an alternative property as Sasha required palliative care. A notice to quit for Sasha and Latif was served in November.

- 14.10.49. Shortly after this 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.

15 Overview

- 15.1. The period examined in this review was January 2017 until Sasha's death in December 2023. Her relationship with Latif began late in 2017, but she had been in what appears to be a similarly exploitative and violent relationship prior to that starting.
- 15.2. The relationship was coercively controlling and extremely violent from its inception and based on the chronology and Sasha's family views control was exerted tactically according to Sasha's situation. For example, economically, through trauma and sexual exploitation and by using others to harm her.
- 15.3. Sasha lived with multiple disadvantages and many services that tried to support her were inaccessible to her, she had long-term support from domestic abuse services but they along with all others found establishing opportunities for change difficult.
- 15.4. Latif managed to control Sasha with violence and manipulation of her emotional state in order to financially and sexually exploit her, it was the clear belief of the panel that this was not an intimate relationship in his eyes, it was an opportunity to make money from a vulnerable woman.

15.5. The length of the relationship and the complexity of the material presented analytical challenges. Learning was sought not from analysis of process detail in all incidents, as there have been significant policy and practice developments since 2017, but rather from key incident and overarching themes.

15.6. The panel determined that there were key issues to be considered. Namely, the identification and activity in relation to Sasha's exploitation and abuse in her community, the suitability of the MARAC and IDVA models of support for someone experiencing multiple disadvantages, mental health and social care responses to vulnerable adults, the accountability of perpetrators of abuse at MARAC and in policing and police investigation and charging activity.

16 Analysis

16.1 Introduction

16.1.1. Sasha's family were very clear that she was a kind, generous and loving person, displayed in her care for animals and people, especially those who were vulnerable. It is clear from the records that Sasha struggled significantly with self-love and that this was exploited by men intent on causing harm for their own advantage. Sasha's internal working model is discussed here to set the scene for her vulnerability to exploitative behaviours.⁴²

16.1.2. All panel members agreed that Sasha was an extremely vulnerable woman, who was subjected to multiple and significant violence and abuses throughout her lifetime. Her family described a problematic and emotionally cold relationship with her father, in their view this left Sasha with a significant level of emotional vulnerability and directly contributed to her difficulties in relationships and with problematic alcohol consumption as an adult.

16.1.3. The importance and value of fatherhood for children is a complex area where there is domestic abuse, and fathers' involvement is not always best for children if they perpetrate harm, and noted to be of concern when areas such as family courts have significant failings in handling these risks.⁴³ Sasha's father was not

⁴² Internal working models are a central premise of attachment theory. Also known as a cognitive framework, they are a mental representation of oneself, the attachment figure (typically a caregiver), and the relationship between them. It develops in early childhood based on experiences with primary caregivers and shapes how individuals understand and interact with others, including in future relationships. The model was proposed by Bowlby (1969).

⁴³ [Assessing risk of harm to children and parents in private law children's cases, Ministry of Justice. 2020](#)

understood by the panel to be domestically abusive, but rather emotionally cold to his children, according to her mother and son's descriptions. Children with healthily involved and emotionally warm fathers are more likely to be emotionally secure, maintain better social connections with peers, have stronger self-esteem and a better sense of identity, making them more emotionally secure as adults.⁴⁴

16.1.4. Internal Family Systems therapy offers a helpful window into the development of the personality for children and adults. In this modality, we see every human as being composed of 'parts' – sub-personalities that are natural for any person. However, where these parts are subject to trauma or attachment injuries, they act differently to protect the individual but can also freeze in that state and carry on into adolescence and/ or adulthood becoming outdated and harmful 'burdened parts.' These burdened parts are 'infected' by extreme beliefs and emotions.⁴⁵

16.1.5. The author of this model describes children who are rejected, traumatised or hurt by their caregiver having parts that become burdened by feelings of, *'worthlessness, powerlessness, emotional pain or terror, and that consequently they are not so much fun to be around.'*⁴⁶ Sasha's family noted that she could be challenging given the emotional highs and lows that she experienced and that agencies could find it difficult to work with her, but they were also very clear that this behaviour was driven by the defence mechanisms she had developed in childhood, that were problematic for her as an adult. Her attachment injuries from childhood could have made it difficult for her to work from a position of trust with professionals as she contended with chronic fears of rejection and abandonment. Sasha also experienced significant loss when her son was removed from her care, as did he.

16.1.6. The panel agreed that this must be reflected in the report to contextualise Sasha's adult life experiences in order that agencies continue to learn and focus on the early life of children, and the devastating impacts of domestic/ emotional abuse and neglect.

16.1.7. Sasha's family describe an intelligent woman who wished to become a lawyer but because of economic pressures, went to work instead and was successful, at a young age, as a health and safety professional in the building trade. Unfortunately, there was a culture of drinking in this working environment, and Sasha was vulnerable to addiction.

⁴⁴ [Engaged Fatherhood for Men, Families and Gender Equality, ed: Grau et al, 2022](#)

⁴⁵ Internal Family Systems Therapy. Richard Schwartz. The Guildford Press, 2020

⁴⁶ ['These parts will fight to the end to protect you.' Interview with Richard Schwartz. British Psychological Society \(Accessed 8.4.25\)](#)

16.1.8. The panel noted that the family informed them that Sasha was advised to give up her (mortgaged) home and job to focus on her son by a children's social worker. Sasha's family did not feel this was good advice, but Sasha was fearful of the consequences of social work intervention and followed it. Consequently, she moved to an area of significant deprivation, where she became isolated, became alcohol dependent and increasingly vulnerable to predatory behaviours. It was the view of the panel that interventions should be made with consideration to the unintended consequences of them, especially as these consequences had significantly negative impacts for Sasha's son.

16.1.9. The panel were also concerned that learning from this review did not fall into victim blaming, Sasha was a vulnerable woman who was exploited and abused by many predatory men. At no point was this her fault. However, they recognised that Sasha's tragic death afforded an opportunity to explore the childhood attachment trauma that Sasha likely experienced and its impact on her vulnerability so that agencies might better understand the services and considerations needed to provide support and safety.

16.2 Domestic and Sexual Violence & Abuse

16.2.1. The IDVA service for Sasha's London borough was provided by the local authority until the 31st of March 2019, when the service was commissioned to Solace Women's Aid on the 1st of April 2019. Sasha had three key IDVAs during the scope of the review. One was provided by the local authority, a new IDVA was allocated following a complaint (the second). This IDVA then continued support when the service was taken over by Solace Women's Aid until a third IDVA was allocated by Rising Sun DVA Service once Sasha moved to Kent.

16.2.2. Of note, in the differing service providers is the improved quality of service once specialist domestic abuse services are overseeing IDVA practice (i.e. from Solace service provision). This is tangible when the VAWG coordinator received a service complaint from Sasha's mum whilst the first local authority IDVA is supporting Sasha and undertakes some of the key activities one would have expected from the IDVA themselves. The IDVAs provided by Solace and Rising Sun had improved practice generally because of routine VAWC⁴⁷-knowledgeable practice supervision.

16.2.3. In Solace and Rising Sun commissioned IDVA services the expectation is that victim-survivors will be supported for approximately 12 weeks. Sasha's support went extensively beyond these timescales and the usual role of a MARAC IDVA (i.e. targeted safety planning interventions) as a result of her ongoing needs and risks.

⁴⁷ Violence Against Women & Children (VAWC) adopted in acknowledgement that Sasha had a son who was also vulnerable to the predatory men who entered her life.

- 16.2.4. 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 the highest risk behaviours from her final perpetrator who coercively controlled her to the extent that she was so frightened that she had little or no ‘*space for action.*’⁴⁸ She felt physically and mentally unable to leave the relationship, despite extensive violence. 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 this 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 too scared to support a prosecution.
- 16.2.5. 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.⁴⁹ 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.
- 16.2.6. She was known to agencies before and throughout the scope of this review as a high-risk victim of DVA. This is seen in the volume of MARAC referrals made on her behalf – with 11 hearings taking place between 2018 and 2023, and in the extreme physical and sexual violence she was subjected to within her relationships. However, the panel were of the view that Sasha’s experiences were not best served by the sole application of the lens of DSVA, which is further [explored below](#).
- 16.2.7. Whilst focussing on the DSVA element of her support the panel noted that there was a significant amount of commitment to helping her across agencies and that many helpful uses of policy and flexible practice occurred. They particularly noted Sasha’s second IDVA via Solace Women’s Aid and her third IDVA via Rising Sun going ‘above and beyond’ their practice methodologies to endeavour to support Sasha to safety. One example of this is the length of time that Sasha remained open to these services, which is usually around 12 weeks. This view was supported by Sasha’s family, who specifically noted the good practice by Rising Sun. Housing Officers in both L&Q Housing and Town A Housing Teams also undertook extensive work in seeking positive outcomes for and with Sasha. The London-based VAWG⁵⁰ Coordinator also played a helpful role in seeking positive outcomes for Sasha. Practitioners also understood Sasha’s need to have her dog as an emotional support, her dog was a barrier as she could not be parted from it. Some work was undertaken to enable her to move with her dog, but this largely depended on a housing move rather than to a supported or safe accommodation.
- 16.2.8. 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

⁴⁸ Professor Liz Kelly, Domestic Violence Matters, 2010

⁴⁹ [UNHCR, Gender-based violence \(Accessed 8.4.25\)](#)

⁵⁰ Violence Against Women & Girls

desensitised to its impact upon her, which is evident in her graphic descriptions of the abuse she experienced, 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.'*

- 16.2.9. There are many references to Sasha 'minimising' her abuse. The panel noted the problematic nature of this concept – where a lack of professional curiosity about its meaning exists and we fail to ask ourselves 'why is this happening?'. Victims of domestic abuse minimise for a variety of reasons. It may be that they are desensitised, or that they lack awareness of the existence of abuse, or that this is so routine in their lives that it is normalised. Violence and abuse can be so prevalent in women's lives it can merely be *'the way things are'* which reduces help-seeking.⁵¹
- 16.2.10. It can also be that they are subject to such levels of control that they self-blame to a shocking extent – this is evident in a Liaison Psychiatry Service (LPS) record, *'Sasha says she does not care about the violence as she is used to it... it is my fault I annoy him.'* The panel were of the view that Sasha's consistent and graphic descriptions of her experiences to many and sometimes to some and not others, along with her self-blame were evidence of her fear and the extent of her coercion, and the impossible choice she faced, i.e. that she would have to leave him and face significant adversity alone.⁵²
- 16.2.11. The panel reflected on the key incidents where insights into this conflicted position existed. In the above cited notes, held by MPS, as Latif is arrested Sasha is noted to be shouting that this *wasn't her fault* – a clear indication of her continuous fear of reprisal. It becomes clear when we take this position to understand why Sasha often refused to participate in risk assessment practice or to follow through on reports of incidents to the police. The policing issue is explored in the [Managing Perpetrator Behaviour](#) section, but the panel reflected initially on the risk assessment practice and considered any lessons that could be learned for women in Sasha's situation in future. They determined to use the four purposes of the MARAC⁵³ process, as defined by Safe Lives.
- 16.2.12. It is important to note that perpetrator accountability usually sits second in this list given its importance in practice, but for the purposes of flow in this analysis they have been organised as:
1. Safeguarding victims of domestic abuse
 2. Make links with all other safeguarding processes
 3. Manage perpetrators behaviour
 4. Safeguard professionals

⁵¹ [Too complex for complex needs, Changing Lives](#). 2018

⁵² [Why victims minimise their abuse](#) [Accessed 20.3.24]

⁵³ MARAC – Multi-Agency Risk Assessment Conference model of risk management

16.3 Safeguarding victims of domestic abuse

16.3.1 Multi-Agency Risk Assessment Conferences (MARAC) & IDVA practice

- 16.3.1.1. 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 actuarial⁵⁴ and structured professional judgement approach.⁵⁵
- 16.3.1.2. There were 28 mentions of DASH assessments in the chronology of agency records during the time that she was in a relationship with Latif. There was only one instance where risk should have been identified as higher by MPS⁵⁶, 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.
- 16.3.1.3. 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.
- 16.3.1.4. SafeLives, in a recent MOPAC report, note 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.'* In this report they analysed MARAC practice across London and identified inconsistent approaches in practice and outcomes.⁵⁷
- 16.3.1.5. These meetings are not the sole safeguarding practice for high-risk victims but are the site at which the surrounding activity is drawn together to determine which actions have taken place and what else could or should be done. This could include referrals to other safeguarding processes, such as Children's or Adult's Social Care. Victims who are subject to high-harm abuse can be referred to this mechanism without

⁵⁴ Mathematical modelling of risk factors

⁵⁵ In 2022 Kent Police adopted a new tool, DARA, this is not included in the report as the learning regarding risk management are not about the tools (i.e. process), but rather the management of outcomes.

