Domestic Homicide Review

Safta

July 2022

Executive Summary

Independent Report Writer: Elizabeth Hanlon

Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

Review completed: 15 February 2024

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1. Safta

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

2. Timescales

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

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

2.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 16th May 2022. The panel agreed that the death of Safta met the criteria for a DHR, and this review was conducted using the DHR methodology.

2.4 The DHR was started in May 2022 when the first meeting took place and concluded in February 2024 after the family had final sight to provide further feedback and amendments. The panel met on five occasions, where they identified the key learnings, set the terms of reference, examined IMRs and agency information, and scrutinised the overview report and its recommendations. An action plan was developed and populated by panel members prior to Home Office submission.

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

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

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

2.7 This overview report has been compiled with reference to the comprehensive Independent Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

3. Contributors to the Review

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

3.2 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
The Education People, Education Safeguarding	Independent Management Review

East Kent Hospitals University Foundation Trust	Independent Management Review

4. Review Panel Members

4.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had no relevant contact with Safta and/or Alexandru. It also included a senior member of the Kent Community Safety Team and an advisor from the Kent Police Diversity Academy.

The members of the panel were:

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

5. Chair and Overview Report Writer

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

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

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

6. Terms of Reference

6.1 The Terms of Reference for the Review can be found in Appendix 2.

7. Background Information

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

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

7.3 In March 2022, Safta called the Police to report a domestic situation between herself and Alexandru. This was the first time that she had reported any DA within their relationship to professionals. During her interview, Safta reported to the Police a long history of sexual assaults and controlling coercive behaviour. Safta reported that the relationship between herself and Alexandru had gotten considerable worse during the Covid-19 lockdown. Safta identified

to the Police that she had taken a non-molestation order out against Alexandru the previous month to prevent him from harassing, threatening, or using violence towards her. The order however, allowed Alexandru to still live in the family home that they shared with their child. Tanta identified that Safta had not requested that Alexandru moved out of the family home as she believed that that was best for child A.

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

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

8. Summary Chronology

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

8.2 On the 26th March 2022 Safta contacted the Police stating that her ex-partner Alexandru, had entered her room where she was sleeping with child A and had woken her. He was threatening to take his own life and at the same time refusing to leave and was touching her. Safta identified to the Police allegations of physical and sexual abuse on her including coercive controlling behaviour, over several years. Police officers attending the home address completed a Domestic Abuse Risk Assessment (DARA). The assessment was recorded as medium risk. Safta also disclosed to officers that early in their relationship Alexandru had told her that if he was ever arrested or entered into another relationship that he would cut her head off.

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

8.4 On the 26th March the school where child A was a pupil received an Operation Encompass[1] safeguarding notification from the Police in relation to an allegation of historical physical and sexual abuse against Safta by her partner Alexandru. The school records receiving the notification but there are no further notes detailing what action took place. Neither school attended by child A had any safeguarding concerns regarding them until the secondary school received an Operation Encompass notification from Kent Police

8.5 On the 1st April Safta provided an Achieving Best Evidence (ABE) interview during which she reported a lengthy history of sexual abuse, rape, physical assaults, and coercive controlling behaviour taking place over several years. An Independent Sexual Violence Advisor (ISVA) referral was agreed, and a referral was made. The risk assessment was completed with Safta at the time that Alexandru was arrested however, the risk assessment was not re-assessed following the ABE.

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

9. Key Lessons and Recommendations.

9.1 Risk assessments and DARA

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

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

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

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

9.5 The Police IMR writer identified within their report that the evidence gained during the investigation indicated that Alexandru believed that he had a 'right' to Safta as she was his wife and could not accept that the relationship had ended. The possibility of economic abuse within the relationship does not appear to have been taken into consideration nor the impact on Safta of not working. The risk assessment is designed and used by officers to try and identify risks which include the financial implications there might be for the victim of domestic abuse.

9.6 DARA risk assessment Safta identified that she was often denied access to money and that Alexandru controlled what she was allowed to spend her money on. Safta had agreed not to go to the workplace as she wished Alexandra to continue to work so that he could support the family. This should have been viewed as an area of control over Safta by Alexandru and further questions should have been asked of Safta. Consideration should have been given as to how Safta was going to be able to support herself and child A and how would this impact upon their safety.

9.7 Non-molestation Order

9.8 It was highlighted that the Family Court had made good use of technology during the Covid-19 restrictions and had continued conducting their hearings remotely. This was identified by the panel as good practice. The non-molestation order was made against Alexandru on the 16th of February 2022.

9.9 Operation Encompass

9.10 The Operation Encompass notification received by the school noted that child A was 'present' during the domestic abuse incident but that they had not witnessed it. The Designated Safeguarding Lead (DSL) for the school shared the notification with the DSL team to monitor child A and filed the information. The school had no identified safeguarding concerns for child A at this time.

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

9.12 Services for EU Nationals who are victims of domestic abuse.

9.13 Although it was identified that support is available for victims of domestic abuse from several arenas within the County of Kent and Medway there is limited specific support targeting those from a non-British background. The Domestic Abuse website[2] for Kent and Medway which offers support and

[2] https://www.domesticabuseservices.org.uk/

signposts victims of domestic abuse towards support services is also able to be translated into different nationalities. Highlighted is work taking place in Canterbury by emic[3] Ethnic Minorities in Canterbury who offer support and advise across a variety of issues including domestic abuse. Emic were involved in a raising awareness campaign in relation to domestic abuse in 2022 highlighting areas of available support also encouraged communities to become domestic abuse champions and highlighting the 16 Days End Domestic Abuse campaign. This is encouraging but again is limited to people searching and accessing the website for support and advice.

