



# **EALING COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW**

## **Overview Report into the homicide of Kat 2015**

**Independent Chair: Jessica Donnellan**

**Independent Authors of Report:**

**Jessica Donnellan and Sally Jackson**

**Associates Standing Together Against Domestic Violence**

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The panel would like to offer their sincere condolences to the family of Kat, who clearly was much loved, and to thank them for their participation in this review

# DHR EALING COMMUNITY SAFETY PARTNERSHIP

## CASE OF KAT

### Overview Report

#### 1. INTRODUCTION

##### 1.1 Details of the incident

- 1.1.1 Kat was last seen alive by her youngest sister one Sunday in November 2015. Three days later, Theo told a relative that he had killed Kat. The relative immediately called the police who attended Kat and Theo's home address where they found Kat's body.
- 1.1.2 A post-mortem examination gave the cause of Kat's death as the combined effects of stab wounds to the neck, blunt force trauma to the head and compression of the neck.
- 1.1.3 On 19<sup>th</sup> May 2016, following trial, Theo was found guilty of Kat's murder and sentenced to life imprisonment, with a minimum term to serve of 14 years.
- 1.1.4 The panel would like to express its sincere condolences to Kat's family and friends for their loss.

##### 1.2 Domestic Homicide Reviews

- 1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.
- 1.2.2 This review has followed the 2013 statutory guidance for Domestic Homicide Reviews as the review had already commenced prior to the publication of the refreshed 2016 guidance.
- 1.2.3 The purpose of this review is to:
  - a. Establish what lessons are to be learned from the domestic homicide regarding 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 agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- c. Apply those lessons to service responses including changes to policies and procedures as appropriate.
- d. Prevent domestic homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.4 The review process does not take the place of the criminal or coroners' court nor does it take the form of any disciplinary process within any of the agencies involved.

### 1.3 Timescales

1.3.1 The Metropolitan Police Service notified Ealing Community Safety Partnership on [date] that the case should be considered as a DHR. The Ealing Community Safety Partnership decided to conduct a DHR on [date], notified the Home Office on [date] and commissioned Standing Together against Domestic Violence to provide a chair and report writer for this process on 23<sup>rd</sup> March 2016.

1.3.2 This Domestic Homicide Review (DHR) was commissioned by Ealing Community Safety Partnership in accordance with the Revised Statutory Guidance for the conduct of Domestic Homicide Reviews published by the Home Office in March 2013.

1.3.3 The first meeting of the review panel was held on the 6th June 2016. Subsequent meetings were held as follows:

- 5<sup>th</sup> September 2016 where IMRs were considered;
- 15<sup>th</sup> March 2017 where the first draft report was reviewed;
- 5<sup>th</sup> October 2017 where the second draft report was reviewed.

1.3.4 The report was handed to Ealing Community Safety Partnership on 20<sup>th</sup> September 2018.

1.3.5 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred due to:

- Access to the perpetrator in prison for interview;
- Engaging the victim's employer in the review process;
- The availability of the Chair / report author and subsequent change in author due to the original Chair/Author no longer being available due to a personal bereavement.

## 1.4 Confidentiality

- 1.4.1 Until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel, the findings of this report are confidential, available only to participating officers / professionals and their line managers.
- 1.4.2 To protect the identity of the victim, the perpetrator and family members, this report has been suitably anonymised in accordance with the guidance. The specific date of death has been removed and only the independent Chair and Review panel members are named.
- 1.4.3 The following anonymised terms have been used throughout this report:
- The victim is referred to as Kat;
  - The perpetrator is referred to as Theo.
- 1.4.4 The pseudonym for the victim was chosen by her family and the panel agreed the pseudonym for the perpetrator.

## 1.5 Equality and diversity

- 1.5.1 The Chairs of the Review and the Review Panel considered whether the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation were relevant to this review.
- 1.5.2 In identifying the relevant equality and diversity issues for Kat and Theo respectively, the Review Panel noted that:
- 1.5.3 Kat was a British Asian women of Sikh heritage, although there was not evidence of her practising for some years. She was 48 years old at the time of her death. She was a heterosexual woman from a close family where she was the eldest sister. There is no evidence of any disability and she was not pregnant or a mother. Her family disapproved of her relationship with Theo due to his ethnicity.
- 1.5.4 Theo is a Black African-Caribbean man raised in West London by his single mother. Theo had some problems with dyslexia which made writing documents difficult. He was 49 at the time of the murder. He was previously married but now divorced and living with his elderly mother for whom he had some caring responsibilities. His daughter (who lived separately) also had care needs following a life changing medical condition two and a half years prior to the murder.
- 1.5.5 The Review Panel subsequently identified the following equality and diversity issues in this review as being:
- Ethnicity – and the complexities of an Interracial relationship