⁵⁶ On one occasion Sasha was rated as standard risk by MPS following an incident and the IMR author noted that, *'This should have been graded as a high-risk incident due to her previously recorded Police contact. [Latif] should have been arrested and interviewed regarding the matter, and a MARAC referral could have been considered.'* They further note that due to policy and training changes in the intervening four years they do not see any recommendations to be made.

⁵⁷ [Managing risk of serious harm from domestic abuse in London, SafeLives. 2025](#)

consent, and this happened in relation to Sasha on multiple occasions which was expected practice.

- 16.3.1.6. Reflecting on the volume of DASH assessments undertaken in relation to Sasha's circumstances, the panel noted, that she did not require an actuarial assessment, the extent of the abuse she faced, and the history of Latif as a high-harm perpetrator were enough for a contextually informed professional judgement across the entire relationship; Sasha was not going to stop being a high-risk victim of domestic abuse whilst Latif remained in her life.
- 16.3.1.7. The panel noted that there was a significant amount of positive and at times laudable behaviour by agencies in their attempts to keep Sasha safe including, being aware of the importance of her attachment to her dog, information sharing, the proposed convening of professional discussions, advocating for other agencies to go 'above and beyond' usual practice, raising the alarm when concerned about breaches of legal orders and continuing to offer options despite them being previously declined. The benefit of hindsight when reviewing a timeline makes it apparent that the sheer complexity of Sasha's needs made safeguarding her difficult within the available agency systems. In this section IDVA and MARAC practice is considered, in later sections complex and disadvantaged lives in the context of multi-agency practice is further explored.
- 16.3.1.8. However, it was the panel's view that with the benefit of hindsight the London and Kent MARACs were, overall, an ineffective site of safeguarding for someone in Sasha's situation, with process over outcomes being the primary methodology. The panel noted issues with professional curiosity and knowledge of coercive control; reflections on creative engagement; considerations of the victims wishes and feelings; and risk management and safeguarding practice, including reviews of what was being achieved (outcomes).
- 16.3.1.9. In the first instance, professionals working across the issue of domestic abuse must be curious about the experiences of victims, and consequently the behaviours of the person causing harm. This must be situated within a sound knowledge of the nature of coercive control. With the benefit of hindsight Sasha can be seen to be increasingly subject to Latif's control across the chronology, there are increasing mentions of his presence, at appointments as well as on the phone and practitioners could also have considered his use of third-party abuse, and his use of separation as a tactic of control too. It was the panel's view that each MARAC offered an opportunity to reflect on the extent and development of his control of her, using this to build creative thinking about interventions. However, the panel were also aware of the burden that MARAC meetings face with time for reflection increasingly limited.
- 16.3.1.10. Some of the ability of MARAC to function was hindered by services 'engagement' of Sasha, the second point. A clear example existed in the numerous references to contact not being made with Sasha but limited professional curiosity regarding why this was the case. There are times when Sasha tells people that her post is disposed of and that her phone is often changed by Latif. However, this did not result in any

creativity in contacting her. There were one or two mentions at attempts at contacting her through her GP, but there is no overt acknowledgement and consideration of the control she experienced in the context of 'engagement'.

- 16.3.1.11. The failures of Sasha's safety plans usually sat in the context of her 'engagement' with services rather than proactive attempts to intervene and 'reach' Sasha creatively. The panel noted that Sasha's final two IDVAs did manage to engage her, to a greater extent, because they were committed to doing so. However, her first IDVA was a critical opportunity for early intervention and at this time the narrative of Sasha's poor engagement was written into her history. However, the panel noted that between February and July 2018 there were three MARAC meetings in Sasha's London borough and during this period the IDVA made 21 case notes, only three of these are contacts with Sasha. Two are Sasha reaching in for help, and one is a colleague of the IDVA giving Sasha a court update.
- 16.3.1.12. In September 2018 there is a supervisory note relating to Sasha's lack of engagement and a view to case closure as '*last high-risk July 2018*' – when there had been no attempts to contact Sasha recorded between July and this time. This was poor IDVA and case management practice.⁵⁸ The panel further noted that MARAC could and should act as a site where creative attempts to engage and support victims is debated and professionals are challenged when victims are placed in the position of 'hard to engage'. The reflection should take the approach of how services become more accessible, rather than situating responsibility with the victim.
- 16.3.1.13. Concerningly, there was also a marked gap in the Kent MARAC referrals with no referrals between November 2020 and May 2022 despite five police incidents that were marked as 'high risk'. The Kent Police IMR author recognised this and prior recognition of this as an issue in other Domestic Homicide Reviews with a recent Homicide Prevention Debrief (single agency Police debrief). An action is currently in place for Senior Leaders within the Public Protection Command to ensure supervisors are aware of this issue and ensure it does not continue.
- 16.3.1.14. The panel noted that some MARAC actions lacked meaning in the context of sporadic contact with Sasha, for example, an action of '*continue support*' for the IDVA twice in 2022 contains no context as to whether or what outcome that might achieve. There were numerous other examples where thinking creatively about engagement could have taken place. It was their view that given the pressure on the MARAC system and Sasha's multiple disadvantages her multi-agency process should have been separated and seen as an ongoing need for a professional's safeguarding meeting, especially as Sasha was clearly expressing her disappointment in statements, such as, '*I'm not getting support from anyone, thank you for your input, I'm in [town] with nothing and no one...*'

⁵⁸ According to SafeLives [Case Management Pack](#) – IDVA practice with those deemed to be high-risk of harm should be subject to four weekly oversight by a supervisor, and risk assessments should take place six weekly.

- 16.3.1.15. This example speaks to the third instance – hearing and considering the victim’s wishes and feelings. For example, when Sasha was noted by her IDVA to have been *‘hit around the head four times’*. The panel noted that the IDVA identifying Latif as a serial perpetrator was good practice. However, the safeguarding solution she was offered was temporary accommodation without her dog. This further spoke to a lack of inclusion of Sasha’s voice or wishes, she was often offered solutions that she clearly described as being unsuitable options for her, for example, it was often noted that she *‘will not be separated from her dog.’* However, the panel noted that there was a missed opportunity to intervene when Sasha’s dog died. A coordinated safety planning approach could have presented an opportunity to support her away from Latif at this time.
- 16.3.1.16. Owning a dog was a significant emotional support to Sasha, especially as she had limited opportunities for other emotional support interventions. The panel noted that agencies did hear this, but their solutions were largely related to her separation from her dog, this would never be achievable. The panel also noted that Sasha’s expressions of her *‘need’* for Latif’s protection and her *‘sadness’* when she was on her own were key flags to understand the complexity of her potential separation from him.
- 16.3.1.17. The IDVA did attempt to be in touch with Sasha around the above-cited incident but notes that *‘despite... ongoing efforts... to reduce risk’* in relation to Sasha’s safety plan this is not being achieved. This speaks to the final point, reflecting on prior actions and their success or failures is critical for risk management and change-focussed practice.
- 16.3.1.18. The inability of practitioners to adopt this reflective and creative thinking led to desperate attempts to gain support wherever possible. The panel felt this was evidenced in 2019 with a late March note by an unknown author noting *‘step down and refer to Pause’*. There are two mentions of Pause referrals for Sasha. This is a service that supports women who have experienced child removal and have a high-risk of future pregnancies, which Sasha did not appear to be. These seem to be somewhat desperate attempts to engage Sasha in alternative service provision, a common experience for those with multiple disadvantages as they are *‘pushed’* around the system.
- 16.3.1.19. Across London and Kent, the MARAC process operated as just that, a process. It required an outcome focus with opportunities to reflect on the achievement of outcomes, not just today’s incident. In the panel’s view, in Sasha’s situation that reflection should have included more responsibility being placed on Latif (addressed later) and on whether MARAC was the right safeguarding approach. The difficulty of generating opportunities for successful outcomes for Sasha can be seen as her Kent IDVA pleas for some mental health support for Sasha at a MARAC meeting.
- 16.3.1.20. In the face of extremely high harm behaviour safety planning must be creative and driven by the practitioners, not the victim. Agencies were fully aware of the significant risks that Sasha faced, these were known and recorded and described across MARACs: Threats to kill (*‘daily’ ‘threat to cut off head with a saw’*); repeated strangulation events (*‘until passing out’*); financial abuse (*‘protection money being*

paid’); sexual exploitation (*forced prostitution*); suicide attempts and poor mental health; escalations of abuse; Latif as a serial perpetrator (*aggressive and controlling/ capable of killing/ preys on vulnerable women*) and Sasha as a vulnerable adult.

- 16.3.1.21. One example of a potentially proactive stance was an action to hold a professionals meeting. However, this did not take place until eight weeks after the February MARAC at which it was discussed. Given the high-harm nature of Latif and our understanding of the dynamic nature of DVA risk management generally the panel believed this was a missed opportunity to take swift action and design a cohesive intervention focussed safety plan and give Sasha the message that her safety mattered. The panel also noted that despite agencies often going above and beyond scope, it was still marked by a lack of creativity in attempting to engage with Sasha outside of the service silos.
- 16.3.1.22. Fundamental to this proactivity is an awareness of the need to support the victim to gain space for action, often by relieving the stress they face, raising their understanding of the impact of coercion on them and helping them to move towards change. Sasha’s support happened largely on an incidental basis, in London with the first IDVA re-opening her case file a few weeks after closing it, the second IDVA giving some additional continuity and further incidents occurring that led to incident-based police involvement for Sasha. The first London IDVA focussed efforts largely on gaining a property move for Sasha until January 2019 when Sasha’s mum complained about the poor support. Consequently, the VAWG Coordinator stepped in and spoke with Sasha. Her conversation was observed by the panel to include some of the good practice that could have been ongoing throughout the prior year – exploration of small steps towards changes and discussing the dynamics of domestic abuse, an approach that, had it been adopted earlier, might have supported Sasha through the stages of change.⁵⁹
- 16.3.1.23. The important need for continuity and review of safeguarding can be seen in the first Kent MARAC for Sasha which contained a full summary of the issues and risks present in the relationship, but the action planning continuing to follow the pattern of the London meetings – actions without outcomes, creativity or reflection. A missed opportunity occurred at this meeting to bring forward the action of ‘*police to focus on evidence-led prosecutions*’ from London, which could have been developed into a forward-thinking plan about evidence gathering and case building for safeguarding practice which would take the onus from Sasha. It was the panel’s view that MARACs in Kent should follow the London approach of inviting an external review of practice which could formulate a fuller understanding of development needs, especially as a new approach has recently been implemented and is prime for review.
- 16.3.1.24. Generally, the MARACs held about Sasha, in the panel’s view, lacked a proactive stance in Sasha’s protection and failed to centre the risks posed by Latif and others. Actions were usually passive, for example, referrals to other services (mental health,

⁵⁹ The Prochaska and DiClemente's Stages of Change Model, also known as the Transtheoretical Model, outlines a process of change through five stages: precontemplation, contemplation, preparation, action, and maintenance. This model helps individuals and professionals understand the process of behaviour change, particularly for overcoming addictions and domestic abuse coercion.

exiting prostitution, step-down to outreach, inform police proactive unit and have information on police screens), without review and consideration of what effect these were having. This passivity proved unhelpful to Sasha and each MARAC was a missed opportunity to target intensive support for her with a focus on disrupting Latif's behaviour and enabling her to break free from coercion. The panel noted that in the final London meeting the housing officer made clear their concerns about Latif and the essential need for '*target hardening*' which appears to have been addressed through the policing actions but is a striking recognition of how dangerous he was without any solidity of intervention. The concept of hardening the target, i.e. making it impermeable to assault is one that speaks to the need for us to implement interventions and approaches that create safety on behalf of the victim.

16.3.2 Victim blaming

- 16.3.2.1. The panel noted that this review had much historic information and that in terms of victim blaming we should be more aware of this issue today and be using different language than some of that contained within this report. However, some members of the panel noted that we all too often still see problematic language used. The purpose of a review is to '*illuminate the past to make the future safer*' and in doing so it must be acknowledged that the chronology evidenced that how Sasha was viewed by professionals had an impact on how she was helped. Her family felt clear that this affected her support, although they were generous about the challenges of working in such complex circumstances, many of which are outside the control of individual practitioners.
- 16.3.2.2. One of the ways in which Sasha was viewed is in the concept of 'engagement'. Some of the phrases used to describe Sasha's 'engagement' were very problematic. The first of these is '*client calls the police and then disengages*' which shows a lack of understanding that many women call the police as part of their own safety planning to end an incident but will be too afraid to pursue any further police involvement. This could be understood if there were continuity in understanding Sasha's circumstances, especially as she was describing herself as '*very frightened*' as early as 2018 and she had a significant history of reprisal assaults.
- 16.3.2.3. The panel also observed a lack of professional curiosity regarding the meaning of *engagement*. Sasha was routinely described as '*doesn't engage well with services*' but at no point did agencies consider themselves as the potential barrier. With hindsight, we can see that her isolation was enforced through monitoring and control of her communications, disabling her 'engagement'. These are not uncommon tactics of those with coercively controlling behaviours. Sasha did also have problematic alcohol consumption and a period of drug misuse which would make her lifestyle more erratic. The panel noted that across the three IDVAs that provided her with support practice in terms of creativity and flexibility improved each time. Despite IDVA practice improvements systemic and other issues created barriers to her engagement. Where additional barriers exist, they should, in good practice, be considered together, with

agencies seeking to understand how they can make themselves available to safeguard the victim-survivor.