9.14 More targeting work is required to raise awareness of domestic abuse within those hard-to-reach communities to highlight what domestic abuse is and areas where support is available. Agencies should consider various methods to provide outreach in their communities and to provide the information, help and support needed in the appropriate format.

9.15 The impact of age on domestic abuse.

9.16 In the context of Alexandru and Safta's relationship, there was a 19-year age difference, which may have been a factor leading to the marriage breakdown. There is limited research available on this subject, but a study in 2004[4] revealed that there was a heightened risk on intimate partner homicide where there was an extreme age difference.

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

[3] https://emic.org.uk/

[4] https://www.researchgate.net/publication/8100312_Couple_Age_Discrepancy_and_Risk_of_Intimate_Partner_Homicide

9.18 Homicide and suicide.

9.19 There is limited research into Homicide followed by suicide. Figures published in 2022[5] identified 16 incidents in England and Wales. Most perpetrators are male, most victims are female, usually a partner or ex-partner. Homicide-suicide is less than 1% of all suicides.

9.20 An article published in April 2016[6] showed that the incidents of homicide-suicide were commonly preceded by relationship breakdown and separation. 62% of the perpetrators had mental health problems. A quarter of the perpetrators visited a GP for emotional distress within a month of the incident and self-harm and domestic abuse were common.

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

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

10. Conclusion

10.1 Safta was a hard-working mother who was sadly murdered by her husband who then took his own life. The relationship between Alexandru and Safta appears to have broken down eighteen months before the murder and during that time Safta had taken steps to start to remove herself from Alexandru. She had started a new business so that she could have her own income and would be able to have more control over the work that she did. It was identified by Tanta that Alexandru was in charge of the business and as such he would pick and choose the jobs he wanted to do and would give the lesser jobs to

[5] https://sites.manchester.ac.uk/ncish/reports/
[6] https://link.springer.com/article/10.1007/s00127-016-1209-4

Safta and other staff members. Tanta did however identify that over time Alexandru became reliant on Safta for the smooth running of the business as she was in charge of the majority of the activities within the business.

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

10.3 Alexandru had started an affair with another female and had put her into the business as the receptionist. This had caused a significant breakdown in Alexandru and Safta's relationship which she identified as being something she could not come back from. There are significant events throughout the last few months of Safta's life which highlight the shift in power and ultimately the heightened risk within the relationship. Safta had removed from the martial bed and was sleeping in the spare bedroom. She had started a new business, had taken out a non-molestation order and ultimately reported Alexandra to the Police, resulting in his arrest. These highlighted changes in circumstances untimely resulted in Safta's murder and Alexandru's subsequent suicide.

11. Recommendations

	Recommendations for Kent Police	
1	Kent Police to update their DARA risk assessment training to make sure that the training incudes the significance of the risk assessment questions and the impact that the identified risks have on victims. Referral pathways including non-commissioned services are to be highlighted to frontline staff so that they can provide suitable information at the initial stages of their involvement.	**Kent police**

	Recommendations for Kent Police	
2.	Initial DARA risk assessments must be updated or followed up by secondary DASH risk assessments following each stage of an investigation to make sure that the risk assessment accurately reflects the most appropriate risk.	**Kent Police**
3.	Specialist staff investigating domestic abuse, coercive controlling behaviour would benefit from awareness raising on the risk factors identified through academic research and the impact that these risk factors have on a relationship including the link to homicide.	**Kent Police**

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

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

	Recommendations for all agencies	
8	All agencies are to receive a briefing in relation to ACEs and the impact that adverse childhood experiences can have upon a child who is subjected to or present when domestic abuse to taking place within a household.	**Kent and Medway Childrens Partnership and the Kent and Medway Adults Board.**
9	The services within the SARC in Kent and Medway is to be highlighted to all frontline practitioners who may have contact with victims of sexual assaults, to reinforce the pathways of support available.	**Kent and Medway Domestic Abuse and Sexual Violence Board.**

Appendix 1

GLOSSARY

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

Abbreviation / Acronym	Expansion
ACEs	Adverse Childhood Experiences
DARA	Domestic Abuse Risk Assessment
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
KCSP	Kent Community Safety Partnership
KMDASVEG	Kent and Medway Domestic Abuse & Sexual Violence Executive Group
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service

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

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

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

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which

recovery, whether physical or psychological, can be expected to be difficult or impossible.

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

Domestic Abuse (Definition)

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

(1) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a)A and B are each aged 16 or over and are personally connected to each other, and

(b)the behaviour is abusive.

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

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

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

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

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

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

(b)obtain goods or services.

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

Controlling behaviour is:

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

Coercive behaviour is:

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

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared between representations of relevant statutory and voluntary sector organisations about victims of domestic abuse who are at the greatest risk. Victims do not attend MARAC meetings; they are represented by their Independent Domestic Violence Advisor (IDVA).

There are thirteen established MARACs across the whole County which are facilitated by MARAC Coordinators employed by Kent Police. Kent Police also employ a MARAC Central Coordinator, who is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for absent Administrators at MARAC meetings.

The Central Coordinator is also responsible for ensuring that the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated, and that each MARAC adheres to them. A further responsibility of the Central Coordinator is to provide training for MARAC members and chairpersons.

Appendix 2

Kent & Medway Domestic Homicide Review

Victim – Safta

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

1.1 Specific Issues to be Addressed.

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

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

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

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

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

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

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

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

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

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

1.1.1.10 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Safta, Child A and promote their welfare, or the way it identifies, assesses, and manages the risks posed by Alexandru? Where can practice be

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

1.1.1.11 Did any staff make use of available training?

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

1.1.2 **Key lines of enquiries**

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

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

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

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

5.1.2.5 Op Encompass and referral pathways following allegations of abuse.

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

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