- 16.3.2.4. The panel identified the worst form of victim blaming, which led to poor safeguarding, in the description of Sasha as ‘dogging’⁶⁰ in a local park, as being a ‘sex worker’ and later that ‘*There is information that travellers and various men were coming to her flat and she was performing sexual acts.*’ Research relating to Sasha’s higher risk of harm because of potential prostitution was case noted once by the IDVA but does not then lead to an analytical conclusion that she might need more intensive and targeted support.
- 16.3.2.5. Sadly, Sasha repeatedly and openly told agencies that she was forced to have sex with men by her perpetrators. It was discussed in MARAC that ‘*Sasha disclosed that [Latif] takes her to jobs where she has sex with different males.*’ The term dogging is a value-laden pejorative that entirely fails to recognise the risks that she faced in her community and similarly, the label ‘sex worker’ implies that Sasha is choosing to engage in survival sex.⁶¹
- 16.3.2.6. A common feature of domestic abuse is economic control/ abuse which has been a long-known indicator (‘financial abuse’) and was included as ‘economic abuse’ in the Domestic Abuse Act, 2021. Sasha disclosed early that Latif has had her benefits paid into his account and her Mum was trying to resolve this matter. There are multiple mentions of economic abuse from Latif by Sasha, including her benefits being paid into his account, the general control of finances, access to food, clothing and sexual exploitation for economic gain. The panel noted that this man was so clearly focussed on financial gain from Sasha that the hospital in which she died also recorded that he went to the hospital on her death and described himself as her ‘executor’. These fit the descriptions of economic abuse in intimate partner violence (IPV), specifically aligning with Cameron’s ‘schemer’ typology of the financial abuser, whereby:
- ‘[The women] were the victims of deliberate and, they believed, strategically planned schemes to steal their money. They talk about being conned by charmers and dangerous narcissists, but predominantly they talk about their desire to love and trust and to be fair, which blinded them to systematically manipulative behaviours.’*⁶²
- 16.3.2.7. Between the drug gangs, and Sasha’s boyfriends (whose links to the gangs and each other are unknown) it was the panel’s view that victim blaming blinded professionals to the fact that Sasha was a victim of economic exploitation and modern slavery, and should, in fact, have been subject to the national referral mechanism (NRM) for victims. Instead, a referral was made to NCDV for a non-molestation order which would be unachievable given that Sasha and these individuals were not associated

⁶⁰ The practice of watching or engaging in exhibitionist sexual activity in a public place.

⁶¹ Author’s note: the concept of choice in relation to survival sex is problematic of itself, given that it is often the woman’s only choice. This sentence aims to reflect the forced nature of Sasha’s situation.

⁶² [Relationship Problems and Money: Women talk about financial abuse, Prue Cameron, 2014](#)

persons.⁶³ In line with this the Solace WA IMR Author notes that case notes do not capture any exploration of the men that were abusing Sasha, names, addresses and such like, which could have informed a criminal investigation and NRM referral.

- 16.3.2.8. The Modern Slavery Act 2015 came into force on July 31, 2015, consolidating previous legislation criminalising slavery and human trafficking and aiming to combat all forms of exploitation. The MPS website notes that victims of this crime are exploited, controlled or held captive and threatened or punished to stop them escaping or reporting the crime. The panel were of the view that failing to identify Sasha as a victim of this crime presented a missed opportunity to appropriately safeguard her, rendering her increasingly traumatised and vulnerable and reducing her ability to escape, reduce her coping with substance misuse and address her increasingly poor mental health.
- 16.3.2.9. Using the lens of exploitation the panel were of the view that this relationship extended beyond the usual definitions of economic control in an interpersonal relationship and into the realms of the intentional economic exploitation of a vulnerable adult. Cameron notes that the schemer exploits the finances and then leaves, in Sasha's situation she remained a source of income whilst she was either viable for sexual exploitation or latterly when she was in receipt of higher levels of disability benefits. The panel took the view that this situation straddled the concepts of DSVA and cuckooing, with the intimate relationship acting as a mask for the true intention of the individual.

16.3.3 Cuckooing in the context of DSVA

- 16.3.3.1. Cuckooing, also known as home takeover, is a term that has been understood as the takeover of a vulnerable adult's home for the purposes of illegal activity. It is most often associated with drug and gang activity. It functions by methods of financial, physical and/ or psychological control. In addition to that already explored, the panel reflected on Latif's maintenance of control even when they were apart, for example, the sending of someone to 'look after her', who tried to rape her, further establishing Sasha's vulnerability without him. [Hope for Justice](#) outline the tactics, victims and methods of this type of exploitation with most of them being relevant to Sasha's situation:
- She was a vulnerable adult economically and in her mental and latterly physical health.
 - Anti-social behaviour was apparent at her property.
 - She was isolated, anxious and had decreasing emotional wellbeing.
 - She was coerced into drug taking and had debts accrued in her name - 'debt bondage' and was exploited sexually for financial gain.
 - She was controlled through violence and psychological abuse.
 - She could be seen as being exploited through the 'Loverboy method'.⁶⁴

⁶³ [Section 42 of the Family Law Act 1996](#)

⁶⁴ Where the perpetrator offers friendship or a relationship with the victim, then becomes more forceful physically or emotionally.

- 16.3.3.2. People who are victims of Cuckooing can be at risk of modern slavery, developing mental illness, decreased wellbeing, risk of involvement in criminal activities and risk of losing tenancy or ownership of their property. These were all risks that Sasha faced and experienced. Cuckooing is, at the time of writing, being proposed as a crime in its own right within the [Crime and Policing Bill, 2024-25](#).⁶⁵ Three conditions for the offence must be met for action against the perpetrators, one of these being consent, in the presence of capacity to do so.⁶⁶
- 16.3.3.3. The concept of consent and capacity are problematic, and the panel explored this issue in the context of Sasha's experiences and the concept of mental capacity below. However, to note is the issue outlined regarding consent in the footnote – 'B (i.e. the victim of cuckooing) is given sufficient information to enable B to make an informed decision.' The panel questioned whether it would have been possible to support Sasha's understanding of Latif's motives had a different service approach been available.
- 16.3.3.4. Since the growth of awareness regarding cuckooing there have been many practice developments. One of these is the Cuckooing Risk Identification Tool⁶⁷ based on the checklist of 27 questions. It is likely that this assessment would have secured 17 'Yes' responses to Sasha's situation. The authors of this tool note thanks to the creators of the DASH risk assessment tool, indicating the overlapping nature of these issues.
- 16.3.3.5. The panel were of the view that agencies should be made aware of the intersection of these issues for women and other vulnerable adults, like Sasha, to reduce a siloed view of the risks and issues that they face. The panel did note that MPS did endeavour to investigate the issue of sexual assault by local gang members in 2016. Sasha did not wish to speak to the police as a friend had reported it.
- 16.3.3.6. Not seeing Sasha as a victim of modern slavery presented a missed opportunity to activate alternative methods of safeguarding her, and the panel also felt that agencies working with domestic abuse focussed practice methodologies should have greater awareness of the nature of these types of perpetrator's behaviour to expand intervention opportunities and reduce any overt or covert victim blaming, failures to centre the perpetrator and should consider cuckooing risks within multiagency processes. Kent County Council has a Modern Slavery Coordinator who is able to take the learning from this review into practice ensuring that the Duty to Refer is understood for women who may be facing Sasha's experiences.

16.4 Make links with all other safeguarding processes

- 16.4.1. This purpose of the MARAC process offered the panel an opportunity to explore the multiple and intersecting issues faced by Sasha and the ways in which services were

⁶⁵ [Crime & Policing Bill 2024-25 \[Accessed 28.5.25\]](#)

⁶⁶ 5) For the purposes of section 53(1)(c), B consents to A exercising control for the purpose mentioned in section 53(1)(b) only if— (a) B is aged 18 or over, (b) B has capacity to give consent to the exercise of control for that purpose, (c) B is given sufficient information to enable B to make an informed decision about whether to consent, (d) B gives consent freely, and (e) the consent is not withdrawn

⁶⁷ [Cuckooing Research and Prevention network: Risk identification Tool. University of Leeds](#)

unable to or did not coordinate themselves for the purposes of keeping her safe. DVA can have a significant impact on a person's physical and mental health which can see them encounter many interdisciplinary professionals, requiring them to, '*follow relevant escalation pathways to ensure a multi-professional approach...*'⁶⁸ Sasha was a woman who experienced multiple and intersecting disadvantages as a result of extensive trauma and abuse. Consequently, she met many services, on many occasions.

16.4.2 Multiple Disadvantages

- 16.4.2.1 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.'⁶⁹ 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. Disadvantage can also extend to intersectional system barriers, and Sasha's disability and dependence on state welfare were two additional issues that reduced her ability to access the resources she required for her needs.
- 16.4.2.2 In socioeconomically deprived settings, women with multiple disadvantages are rendered more vulnerable to exploitation and abuse cloaked in the guise of a loving relationship and set within the context of risk management (i.e. the avoidance of worse harm through the acceptance of some harm). In the presence of fear and abandonment injuries,⁷⁰ the perpetrator's ability to enact control is strengthened; when the power is weaker, further harms are induced to render the victim more dependent. This dependence is even greater when the individual experiences disability and is coerced into seeing the perpetrator of her abuse as a protective factor.
- 16.4.2.3 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.

⁶⁸ [Domestic Homicide Oversight Mechanism for Health, Chantler et al. 2024](#)

⁶⁹ [MEAM Coalition website homepage \[Accessed 20.5.25\]](#)

⁷⁰ The Unshaming Way, David Bedrick. 2024

16.4.2.4 In 2024 Kent became a MEAM area which entails a commitment to transforming services and systems for people facing multiple disadvantages. In 2021 Kent implemented a co-occurring conditions policy seeking to align practice between mental health and substance misuse services. A prior review (DHR Melissa) recommended the review of this policy to integrate domestic violence and abuse in recognition of the importance of recognising the intersection of these three issues, and to enable practitioners to pool resources and planning in multidisciplinary team settings. Consequently, a separate process was developed – Domestic Abuse Additional Barriers Framework. There is not a two-way cross-reference between these processes that needs to be addressed. There is also reference to a panel meeting that can take place to work across co-occurrence, but this has not yet been implemented. Linking these frameworks is essential given that much of Sasha’s context could be viewed through the lens of coercive control, for example, being coerced into substance use.

16.4.2.5 Sasha’s disadvantages made it difficult to establish contact with her and at times her needs were not considered, for example, the booking of appointments at times when she was unlikely to attend, given her alcohol dependence. Consideration was not given to why, especially as one early case note identified her as ‘agoraphobic’. Bringing agencies together to think curiously can contribute to better engagement practice.

16.4.2.6 In a 2024 report for DLUHC (Department of Levelling Up, Housing and Communities) the barriers and challenges for women facing multiple disadvantages were determined to be overcome in the following ways:

- Improving service and practitioner capability and capacity to support women experiencing multiple disadvantage.
- 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.⁷¹

16.4.2.7 In essence those facing multiple disadvantages require an enhanced coordinated community response⁷² that acknowledges the complex systemic

⁷¹ [Understanding domestic abuse interventions for women experiencing multiple disadvantage: A rapid evidence assessment](#). Department for Levelling Up, Housing & Communities, April 2024

⁷² 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]

barriers that they face. The headings from the DHLUC report have been used in the following sections to frame the analysis of agency responses to Sasha beginning with the last and working backwards.

16.4.3 *Providing tailored, relational recovery support in safe spaces*

- 16.4.3.1 Women experiencing multiple disadvantage find it particularly difficult to access support. Domestic abuse support is characterised by a focus on supporting people to escape current violence and address basic needs (action-focussed), not on addressing the impacts of past trauma and the need for stabilisation/ recovery (stability/ recovery-focussed).⁷³ Consequently, women experiencing multiple disadvantage accessing generic services, often find a poor fit between their needs and the support available, causing them to be excluded or disengage.⁷⁴
- 16.4.3.2 Trauma-informed service provision is an essential requirement of the approach for those who have experienced complex relational trauma, with recovery occurring in relationships that lay a foundation for healing through a sense of safety, belonging and connection.⁷⁵ In Sasha's situation she was coerced into feeling that Latif was security, and agency practice needed to focus on creating a replacement of that relationship to assist Sasha towards the opportunity for action-taking.
- 16.4.3.3 One of the primary *safe spaces* for those fleeing domestic and sexual violence is refuge. The panel observed that multiple attempts were made to engage Sasha in considering refuge support. However, it was their view that given the extent of her risks and needs this was unlikely to be a viable support solution for her. She was alcohol dependent (most refuges are 'dry' houses), emotionally dependent on her dog (she was clear that she would not be leave it), and she was diagnosed with Emotionally Unstable Personality Disorder (EUPD)/ had attachment injuries (which exacerbated her feelings of dependence on Latif making it difficult for her to live in a low support setting without succumbing to emotional dysregulation). There are only three refuge services nationally that offer the specialist support that Sasha needed and at no time was specialist refuge discussed in relation to her needs.⁷⁶
- 16.4.3.4 Another *safe space* option for Sasha could have been a residential detox centre, somewhere that she would have had access to abstinence programmes with therapeutic and medical support. Sasha had used alcohol problematically since early adulthood, and tragically this addiction caused her son to be removed from her care. There were times, when living in London, that Sasha was referred to and attempts made to engage her with alcohol services. At one point, enquiries were made regarding the prospect of a residential detox. The panel acknowledged that, once living in Kent, the

⁷³ [Film 6: Explaining complex trauma and its impact on families, Sheena Webb. Research in Practice](#)

⁷⁴ Ibid.

⁷⁵ [Practical Guide for implementing a trauma-informed approach, SAMHSA. 2023](#)

⁷⁶ [The Annual Audit 2025. Women's Aid](#) [Accessed: 20.4.25]

Forward Trust worked extensively in their efforts to engage her in support, and her family identified that once Sasha was diagnosed with cirrhosis of the liver, she felt driven to change this behaviour.

16.4.3.5 The Forward Trust undertook a significant amount of good work in trying to support Sasha and note in their IMR that she maintained a *‘goal of abstinence, and at times achieved this for significant periods’* and had *‘determination with this goal’*. Despite being observed by the IMR author as maintaining regular contact across her four treatment episodes it was *‘characterised by a preoccupation with her relationship, and the distress she was experiencing as a result of that.’* This preoccupation spoke, in the panel’s view, to a need for the tailored, relational recovery support to have a clear mental health/ emotional stability focus.

16.4.3.6 However, the panel observed that the detox plan for Sasha in Kent was a late intervention and that an earlier intervention when Sasha was expressing a desire to detox (whilst living in London and before Latif’s control had become so debilitating) was a missed opportunity to enable her a life-changing action. The panel asked themselves – what if Sasha was given residential care in a rehabilitation centre for substance use with associated psychological therapy earlier in her journey? Although the outcome and success could not be predicted, the potential for a positive impact on Sasha and her family’s suffering is immeasurable.

16.4.3.7 A panel member observed that residential placements are expensive and depend on the commitment of the individual. All that we know is Sasha did express at times, early in her journey, a desire to feel better, be free from abuse and be abstinent. In bald economic terms it is highly likely that a six-month rehabilitation clinic stay would be much less expensive, at £78,000,⁷⁷ than the likely cost of the services involved in her support over the scope of this review,⁷⁸ let alone when they are combined with the economic and social costs of her death which for a single death, in the context of domestic abuse is £2.62m.⁷⁹ It cannot be stated that this would have been a successful intervention of course, but trauma experts tell us that in order to heal one must have hope that healing is possible. It is evident from the chronology that Sasha’s hope dissipated in line with the encroachment of Latif’s control of her. Placing Sasha’s life in an economic equation is not a wholesome act. The panel agreed to do so as they felt that Sasha’s situation exemplified the need to provide appropriate, early intervening services for those living with multiple disadvantages.

16.4.3.8 The panel considered the intersection of approaches, and suitability of these in relation to Sasha’s emotional stability and mental wellbeing. Sasha was known to attempt suicide and express suicidal ideas frequently. The panel noted that no agency

⁷⁷ [How much does rehab cost? Which Rehab](#) [Accessed: 20.4.25]

⁷⁸ In its 2019 report, The economic and social costs of domestic abuse, the Home Office estimated that domestic abuse costs society approximately £66 billion in a single year, equating to around £85 billion in July 2024 prices according to the Domestic Abuse Commissioner’s submission for the Autumn 2024 Budget.

⁷⁹ Figure updated from the 2019 Home Office report by Oliver et al in [Crossing Pathways: Key Findings Report, Cartwright & O’Halloran \(on behalf of Standing Together\) 2025](#).

appears to have offered her a bespoke suicide prevention plan, which demonstrate promise in relation to lowering the risk of suicide and would be in line with NICE best practice guidance. However, they further noted that suicidality should be viewed in the context of Sasha's overall psychological difficulties in the context of trauma, coercion and control.

- 16.4.3.9 A potential *safe space* for those who find themselves in Sasha's position is mental health provision. The Solace IMR author noted from an analysis of emails, in relation to Sasha's London mental health support, that *'Sasha's involvement with mental health services was minimal and it appeared there was minimal work they were able to undertake with her due to factors affecting engagement including alcohol use. There was therefore no viable offer of therapeutic support available to Sasha which may have provided her with an opportunity to explore her intimate relationships and other important relationships in her life.'* This was something with which the panel agreed, with some members noting the problems with providing the level of service required in a system that has experienced consistent defunding and 'austerity' measures. However, this report is meant to *'illuminate the past to make the future safer'* and ethically should do so without bending to available resources but rather be challenging for more.
- 16.4.3.10 The panel acknowledged an improvement that has taken place in the London Community Mental Health Service, Oxleas, since Sasha lived in London Commissioning of co-occurring mental health alcohol and drugs posts across the trust which should improve the issue, that Sasha faced, of being told that she could not access mental health support until she had addressed her substance use.
- 16.4.3.11 Secondary mental health services in Sasha's London borough had multiple points of contact with Sasha until she moved to Kent. The IMR author specifically noted, *'We may consider from the chronology that systems did not promote longer term intervention allowing for relationship building and developing a trusting space as per trauma informed practice. Sasha's reluctance to engage with any service to keep her safe from harm impacted on the possibility of suitable therapy to meet her PTSD needs. She regularly reached out for help, but longer-term pathways were not available for her needs. It is suggested that there is a lack of services for service users suffering distress who continue to be in a relationship with perpetrators of abuse. This is seen as a national problem and continues to contribute to the continued trauma people, such as Sasha, suffer.'*
- 16.4.3.12 The IMR author also identified many areas of good practice in their work with her including: inviting her to assessments in safe spaces, extensive liaisons across the multi-agency landscape, making safeguarding referrals, undertaking welfare calls to the police when appointments were cancelled by Latif, recognition of coercive control and economic abuse, workers supporting her practically (specifically to gain her own bank account), exploring housing options that would accommodate her dog, maintaining an open-door despite non-engagement.

16.4.3.13 There were also several areas of learning including crafting safety plans with victims of domestic abuse so that on-site safety needs are managed appropriately, facilitating self-referrals with the individual or checking they have happened prior to case closure, exploring motivation and the intersection of differing needs and impacts on health and wellbeing, considering a lack of availability of longer-term pathways suited to someone with Sasha's needs, exploration of the patterns of substance misuse and/ or coercion that may better inform an assessment of need and consideration of legal reviews of capacity to make decisions in the context of coercion and control, despite high court inherent jurisdiction⁸⁰ decisions rarely being progressed (further explored below).

16.4.3.14 As attempts were made, when Sasha lived in Kent, to hold Latif accountable and he variously was imprisoned, 'tagged', or was subject to DVPOs, the panel noted that Sasha's suicidal behaviour and emotional distress escalated with Sasha specifically describing her distress being as a result of being, '*worried that Latif was going to prison and she was unable to see him.*' Most of her primary healthcare appointments were related to her mental health needs, and the panel observed that her GPs did the best that they could within their gift, often making referrals for secondary mental health support. Her family observed that she was prescribed a significant volume of psychiatric medications, with her mum describing the '*carrier bag of pills*' that she would bring when she came to stay.

16.4.3.15 The issue of medication is indicative of a psycho-pathologisation of Sasha's trauma and attempts to 'fix' Sasha's problems with medications. The panel were of the view that medication does, of course, have its place in a treatment approach. However, with a medicine-only approach, there is a failure to acknowledge the reality of Sasha's experience – '*treating*' her for the impact of violence upon her sidelines realistic opportunities for recognising that she was having a normal response to abnormal experiences and this consequently reduces opportunities for healing.⁸¹ In a recent report eight of ten consulted survivors identified long-term counselling and mental health support as their priority need, yet only four were able to access it.⁸² As noted by the Oxleas IMR author this is a systems-based national problem specifically affecting those with trauma-situated disorders, such as, EUPD.⁸³

⁸⁰ The High Court's inherent jurisdiction provides a "safety net" to protect vulnerable adults who may be subject to coercion or undue influence, even if they have capacity to make their own decisions. This jurisdiction allows the court to intervene and make orders to safeguard vulnerable individuals, particularly when statutory powers are insufficient or inappropriate. It's a last resort measure, used when there's a genuine risk to an individual's well-being and they are prevented from protecting themselves.

⁸¹ [Deconstructing Disorder: An ordered reaction to a disordered environment, Rosenthal et al. Journal of Trauma & Dissociation. 2015](#)

⁸² [A Patchwork of Provision, Domestic Abuse Commissioner, 2023](#)

⁸³ EUPD is also known as Borderline Personality Disorder (BPD) and is strongly linked to childhood trauma, with a significant portion of individuals with BPD reporting experiences of abuse and neglect. While not all cases of BPD are solely trauma-related, studies suggest a high correlation, with some researchers proposing that childhood adversity is a key factor in the development of BPD. [Childhood Adversity and Borderline Personality Disorder: A Meta-Analysis, Porter et al. 2019](#)

- 16.4.3.17 Sasha had some support from mental health services in Kent, she did receive some support, and the mental health team undertook some good practice (set out below), but she found it difficult to access the services, was at times referred back to her GP and found the available models inaccessible. Specific issues were observed by the panel, for example in 2021. Sasha was not meant to be seeing Latif, as he awaited his court case, had her beloved dog put to sleep and her mental health deteriorated significantly. On one occasion (July 2021) Sasha's mum contacted the Single Point of Access due to Sasha's distress but the *'criteria for interventions were not met'* and she was referred back to her GP.
- 16.4.3.18 Some months later, after significant attempts by other professionals to ensure Sasha received an assessment, the KMPT IMR author notes, *'Following a review and discussion it was established she could be discharged back to her GP.'* This was in the context of several months where Sasha had taken multiple overdoses and described that she would kill herself if Latif were imprisoned. In fact, she was referred again within three weeks by her GP, which was declined, and was unresponsive following an overdose four weeks later. In early 2022 Sasha text messaged her IDVA stating, *'Very disappointing, yet again referred back to gp...'* and *'I don't want to "engage " with people that right you off, mental health laughable...'*
- 16.4.3.19 Secondary mental health services in Kent had multiple points of contact with Sasha from 2018, either in the context of hospital admissions, based on agency or self-referrals. She was seen by both the Liaison Psychiatry Service (LPS) and Community Mental Health Team (CMHT). At times Sasha would leave a hospital setting prior to being seen by LPS or describe practical needs that led to mental health support not being seen as her primary need, which led to signposting referrals. The panel acknowledged that fluctuating presentations of need create assessment difficulties for practitioners. However, the panel were of the view that community mental health services require greater understanding of coercive control and violence against women and the impact that these have on mental health, with a view to developing trauma-informed support modalities.⁸⁴
- 16.4.3.20 The KMPT IMR author noted many instances of good practice: cross-agency collaboration, arranging telephone contact when Sasha advised not receiving mail, challenging the police service when they identified that Latif had been bailed to Sasha's address despite conditions not to contact her, reports of safeguarding concerns and checks that safeguarding was in place and referrals without consent due to risk levels, along with some areas of learning. The areas of learning were providing reasonable adjustments to communication challenges in the form of alternative communication methods, for example, when Sasha was drowsy or when she had lost teeth which affected her ability to speak, consistently raising safeguarding concerns without consent where significant concerns arise and applying professional curiosity to a patient beyond their visible presentation and their responses to questions, such as, *'do you feel safe?'*

⁸⁴ [Living without Hope, The Woman's Trust, 2024](#)

16.4.3.21 The KMPT IMR author noted that mental health services in Kent experienced significant staffing shortages during the time of Sasha's interactions with them, and that significant changes to working practices with the purposes of improving care delivery have since taken place. In 2023 there was a move to a locality-based model of care along with a transition to a Mental Health Together model aiming to offer faster, more personalised support from a single source, rather than requiring individuals to navigate multiple services. This model focuses on a holistic approach, addressing mental health, physical health, and social well-being, including employment and housing, within one care plan.⁸⁵ Mental health practitioners training on coercive control has also been improved since Sasha's death, and they now have a co-located IDVA providing direct support and practice development opportunities. It was the panel's view that this review could be used in these sites to assist in reflections on how this new model is achieving better outcomes for those in Sasha's position.

16.4.3.22 Picking apart Sasha's primary need was a chicken and egg scenario in the face of such complexity, and it is recognised in research that it can be used to justify the transference of responsibilities around the system in the face of capacity pressures.⁸⁶ Coordinating services to work holistically is noted as best practice when working with multiple disadvantage to avoid re-traumatising and demoralising transitions, an opportunity to improve practice also exists in the development of shared treatment/ support plans with a lead professional being identified who can focus on the development of a safe and trusting relationship.⁸⁷

16.4.4 Integration or co-ordination of domestic abuse services with support for multiple disadvantage & Improving service and practitioner capability and capacity to support women experiencing multiple disadvantage

16.4.4.1 Given the changing knowledge and practice landscape for domestic abuse support the panel focussed on the IDVA support that Sasha received when she moved to Kent in the context of her multiple disadvantages. They acknowledged the extensive work that was undertaken by IDVAs, on the whole, in efforts to develop a CCR approach for Sasha, with significant advocacy for her with the police, adult social care and mental health services.

16.4.4.2 The work was informed by best practice, for example, the IMR author noted that Sasha was not scored as high risk when she self-referred into the service in April 2022 but was reallocated to the same IDVA for continuity of relationship with a focus on re-engagement. As Sasha had also given permission for the IDVA to speak with Sasha's mum, she maintained regular contact with her in order to gain a clear picture and maintain lines of communication.

⁸⁵ [Mental Health Together, Kent & Medway Social care Partnership Trust. 2024](#)

⁸⁶ [Systems change for people experiencing multiple disadvantage, Fulfilling Lives LSL Research and Learning Partnership. March 2022](#)

⁸⁷ Ibid.

16.4.4.3 The panel noted that from April 2022 Sasha was being open about the issues she faced and the IDVA worked motivationally to develop the possibility of change. She used tools like a pros and cons list, during which Sasha stated, *'there is nothing good'* and in May she acknowledged abuse, described walking on eggshells and that this was 'humiliating'. However, following this Sasha disengaged from the service, and the panel hypothesised in line with Sasha's family's statements that abuse had been escalating towards Sasha since her diagnosis of cirrhosis of the liver in February 2022.

16.4.4.4 Following this diagnosis Sasha had periods of alcohol abstinence, and her Mum described her as gaining more clarity. She had started to self-care and to recognise the abuse that she was experiencing, and she had told her mum that, despite not being a drinker, Latif was drinking routinely at home, something she recognised as cruel and intentional to encourage her to drink. With the benefit of hindsight and as previously described we now know that Sasha was experiencing an escalation in control and assaults which culminated through 2022 in her stroke in November. This period could be seen as a missed opportunity to provide intensive and targeted support through the application of a coordinated, curious multiagency response that understood Sasha's risks and her reduced ability to manage them in line with prior panel observations regarding the co-occurrence of issues in Sasha's life.

16.4.4.5 In Sasha's situation the multiagency approach crucially included adult social care (ASC). In London Sasha was routinely referred to ASC, with practitioners doing so through various routes, based on their internal policy requirements. The first mention is in 2016 when a GP notes that ASC have supported Sasha's home move. One other mention shows ASC in London undertaking signposting activity based on Merlin reports from police officers as recorded by the domestic abuse charity who received the signposting. There were three London Merlin reports by police officers. There was no evidence of a Section 42 enquiry taking place in response to any of these alerts.

16.4.4.6 London now has a Community MARAC (C:MARAC) approach which is operational in Sasha's former area of residence. Today, the volume of Merlin reports and MARAC referrals that she was subject to would trigger a hearing at this process. C:MARAC is a pathway that aims to have proactive, ongoing and outcomes-focussed multiagency meetings for those with multiple disadvantages. Kent and Medway have introduced MARM (Multi-Agency Risk Management Framework) 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 framework, but where a multi-agency approach would be beneficial.'*⁸⁸

⁸⁸ [Multi-Agency Risk Management Framework, KAMSAB \(Published 1.4.25\)](#)

16.4.4.7 Today Sasha may have benefitted from referral into C:MARAC/ MARM. The MARM protocol identifies that, *'The agency identifying the need for a MARM should have identified and attempted all they can to reduce or minimise risk, including any other relevant multi-agency meetings and/or referrals, prior to initiating the MARM. If risks remain, the organisation can then arrange a MARM meeting, which is designed to enable a collaborative, coordinated and multi-agency response to risks ensuring timely information sharing, a holistic assessment of risk and the development and implementation of multi-agency risk plans.'* It further states, *'Professionals must also refer to relevant statutory frameworks and operational policies which they are required to follow.'*

16.4.4.8 Sasha was referred, as we have seen, on numerous occasions to MARAC. It would be important for professionals to identify when deciding on appropriate routes of support that MARAC was not the right setting for her safety needs to be met.

16.4.4.9 Referrals may come into ASC in a number of ways and two possible outcomes out of many options can be Care Needs Assessment or Adult Safeguarding.

16.4.4.10 Care Needs Assessments are a statutory entitlement looking at *'how your needs impact on your wellbeing and the outcomes you would like to achieve in your daily life... Your needs could be eligible if you are not able to do a combination of certain things that significantly affect your wellbeing. These may include washing yourself, getting dressed, going to work, college or volunteering and/ or keeping your home safe for you to live in.'*⁸⁹

16.4.4.11 Kent ASCs first record relates to a KMPT request for a Care Needs Assessment in January 2021. The ASC team undertook referrals for Sasha to the Single Point of Access⁹⁰, the Forward Trust and to the KERS team. However, the initial assessment took place based on the information contained within the KMPT referral when Section 9 of The Care Act states that an assessment of needs must, *'involve the person in the assessment and, where appropriate, their carer and/ or someone else they nominate.'* It is of note that it was probable that Sasha would have given permission for her mum to be spoken to by social care staff. It is also of note, that where safeguarding is of concern it should take place before any assessment of care and support needs.

16.4.4.12 As part of the review panel process the ASC representative flagged that *'Kent Enablement Service (KERS) offer a short-term service designed to help you achieve*

⁸⁹ <https://www.kent.gov.uk/social-care-and-health/adult-social-care/care-and-support/how-to-get-adult-social-care-support/care-needs-assessments>

⁹⁰ A KMPT service for adults with mental health needs offering telephone support to people known to KMPT.

your personal goals and enhance your independence at home and in the community' which may mean a Care Needs Assessment is no longer required.

However, due to service demands the KERS team acted on this referral at the end of 2021 noting at the time that this referral was more than six months old (it was, in fact, nine months old).

16.4.4.13 However, there was also an alternative approach implements, in the intervening period, in May 2021 following a RED Board multidisciplinary meeting⁹¹ Sasha was placed on the waiting list for an ASC specialist mental health worker which was good practice, but again this screening did not take place until November and after Sasha's IDVA had chased ASC in the October outlining Sasha having mobility and other health issues and requiring support. In essence, this left Sasha without an assessment of her needs or a statutory intervention for most of 2021.

16.4.4.14 When the interventions did commence it was decided that the Adult Social Care mental health screening needed to be face-to-face. Sasha's mum was spoken to which was good practice, and at the end of November similar signposting plans are made as a result of the assessment, with the added statement, *'Although not allocated yet, the assessing ASC MH practitioner on duty continues to follow through plans and maintain relationship with [Sasha], with links with Rising Sun IDVA and other referrals to support [Sasha].'* The assessing practitioner later emailed the IDVA stating, *'we're very concerned for [her] wellbeing and at this time I feel she could use support from the services around her whether she is engaging or not.'*

16.4.4.15 It was the panel's view that despite the ongoing and generally helpful involvement of the mental health practitioner from this point until Sasha's death, the lack of a robust care needs assessment/ safeguarding enquiry earlier in the year, that included her family's voices, presented a missed opportunity for coordinating her support.

16.4.4.16 In the second instance, there were the clear safeguarding needs that Sasha faced. Kent's policy states that the aims of adult safeguarding are to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, to stop abuse or neglect wherever possible, to safeguard adults in a way that supports them in making choices and having control about how they want to live, to promote an approach that concentrates on improving life for the adults concerned, to raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect and to

⁹¹ At this time KMPT mental health service and Adult Social Care had co-location which would have enabled this discussion.

provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult; and address what has caused the abuse or neglect.

16.4.4.17 A safeguarding concern requires an adult safeguarding enquiry (Section 42) where the statutory eligibility criteria have been met – the individual has:

- care and support needs
- is experiencing, or is at risk of, abuse or neglect
- as a result of their care and support needs is unable to protect himself or herself against the abuse or neglect or the risk of it.⁹²

16.4.4.18 These enquiries are generally from the perspective of the person's wishes, and practitioners would speak with them about the risk of harm potentially determining their right to make 'unwise decisions' in relation to their own safety. The duty does not provide an express power of entry or right of unimpeded access to the individual if they are unwilling or unable to participate in the process but can be undertaken if the situation is deemed high-risk with one of the examples of this being financial abuse.⁹³ Where a decision to proceed with an enquiry is made irrespective of the person's engagement with the process information can be gathered from other agencies and parties.

16.4.4.19 The need to safeguard Sasha as a vulnerable adult became paramount in 2022 when, with the application of oversight, we can see that Sasha was more controlled and abused than ever before. She experienced a stroke and became more dependent on Latif. All of the following analysis applies through to her death, but the period here referred to is used for the purposes of the analysis as the point of potential earliest intervention in Kent, and where a missed opportunity occurred to change the course of 2022 and 2023 for Sasha.

16.4.4.20 The panel noted that prior to 2022 there were limited safeguarding notifications to Adult Social Care in relation to Sasha. The first such notification took place in 2022 by SECAMB in February. In response to this alert a Section 42 enquiry was initiated.⁹⁴ Between February and July Sasha is variously denied meeting the threshold for secondary mental health care, has attempts made at a further care needs assessment in April (because the mental health practitioner advocated for her needs in supervision), has a decision made that she requires case conferencing in

⁹² [The Care Act: Safeguarding Adults, Social Care Institute of Excellence](#) [Accessed 30.6.25]

⁹³ [Care Act, 2014 - Explanatory Notes](#) [Accessed 31.7.25]

June (due to the difficulties in accessing her due to the presence of her partner), is assessed by KERS and has an attempted Section 42 enquiry in June.⁹⁵

16.4.4.21 The case conference was held in July. At one point in July, during some proactive work by the KERS service Sasha advised then, *'I need to get out now.'*, but there is no further reference to this statement, or apparent sharing of the information. The outcome of the case conference was an unannounced visit and a follow up conference. The safeguarding enquiry was closed, *'due to sporadic engagement with Sasha'* at the end of August.

16.4.4.22 The panel noted that the ASC mental health practitioner utilised good practice in advocating for her needs and drawing together case conferencing for Sasha in an attempt to take proactive action. However, the amount of time it took and the dependence on Sasha herself being proactive in engagement/ change were problematic. The outcome was more referrals (mental health and MARAC). However, the panel noted that referrals to other organisation's/ processes are not outcomes, and in line with national review findings, no protection plan was put in place.⁹⁶ The panel noted that such a plan could have been developed today using the new MARM Framework and/ or the pursuit of a safeguarding enquiry irrespective of Sasha's 'engagement' given her level of risk. At the very least Care Act guidance should be followed, and a decision should be taken whether to *'refer the matter to the police to consider whether a criminal investigation would be required or is appropriate.'*⁹⁷

16.4.4.23 In the run up to the closing of the 2022 S42 enquiry Sasha was experiencing liver failure and was hospitalised for this in the autumn. Her dependence on Latif continued to increase, and she continued to be assaulted by him. The six principles of safeguarding practice are user-centred and the concept of making safeguarding personal focusses on engagement and consultation with the service user and/ or their advocate so that, *'their wishes and views are central to the final outcomes as far as is possible.'*⁹⁸ If we take the stance that Sasha was in a position to refuse assessment freely, then the panel noted that Sasha's behaviour could also have amounted to a 'refusal of assessment' which is outlined in Section 11 of the Care Act, 2014, this would have offered another route to continue the enquiry.

⁹⁵ Section 42 enquiry, under the Care Act 2014, is an action taken by a local authority to investigate concerns that an adult may be at risk of abuse or neglect. It's a duty for local authorities to make or cause inquiries if they reasonably suspect an adult in their area is experiencing or at risk of abuse or neglect. This duty applies regardless of whether the local authority is providing services to the adult.

⁹⁶ An analysis of domestic homicide review recommendations for adult safeguarding in England, Chantler et al. The Journal of Adult Protection, 2024. DOI 10.1108/Jap-07-2024-0045

⁹⁷ [The Care Act Guidance \(14.41\)](#) [Accessed 31.7.25]

⁹⁸ [Procedures Online, Adults – Making Safeguarding Personal](#) [Accessed 15.4.25]

- 16.4.4.24 The section specifies that there are two situations in which the local authority must carry out a needs assessment even if the adult refuses an assessment:
- if the adult lacks the capacity to agree to an assessment but the local authority is satisfied that an assessment would be in their best interests; and
 - if the adult is at risk of harm or financial abuse.⁹⁹
- 16.4.4.25 Sasha was experiencing Point b). The panel were of the view that the assessment should have been progressed irrespective of Sasha's engagement with the process and could have incorporated multi-agency perspectives and her family's view.
- 16.4.4.26 In relation to Point a) the panel observed an area of complexity for victims of coercive control with care and support needs in the concept of mental capacity. 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,¹⁰⁰ and show that every effort has been made to encourage and support the person to make the decision themselves,¹⁰¹ 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.¹⁰²
- 16.4.4.27 Under the Mental Capacity Act (2005, amended 2019), you are required to make an assessment of capacity before carrying out any care or treatment if you have reasonable belief someone lacks capacity – the more serious the decision, the more formal the assessment of capacity needs to be. 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. In the first instance, Sasha had been subject to multiple and ongoing instances of head injury and non-fatal strangulation. There are multiple mentions of being hit in the head and incidents/ risks of strangulation from the beginning of the relationship. For head injury the last mentioned is the vicious assault she experienced where she was hit about the face and head with a metal dog lead. Practitioners only knew about incidents that Sasha disclosed when her guard was down. The panel felt clear that, given what we now know, these were likely to be part of her routine experience.

⁹⁹ [The Care Act, Section 11 – Refusal of Assessment](#). 2014 [Accessed 15.4.25]

¹⁰⁰ [Mental Capacity Act, 2005 – Principle 1](#) [Accessed 20.4.25]

¹⁰² *Ibid* – Principle 3

- 16.4.4.28 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.’¹⁰³ 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, 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.
- 16.4.4.29 Sasha could also have been experiencing alcohol related brain injury/ damage (ARBI/ D). It is understood 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.’*¹⁰⁴
- 16.4.4.30 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’*.¹⁰⁵ 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’. This includes space to make independent decisions.
- 16.4.4.31 Coercive and controlling behaviour was made a statutory offence in 2015 and the guidance clearly sets out the need to understand the individuals’ experiences of coercion stating that, *‘questions about rules, decision making, norms and fear in*

¹⁰³ [Too many to Count- Brain Injury in the Context of Domestic Abuse](#). Brainkind, 2023

¹⁰⁴ [Alcohol and brain damage in adults](#). Royal College of Psychiatrists. 2014

¹⁰⁵ [Mental Capacity and Coercion](#). Research in Practice, 2016

the relationship, rather than just what happened' should be asked when looking to identify the offence. The panel recognised that as a result of the severe coercion and control that Sasha was subject to she was adapting her behaviour and decisions to minimise risk, was fearful of the consequences of resistance, was fearful of the negative consequences that outside interference would have on her, and required a focus on trust building, not on ending the relationship.

- 16.4.4.32 Sasha had several assessments of her mental capacity. The first mention is in 2020 where there was an informal determination of her right to engage in an abusive relationship, the last was when she had her deprivation of liberty safeguards (DoLS) revoked in 2023 and was discharged home following her stroke under the care of Latif. These assessments are subject to a two-stage test: Does the individual have an impairment or disturbance of mind or brain function? If so, it is sufficient that the person cannot make the decision, even with support? Not having identified Sasha's potential acquired brain injury has been discussed. However, the panel and Sasha's family noted some further issues with practitioners' ability to effectively use mental capacity assessments in the context of domestic abuse.
- 16.4.4.33 Sasha's son was concerned that interviewing and observation can be a poor test if someone is driven to crave, through coercion and fear, the companionship of someone despite their abuse and are/ have experienced traumatic events. His feeling was that Sasha would easily respond in the ways required to assure practitioners that she was able to understand, retain/ use and weigh information, and communicate her decision articulately. For example, towards the end of her life in a capacity assessment at EKHUFT it was recorded, '*She said she has not been hit for 3 years*'. It is unclear from the records whether this was challenged, considered or dismissed. The panel observed that in the circumstances of coercive control Sasha's motivation to exhibit capacity was problematic and despite her capacity to make informed decisions being observable the assessments themselves were problematic given the extent of the harm she was facing.
- 16.4.4.34 Sasha had the right to a private and family life (Article 8 of the Human Rights Act) and this would often impede decision making, causing practitioners to see her as being 'allowed' to choose her family and maintain privacy. However, this can be limited in certain circumstances. Article 2 (Right to Life) is an absolute right; this means it cannot be interfered with by the state in most circumstances. Article 8 on the other hand is not absolute and can be interfered with where it is lawful, necessary and proportionate.
- 16.4.4.35 The panel noted that this is a challenging area. Determining a lack of capacity does intrude on an individual's human rights, therefore, it must be undertaken with care

and consideration. To deem a lack of capacity there must be a causative nexus, that those who are deemed to lack capacity are, *‘unable to make a decision because of their impairment or disturbance in the functioning of the mind or brain... It is not enough that the inability to decide is simply related to the impairment or disturbance, it must be because of it.’* In Sasha’s situation it was often deemed that she understood the implications of remaining in the relationship and accepting Latif as her carer. However, mental capacity practice is an evolving area and there is evidence that the concept of the right to make unwise decisions contains assumptions about the presence of capacity.

- 16.4.4.36 Unwise decisions should invoke professional curiosity about the circumstances and the person’s ability to make the decision. Whilst Sasha was living in the community curiosity about her capacity to make the decision to live with Latif could have provoked a full capacity assessment. In Sasha’s situation this would likely have required some assessment of the possibility of acquired brain injury, her psychiatric status and the control she faced. It is not possible to say if this would have changed the outcome for Sasha, and the use of capacity assessments in this way are extremely rare. However, if she were deemed to lack the capacity to make the decision about the relationship then a best interests’ decisions could have been made on her behalf.
- 16.4.4.37 In extreme cases where there is a serious risk to life, and where all other legal and support avenues have been exhausted, an application can be made to invoke the inherent jurisdiction of the High Court. The purpose of the inherent jurisdiction is not to overrule the wishes of an adult with capacity, but to ensure that decisions are being made freely. The Court’s jurisdiction may be used to help professionals gain access to an adult.
- 16.4.4.38 Inherent jurisdiction can only be used by High Court judges; it is often called the *‘great safety net’* being used when there is no other avenue to protect a vulnerable person. It should contain a test to identify whether the proposed intervention is necessary and proportionate, and, in the first instance, the court will seek to facilitate the unencumbered decision making of the person, though it is not limited to doing this. Decision making should be in the person’s best interests. Following the advent of the Mental Capacity Act inherent jurisdiction has developed to protect adults who do not lack mental capacity but are vulnerable because of abuse, neglect, undue influence or coercion, this arose from case law which recognised that these acts could deprive someone of their capacity.
- 16.4.4.39 The Oxleas IMR author observed that an increased inclination to use inherent jurisdiction should be considered in their service and, it was the panel’s view, that a robust safeguarding process for Sasha throughout this relationship but certainly in 2021/ 2022 could have determined that she had lost capacity through coercion,

and would have made determinations for proportionate actions, in the first instance, against the abuser, and where necessary enforce protections for her as an abused person. All of these considerations are challenging in the context of Sasha's human rights. However, it was the panel's view that her suffering was such that not doing so presented a missed opportunity to safeguard her from this abuse. It was the panel's view that Kent and Medway should develop guidance on mental capacity and domestic abuse using this to raise practitioner awareness of the issue of unwise decisions in the context of duress and possible brain injury/ damage.

- 16.4.4.40 The panel also noted issues with the representation of Latif, to professionals, as Sasha's carer. The panel were of the view that it was ascertainable that Sasha was being abused and neglected by the person she was describing as her carer. The need to improve practice in separating vulnerable adults from domestically abusive 'family' members is recognised nationally. One such separation issue is evidenced during Sasha's final hospital stay when Latif was allowed to continue visiting her, despite the concerns about his behaviour and her responses to him. It was the panel's view that EKHUFT should consider the learning from this review in the context of their visitors' policy, given that visiting a hospital is not a right for any individual.
- 16.4.4.41 When Sasha was discharged, she had ongoing health needs and needed support/ care. Latif had advised hospital staff that he would give up work to care for her, but within days Sasha was known to be alone as he was out at work. Latif's abuse of a vulnerable adult is addressed in perpetrator management below, but this was a further example for the panel of the need for curious and comprehensive multiagency practice that brings all of the safeguarding pieces together in order to make holistic assessments and construct outcome-focussed and effective plans. It also speaks to the need for agencies to be gathering information that could inform a criminal case in the area of the wilful neglect of a vulnerable adult.
- 16.4.4.42 As previously mentioned in April 2025 Kent and Medway Safeguarding Adults Board published the Kent and Medway Multi-Agency Risk Framework 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 framework, but where a multi-agency approach would be beneficial. It enables a proactive approach which helps to identify and respond to risks before crisis point is reached.
- 16.4.4.43 This framework can be used where no other process, such as MARAC exists or that process is not suitable. On the list of possible individuals for whom the process might work Sasha fits with a possible four of five. The panel felt that this process should be subject to awareness raising across Kent domestic abuse agencies and

GP practices for those living with multiple disadvantages where MARAC (or other multi-agency processes, such as MDTs) are either not available or are not providing outcomes. It is further noted that this framework outlines concerns regarding mental capacity and should be strengthened to cross-refer to the 'Multi-Agency Protocol to Safeguard Adults with Care and Support Needs who are Impacted by Domestic Abuse.' In turn that policy should be strengthened to include Brainkinds' work on domestic abuse related brain injury and the Brain Injury Screening Index.

16.4.4.44 The panel also noted the need for improved adult safeguarding practice across voluntary agencies, in making and securing outcomes from referrals. It was their view that domestic abuse agencies in Kent should undertake a review of their adult safeguarding training, including awareness of the protocol for escalating concerns.

16.4.4.45 Since Sasha's death Adult Social Care have introduced domestic abuse champions across their operating localities. It was the panel's view that this practitioner should engage in a reflective meeting using the learning from this review to consider the internal approaches to those in Sasha's situation.

16.4.5 Adapting or providing specialist housing-based interventions

16.4.5.1 Sasha wanted to be closer to her family, a vital support network for her, and was mostly, very set on this idea. Many professionals worked extensively to achieve this outcome for her. However, Sasha's safety plan hinged on this move with attempts to move her to Kent spanning four years. The advent of the Domestic Abuse Act, 2021 should solve some of the issues that Sasha faced as it has given victim-survivors enhanced rights to safe accommodation previously offered inconsistently. Prior to this Sasha was dependent on the discretion of the local authorities as they attempted to move her, as no management transfers arrangements were in place.

16.4.5.2 Sasha was offered temporary accommodation and refuge on many occasions. She was at times unwilling, and at others unable to access these options because of concerns about her dog and safe areas to live. It is also of note that the level of rent arrears that Sasha accrued at times because of her exploitation, made her housing options very limited. The panel felt that the slow pace of the move could have contributed to her frustration with agencies and her sense that nobody helped. The slow pace could also have contributed to her moving with Latif in 2020 when in 2018 she seemed to be keen to move away and end the relationship.

16.5 Managing Perpetrator's Behaviour

16.5.1 Service provision for perpetrators

- 16.5.1.1 During the review period there were no services to address the behaviour of perpetrators in the London borough under review. From 2022-2023 Solace acquired funding from a private trust to run a pilot perpetrator programme for one year. The area currently has the DRIVE programme as part of a Pan-London provision.¹⁰⁶
- 16.5.1.2 Kent – has a range of OPCC¹⁰⁷ commissioned services focussed on intervening with those who cause harm. These are based on voluntary referrals, the only involuntary approach being court mandated behaviour change programmes.

16.5.2 Perpetrator Accountability

- 16.5.2.1 Managing perpetrator's behaviour, as a purpose of the MARAC process was considered by the panel in relation to Latif's behaviour as a high-harm perpetrator of domestic abuse. Given the inconsistent availability of perpetrator-focussed programmes policing is the most consistent site of these interventions. Sasha's family were clear that they did not feel the approach taken was good enough. They could not understand how so many incidents of violence, that resulted in such significant injuries were neither prosecuted nor subject to any other successful safeguarding mechanisms for Sasha.
- 16.5.2.2 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. The panel acknowledged that there were some attempts to hold him accountable. Most proactively by an officer in Kent who strove to have some charge made and to safeguard Sasha without her having to support the prosecution. However, the panel were clear that a perpetrator of this nature requires a web to be cast around them to disrupt and inhibit their behaviour, they should be kept visible and actively managed. An over-focus on the victim places an onerous level of responsibility on them to change the situation when the need for change and accountability sits with the perpetrator of the abuse.
- 16.5.2.3 The College of Policing identifies eight principles for the Identification, assessment and management of serial or potentially dangerous domestic abuse and stalking perpetrators, noting that the '*safety and support of victims is paramount*'. The principles have been used in conjunction with guidance on evidence-led prosecutions to consider the issue of Latif not being held accountable for his behaviour.

¹⁰⁶ The Drive project is a domestic abuse intervention that aims to reduce the number of child and adult victims by disrupting and changing perpetrator behaviour. The Project focuses on high-risk, high-harm and/or serial perpetrators. Drive implements a whole-system approach using intensive case management alongside a coordinated multi-agency response, working closely with victim services, the police, probation, children's social services, housing, substance misuse and mental health teams.

¹⁰⁷ Office of the Police and Crime Commissioner

Principle 1 & 2: Forces should have processes in place for identifying serial or potentially dangerous domestic abuse and stalking perpetrators and on identification a senior decision maker should decide whether to enter them onto a relevant database.

- 16.5.2.4 The panel felt that the chronology clearly identifies that Latif is a serial, dangerous perpetrator of abuse towards vulnerable women for the purposes of financially exploiting them. This information was known to all agencies. The MARAC process forms part of this mechanism and has already been explored.
- 16.5.2.5 The college of policing guidance states that perpetrators who present this level of risk should be entered onto the VISOR or other database ‘*at the appropriate risk level*’ or as a Potentially Dangerous Person (PDP). They further note that although VISOR has traditionally been used to manage sex offenders, it can and should be used to manage serial domestic abuser perpetrators as PDPs.
- 16.5.2.6 MPS introduced Dauntless as a trial approach and the possibility of this being utilised for Latif was mentioned at a London MARAC meeting. However, this does not appear to have been progressed. Today, subject to his being graded within the top 5%, he may have been included. Operation Dauntless+ does contain a requirement of proactive offender management.
- 16.5.2.7 Kent Police utilise VISOR for the management of PDPs and since a 2023 review by HMICFRS (His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services) have utilised ‘Prevention Debriefs’ as a pathway for reviewing an individual who may then be identified as a PDP and qualify for MAPPA. This change should mean that someone as harmful as Latif would be managed under MAPPA today.
- 16.5.2.8 MPS currently have a pan-London Drive programme operational which is one of the approaches noted in the College’s first principle. MATAAC is another option that a force could utilise to identify, intervene and/ or disrupt the behaviour of the perpetrator, running as a parallel process to MARAC. Kent do have a MATAAC process and work is ongoing, at the time of writing, to develop this process and its links to MARAC. It was the view of the panel that this work is essential to strengthen the links and efficacy of these two processes.
- 16.5.2.9 Kent have also restructured their vulnerability policing with the introduction of a Rape and High Risk DA Team and a Proactive Vulnerability Team (PVT) both utilising investigative practice in line with Op Soteria and extending this to domestic abuse practice. The PVT will focus on standard and medium risk perpetrators and will seek to disrupt perpetrators through criminal charges irrespective of these being related to the interpersonal violence offences. In short, this means focussing on investigating the perpetrator of rape or domestic abuse proactively, and a programme of development called, ‘Developing good investigative habits’ has been formed to support this. Working in this proactive way to safeguard victims through perpetrator accountability could have strengthened the focus on Latif’s behaviour. It was the panel’s view that this review should be used in these Kent teams to reflect on proactive management of those identified as PDPs.

16.5.2.10 It is also important for local areas to look at their commissioning strategies in relation to perpetrator intervention. Perpetrator-focussed programmes such as Drive and MATAAC (Davies, 2018) are showing promise, forming partnerships between statutory and non-statutory agencies to focus on perpetrator risk management. MATAAC is seen to have a positive potential in the management of perpetrators, such as, reduction in offending, with some contentions in relation to victim safeguarding. Drive shows risk reductions of physical abuse by 82%, sexual abuse by 88%, harassment and stalking behaviour by 75% and jealous and controlling behaviour by 73% IDVA's reported risk reduction in 82% of cases across the programme. In Sasha's situation Drive would be the most likely programme, as Latif would be unlikely to volunteer for intervention. It was the panels' view that the Kent's Office of the Police and Crime Commissioner should review its commissioning strategy to ensure that programmes with a disrupt model of perpetrator management are available for high harm perpetrators in Kent and Medway which would support the work of the new policing teams, although, at the time of writing Kent has not been identified as an area that would benefit from a significant Home Office investment in this programme.

16.5.2.11 The Home Office are currently developing a national domestic abuse Perpetrator Strategy and a new Violence Against Women and Girls (VAWG) Strategy which will aim to bring more perpetrators to justice and reduce reoffending. As a minimum local DA Partnerships should review their current domestic abuse/ VAWG Strategy, updating to ensure that the resulting operational tactics around tackling high harm perpetrators of domestic abuse are robust.

Principle 3: Forces should be mindful of the College risk principles in their approaches to identifying and assessing risk.

16.5.2.12 Sasha and Latif's first police contact as a couple was in October 2017, one month after their relationship began. Latif contacted the police as there had been an altercation and Sasha had put his things outside. The MPS IMR author notes the good practice of speaking to each separately, but also flags that, given Latif's history a Clare's Law disclosure could have been made, but the MPS policy was updated five years after it entered the statute. The officer also noted that he '*appears to take care of her very well*', given the history held by MPS about Latif some exploration of his background could readily identify that this was unlikely to be the case. The panel noted that recording this could have created a narrative that Latif was 'okay' which others would access and this incident, having been reported by Latif, could be seen as use of the state against Sasha, coined as '*legal systems abuse*'. She was already fearful of reprisals and the implications of having the police come to her house. The length of time that new statute took to enter practice, and the lack of professional judgement based on Latif's background were missed opportunities to intervene early. The panel noted that generally there was good practice by all officers in identifying the level of risk that Latif presented to Sasha.

Principle 4: There is no duplication of activity to manage the identified cohort (for example MARAC/MAPPA). Principle 5 & 6: Forces should regularly refresh searches of those who are of concern but who are not subject to intensive management, to identify whether there has been any change to their circumstance that would affect their risk assessment, and they should be managed through a multi-agency approach.

16.5.2.13 The processes used today to manage high-harm domestic abuse are partnership approaches developed in a new era of community safety as a way of tackling domestic abuse. Prior to this, single agency responses were typical and there was very little information sharing, particularly between statutory and voluntary agencies. The originating sites of this coordinated community response were domestic violence forums which proliferated in the 1990s, inspired by the 'Duluth approach' in Minnesota, USA. In the College of Policing Principles it states, '*Perpetrator work needs to be cognisant of the whole systems approach and coordinated community response*'.

16.5.2.14 MARAC has become the key model for these interventions and has been previously explored in this analysis, with some further exploration below. However, it was the panel's view that there should be a review of the differing approaches utilised in Kent via MAPPA, MARAC and MATAC considering the intersections, duplication and effective use in managing high-harm, anti-social perpetrators of domestic abuse, this work was in hand at the time of writing.

Principle 7: Intervention options will need to be available and relevant to engaging and non-engaging perpetrators.

16.5.2.15 The panel reflected on the use of DVPOs in relation to Latif's abuse of Sasha. They ensured, in doing so, that they gave parity of voice to Sasha's perception of these orders from her own and her family's views. 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.

16.5.2.16 The panel noted that using these was good practice on the part of police officers who were attending incidents and were often frustrated at their inability to pursue charges against Latif. 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 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.*'

16.5.2.17 Latif was subject to five DVPOs between December 2017 and January 2021, with each instance affording an opportunity for Sasha to experience safeguarding in line with the

Home Office description. DVPO issuing continued much along the same lines throughout the period, so the panel focussed on the first instance and the final one for learning. It was the panel's view that the use of DVPO was on a process rather than outcome-based approach – had it been on the latter there would have been a review as to whether it was achieving anything for Sasha, and what could have been done differently.

- 16.5.2.18 The panel noted that the first DVPO issued was an opportunity to safeguard Sasha at a point at which the coercion and control she was being subjected to might more easily have been disrupted. This was issued in December 2017 and was good practice by the police officers, given that Sasha did not feel able to support a prosecution, limited evidence could be offered, and the officers identified that Latif was a high-harm perpetrator of abuse against vulnerable women. However, the order alone was not enough. Help must be proactive during the life of the order, and as noted by the Home Office guidance the multi-agency professionals surrounding the victim are critical to the *'success of any such process.'* A MARAC referral did take place, but this hearing occurred after the order had expired. At this meeting the IDVA took an action to organise a professionals meeting, but this did not happen until March.
- 16.5.2.19 The panel observed that the IDVA practice although proactive for safety planning in the few days after the incident was complacent through January, with only four records and no proactive recognition of this golden opportunity for supporting change. Sasha was vocally resistant to DVPOs generally, but in this first she merely stated she was *'sad to be on her own'* which could speak to a missed opportunity to intervene whilst Latif had less of a hold on her.
- 16.5.2.20 The panel further noted this lack of hearing Sasha's voice when she was spoken to by her IDVA, on more than one occasion she describes her emotional challenges in being separated from Latif and being on her own. In the context of Sasha's trauma, mental health diagnoses and coercion this, in the panel's view, should alert practitioners to the need for proactive safeguarding and/ or support. It should be clear that Sasha could not reasonably be expected to safeguard herself at this time. Her family were clear that their view of DVPOs utilised in this way merely entrenched Sasha in her dependency on Latif, as he could create situations where she was unsafe while they were in place and *'come to her rescue'* once they were over. Some of this behavioural analysis could take place if agencies came together to reflect on the dynamics of the relationship and seek to disrupt the perpetrators behaviour, as outlined in the discussion above regarding MARAC. It was the view of the panel that the retroactive practice that did happen did not add any meaning or value, in terms of safety and support to Sasha.
- 16.5.2.21 In November 2020 Latif was subject to a final DVPO. The couple were now living in Kent, and the incident related to a neighbour report of an incident. The neighbour described to the police that Sasha told them, *'He beats me day and night.'* The panel acknowledged that the police were proactive in researching Sasha's background and recognising the risks she faced despite denials of domestic abuse. Consequently, they secured a DVPO and referred her to MARAC.

- 16.5.2.22 The panel noted that the IDVA in Kent was proactive in working with Sasha, and that the practitioner's holistic thinking and attempts to gain Sasha the support and help she needed in a variety of ways enabled Sasha's engagement with her. Sasha was clear that she could not cope in the location she had been moved to without Latif, speaking to her dependence and self-blame in statements, such as, *"[She] hates being alone and said she's not the easiest person to live with, and it's not his fault."*
- 16.5.2.23 The panel reflected on the practice improvement during the time of this DVPO whereby the IDVA utilised this golden opportunity to establish a relationship with Sasha. However, the panel believed, as did Sasha's family, that the psychological impact of her trauma and coercion was so entrenched by this time, that without significant therapeutic interventions Sasha would remain unable to take action.
- 16.5.2.24 The panel noted, however, that this example is evidence that no single agency can effect change or adequately safeguard a vulnerable victim like Sasha, it requires a coordinated community response. At the time such an order is made it was the view of the panel that an associated safeguarding process, in the form of a timely professionals meeting at least, focussed on proactive interventions, perpetrator disruption and safeguarding should take place routinely. This could be achieved through the use of a professionals meeting mindset or in the case of vulnerable adults the use of the MARM Framework as previously discussed. For note, the Kent MARAC Operating Model does advise the use of professionals' meetings in situations of complexity.
- 16.5.2.25 A pre-existing model framework exists for this in child protection practice, in the form of the 'strategy meeting' – these are, a multi-agency meeting convened when there are reasonable grounds to believe a child is suffering or likely to suffer significant harm and should be held within a short timeframe of 24 hours. This is congruent with MATAC requirements for 'rapid information sharing' in order to effectively safeguard. A quick response is essential for vulnerable victims like Sasha.

16.5.3 Investigating and evidencing domestic abuse-related crimes

- 16.5.3.1 In 2025 the Office of the Domestic Abuse Commissioner issued a major publication on criminal justice and domestic abuse, drawing on insights from victims, survivors, specialist services and criminal justice inspectorates. The report noted that the HMICFRS PEEL inspections (2021/ 22) showed a majority of police forces *'requiring improvement'* or *'inadequate'* in investigating crimes. In this review both Kent and the Metropolitan Police Service were classified as *'requiring improvement'*. The report showed that there had been a significant reduction (43%) in domestic abuse-related crimes being referred to the Crown Prosecution Service.
- 16.5.3.2 The report identifies that, *'although guidance around the investigation and prosecution of domestic abuse cases is positive, this is not being consistently*

used in practice’ and notes that case building, especially into course of conduct crimes, like coercive and controlling behaviour is ineffective.

- 16.5.3.3 A critical opportunity for reducing the responsibility on vulnerable victims to hold perpetrators to account in policing comes in the form of the pursuit of evidence led prosecution. 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.
- 16.5.3.4 Kent Police updated their evidence-led prosecution policy in 2023 which contains helpful checklists and guidance regarding the ways in which convictions can be secured without dependence on a vulnerable victim. The concept of ELP was scrutinised by the panel via one incident in November 2020 of Grievous Bodily Harm (GBH) by Latif, the case did make it to the Crown Court with a trial date set. However, the prosecutors determined that no evidence could be offered because at that point Sasha was offering an alternative account. These accounts can be disregarded based on fear, but the prosecutor’s decision appears to be based on a lack of alternative sources of evidence.
- 16.5.3.5 In ELP terms this rendered Sasha a ‘*hostile victim*’ someone who, ‘*not only refuses to assist a police investigation but takes steps designed to damage it by providing false information to the police with respect to what has taken place. By providing this false information the victim hopes that the police (or if the case has reached the post-charge stage, the CPS) will be forced to end the prosecution on account of there being a conflict of evidence.*’ Despite this being a challenging and frustrating position for officers, the guidance reminds officer that, ‘*some of the most reluctant and hostile victims of domestic violence will be among the most vulnerable/high risk victims in the community.*’ Consequently, they should not be deterred from a thorough investigation to make a case evidentially viable.
- 16.5.3.6 Section 119 of the Criminal Justice Act, 2003 provides a legal framework that enables the dismissal as unreliable the contents of a retraction statement (alternative account), allowing prosecutors to secure the admission of original ‘truthful’ accounts.
- 16.5.3.7 The CPS guidance also outlines the difficulties of compelling a victim of abuse to present at court as a ‘*hostile victim*’, as they must then be subject to cross-examination. The decision must be taken with consideration to the public interest. It would be a challenging decision to do this to someone as vulnerable as Sasha and would still made her ‘responsible’ for the outcome and placed her at further risk of reprisal.

- 16.5.3.8 In terms of a prosecution based on circumstantial and/ or hearsay evidence, this can be supported by case building activities that seek to support the original statement. Some of the areas for case building in the incident were:
- a. The 999 call – in Sasha’s case this was via a neighbour, to whom Sasha had described *‘he beats me daily’*. On this call it was recorded, *‘[Sasha] had told the neighbour that Latif had hit her in the face with the dog lead, (later discovered this assault had knocked a tooth out and fractured her cheek).’*
 - b. Body worn video – not available at this time but Sasha ran to a neighbour when this incident happened. Her family also described forensic photographs being taken at her mum’s home showing significant damage to Sasha’s face. She described to her IDVA that Latif had wrapped the metal dog lead around his hand and *‘hit her round the face’*, that the incident had happened in the car, and he had then thrown her out of the car. It was unclear what happened to the dog lead or whether any CCTV or other witness data was available. She was treated for her injuries at hospital following a 999 call by the attending officers. Sasha gave a full statement following this incident, but was coerced by Latif from prison into retracting, which her family stated was witnessed by the statement taking officer.
 - c. Comprehensive statements from all first responders – including all verbal accounts provided by witnesses and the victim, in Sasha’s case this would have included the site of the assault if any passersby had seen her thrown out of the car. Details of injuries – doctors had seen Sasha at the hospital and there could also have been descriptions of Sasha’s demeanour and any unusual behaviour along with observations of her levels of intoxication.
 - d. Witness accounts – this is a challenging matter in Sasha’s case. Her mother describes still being afraid of Latif today and asking for supporting statements can be challenging in the face of fear which is based in the realistic prospect of reprisal. Sasha convinced her mum not to give a statement, and her mum was realistic about the risks this posed to Sasha, Sasha’s son and herself. This issue would likely extend to friends, wider family and neighbours. The officer did attempt to secure a witness intimidation charge as Latif, and his father contacted Sasha in an attempt to secure some form of prosecution.
 - e. Bad character – extensive examples of previous bad character were available, and there were examples of fear, a few months earlier in April 2020 MPS had arrested Latif for Actual Bodily Harm (ABH) – the IMR author for MPS noted, *‘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. DASH risk assessment was completed and Sasha answered 'no' to every question.' The following note was made on the crime report, *'Sasha was able to explain that the risk would be increased if Police turned up at their house because her partner would become angry and take it out on her. She also said that she would deny he had harmed her in order to reduce the risk to herself in such a situation.'*

16.5.3.9 The panel noted the sheer volume of evidence held by agencies in relation to Latif's abuse of Sasha, and the opportunity to recognise that Sasha's fear of repercussions was more than enough to prevent her from engaging with the police service, but there was no apparent consideration of an evidence-led prosecution. At times, across the timeline there were verbal accounts from Sasha which officers could have recorded in their notebooks, including accounts that she gave to other witnesses, most notably her GP. On one occasion Sasha was recorded in a distressed state by officers, this was shown to Latif (which would have placed Sasha at further risk) but there is no further record of its use for prosecution or case-building. There were also significant opportunities to evidence previous complaints and intelligence reports as the relationship developed.

16.5.3.10 Circumstantial evidence is evidence that relies on an inference to connect it to a conclusion of fact. Circumstantial cases contain no victim or eyewitness account, and where all available evidence points towards the suspect committing the offence. These are most likely to succeed where there is no other viable explanation. Following an appeal hearing in *R v C* (2007) EWCA Crim 2463 the Court of Appeal encouraged prosecutors to consider presenting circumstantial evidence in cases of victim retraction of statement and support to strengthen the prosecution's case. In doing so, it is also necessary to evidence a victim's fear when building such a case, and to secure bad character evidence, showing a 'significant background of domestic violence.' It was the panel's view that both were possible given the history and extent of agency records.

16.5.3.11 The IMR author for the MPS notes that there were serious concerns for Sasha and efforts were made to push ahead with cases by officers, but these depended on Sasha supporting the prosecution. In conversation the Kent Police IMR author speculated whether evidence led prosecution could have been considered if officers had time to *'take a step back and look at the opportunities.'* The panel remained concerned throughout the process that such a harmful individual is likely to be exploiting other women today.

16.5.3.12 During the Kent investigation of the GBH charge in 2020 Latif was imprisoned for a breach of a DVPO. The panel noted that he had called the police concerned for Sasha's welfare and was found hiding in a wardrobe. The panel speculated that this could have been an example of his manipulating Sasha, knowing that a short

imprisonment would be psychologically destabilising enough for her to withdraw from the more significant GBH prosecution. This again speaks to the importance of coordinated support, analysis and planning during the DVPO period.

16.5.3.13 The panel also noted that although not relevant to the 2020 incident the Oxleas IMR author noted the good practice within the community mental health team when Sasha lived in London within the first two years of her relationship with Latif. They note, *‘The professionals involved in Sasha’s case however took appropriate steps by liaising with the police during professional meetings. This proactive approach ensured that incidents were documented and that there is a record of Sasha’s situation, even though she was not ready to make a formal report herself. By advising professionals to keep records of any incidents, professionals were working to build a body of evidence that could support Sasha if she later decided to involve the police.’* The panel noted that utilising a proactive approach to prosecution could see this cross-agency material be used for case building.

16.5.3.14 It is clear from the chronology that Latif was a coercively controlling anti-social perpetrator of high harm domestic abuse. Coercively controlling behaviour (CCB) 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. The Domestic Abuse Commissioner notes in *Shifting the Scales*:

*“Anecdotal evidence from multi-agency partners and sector specialists indicates that the CPS may be risk-averse when charging domestic abuse-related offences – particularly where coercive and controlling behaviour is involved – with a high threshold being applied. As with the police low resource and high caseloads also impact the functioning of the CPS, particularly in the absence of a specialist domestic abuse unit. This risks such cases being undertaken by staff who are inexperienced in understanding and dealing with domestic abuse”.*¹⁰⁸

16.5.3.15 Low charge rates are likely to be indicative of how proving patterns of abusive behaviour can be more time consuming. This offence requires evidence of a course of conduct over time which takes time. 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.

16.5.3.16 The panel wished to acknowledge that the officer in the case across the course of the Kent incident undertook a significant and dedicated activity in attempting to secure some outcome against Latif including a witness intimidation charge. The purpose of a review is not to apportion blame on any agency or individual but to

¹⁰⁸ [Shifting the Scales](#). Domestic Abuse Commissioner, 2025

seek learning, to 'make the future safer' by 'illuminating the past'. The panel believed that this review should be used to inform the ongoing development of an evidence-led policing culture for Kent Police in conjunction with the CPS via the Joint Justice Plan (2024) recommended Scrutiny Panels. These are currently taking place in Kent where there is a decision for No Further Action but should be extended to situations where cases are dropped as they go to court (e.g. when the victim retracts/ offers an alternative account). This would allow a review of whether the case should reasonably have depended on the victim's testimony.

Principle 8: Evaluate implementation and outcomes of interventions to ensure they have the best chance of achieving the desired outcomes.

- 16.5.3.17 This principle applies in the sense of this review itself and the learning therein as well as the considerations set out above about the use and interaction of multiple perpetrator management processes.

16.6 Safeguard Professionals

- 16.6.1 The panel wished to reflect the potential impact on professionals of the work with Sasha. She was frank in disclosing significantly upsetting information in detail e.g. stating that a former partner was tortured and murdered, stating that she is sexually exploited by others, saying she had been repeatedly strangled by different partners and that weapons have been used during some of these assaults. Agencies and Sasha's family also had to contend with the consequences of these assaults and in terms of her being stuck in an abusive situation.
- 16.6.2 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. 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.
- 16.6.3 Another example of the challenges faced by professionals working with this situation was the investigating officer who handled Latif's possible prosecutions between November 2020 and January 2021. It is noted by the IMR author that they recognised and understood that *'Sasha was an extreme victim of domestic abuse, manipulation, and control by [Latif].'* The panel acknowledged that they made a series of welfare checks and endeavoured to secure a charge against Latif, including one of witness intimidation. The IMR author further noted that, *'During the investigation the officer received a number of threats that appeared to have been made by [Latif] and relayed by Sasha, to the extent that the officer was issued with a panic alarm.'*
- 16.6.4 As a purpose of the MARAC process the panel were of the view that the review should acknowledge the impact on practitioners of this work. When using this lens, it is easier

to understand how professionals might become desensitised to the risks that Sasha was describing to them, and how easily this might translate into psychologically defensive victim blaming. Sasha's first IDVA was clearly unsupervised, and this was evident in poor risk management. Many agencies participated in process, rather than outcomes-focussed practice at MARAC in London and Kent which is indicative of the impact of high-volume high-risk practice loads on professionals doing the best that they can in the face of overwhelming adversity.

17 Conclusions

- 17.1 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.
- 17.2 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.
- 17.3 The perpetrator of her coercion was able to continue to violently abuse, exploit and control her because agencies were not able to successfully intervene to safeguard her.
- 17.4 Consequently, she became increasingly unwell and disabled until she died in hospital.
- 17.5 The review identified many attempts at good practice, and many agencies who tried to support Sasha within the confines of their policy and practice.

18 Lessons to be Learnt

18.1 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.

18.2 *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.

18.3 *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.

18.4 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.

19. Recommendations

The Review Panel makes the following recommendations from this DARD:

	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

	Recommendation	Organisation
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 disadvantages. This should trigger additional professionals' meetings in line with 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.	MARAC Operational Group - Kent 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

	Recommendation	Organisation
	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).	
7.	KMPT should use the learning from this review to undertake reflective practice with Mental Health 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.	KMPT
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

	Recommendation	Organisation
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 abuse and coercive control, drawing on nationally available resources.	KMSAB Policy Procedures Working Group Oxleas
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	Kent Police

	Recommendation	Organisation
	teams (Rape and High-Risk DA/ PVT) and the MATAAC/ MARAC processes.	
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 coordinated case building response can be developed that would support policing practice whilst maintaining practitioner safety and victim engagement.	Kent Police
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

20 Action Plan

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GLOSSARY

Abbreviations and acronyms are listed alphabetically. Explanation of terms are included in the footnotes of the report.

AAFDA	Advocacy After Fatal Domestic Abuse
ABH	Actual Bodily Harm
ASC	Adult Social Care
BWV	Body worn video
CCB	Coercively Controlling Behaviour
CHRTT	Crisis Resolution and Home Treatment Team
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DA	Domestic Abuse
DARA	Domestic Abuse Risk Assessment
DARDR	Domestic Abuse Related Death Review
DASH	Domestic Abuse, Stalking, Harassment and Honour-Based Violence risk assessment
DASV	Domestic Abuse and Sexual Violence
DHR	Domestic Homicide Review
DNA	Did Not Attend
DVPO	Domestic Violence Protection Order
EUPD	Emotionally Unstable Personality Disorder
ED	Emergency Department
GBH	Grievous Bodily Harm
GP	General Practitioner
HIDVA	Hospital Independent Domestic Violence Adviser
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Report
MARAC	Multi-Agency Risk Assessment Conference
MARM	Multi-Agency Risk Management
MPS	Metropolitan Police Service
NFA	No Further Action
NRM	National Referral Mechanism
PNC	Police National Computer
SPOA	Single Point of Access

Appendix A



DHR 63 Terms of
Reference

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