- Caring responsibilities

1.5.6 These issues are considered further in section 3.9.

1.5.7 Sex should always require consideration in DHRs and this is particularly important in this case for two reasons:

- Sex is considered a risk factor because the overwhelming majority of victims of domestic violence and abuse are female, with perpetrators being overwhelmingly male. Research has also shown that intimate partner homicides are disproportionately perpetrated by men upon women (ONS, 2014).
- Recent case analysis of intimate partner homicides has been consistent with research. STADV and the London Metropolitan University<sup>1</sup> noted that the majority, 23 out of 24 of intimate homicides had a female victim and a male perpetrator. This finding is consistent in the Home Office recent analysis of intimate partner homicides.<sup>2</sup> The Review Panel provided special consideration to these issues throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.

## 1.6 Terms of Reference

1.6.1 The full Terms of Reference are included in **Appendix 1**.

1.6.2 The review looked at the involvement of statutory and voluntary agencies with Kat and / or Theo during the period of 1<sup>st</sup> December 2010 to the date of death in December 2015. This time frame was agreed as it gave a enough time on which to create a picture of their relationship considering that there had been very little contact with agencies. Incidents before 2010 were summarised and also considered.

1.6.3 The panel agreed that key lines of enquiry would include Theo's behaviour historically, and knowledge of the relationship from both Kats family and workplace

1.6.4 The review panel comprised agencies from the London Borough of Ealing, where Kat and Theo resided. Latterly it emerged that Kat had been registered with a General Practitioner in the London Borough of Harrow so the practice was subsequently engaged with the review, albeit somewhat remotely.

1.6.5 Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

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<sup>1</sup> Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

<sup>2</sup> Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office



## **1.7 Parallel and related processes**

1.7.1 **Inquest:** No inquest was held.

1.7.2 **Criminal trial:** On May 2016, Theo was convicted of Kat's murder and sentenced to life imprisonment, with a minimum term to serve of fourteen years. The OIC of the murder case, a representative from the MET police Serious Crime Review Group and Ealing Borough police all attended the 1<sup>st</sup> panel meeting.

1.7.3 There were no other processes conducted contemporaneously that impacted upon this review.

## **1.8 Panel Membership**

1.8.1 The panel consisted of the following agencies and representatives:

- a. Jessica Donnellan, Chair & Report Author, Standing Together against Domestic Violence
- b. Sally Jackson, Report Author, Standing Together against Domestic Violence
- c. Pam Chisholm – Metropolitan Police Service, Specialist Crime Review Group  
(until the 2<sup>nd</sup> Overview Report Meeting as retired)
- d. Janice Cawley – Metropolitan Police Service, Specialist Crime Review Group
- e. Ben Warriss – Metropolitan Police Service, Ealing Community Safety Unit
- f. Ann Coles – Ealing CCG, Designated Nurse Safeguarding Children
- g. Joyce Parker – London Borough of Ealing, Community Safety Team
- h. Hilary Lucas – Central & Cecil Housing Trust, Area Manager
- i. Stuart Webber - National Probation Service, Head City of London, Hackney and Tower Hamlets
- j. Sophie Shah – London Borough of Ealing, Adult Social Care Services, Service Manager
- k. Pragna Patel – Southall Black Sisters, Director
- l. Caroline Birkett – Victim Support, Head of Victim Support Services for West and South London

1.8.2 The Chair of the review thanks everyone who contributed their time, patience and cooperation to this review.

1.8.3 Southall Black Sisters were not able to attend every meeting due to sickness. While it is important to gain the knowledge and expertise of specialist agencies without compensation for their time it can be difficult for them to release staff for a review such as this.

## **1.9 Chair of the DHR and Author of the Overview Report**

- 1.9.1 The Chair and report author of the Review is Jessica Donnellan, Senior Projects Coordinator and DHR Chair at Standing Together against Domestic Violence (STADV). Jessica has received Domestic Homicide Review Chair's training from STADV. She joined STADV in January 2011 to set-up the Domestic Violence: Health & Maternity Project, run in partnership with the NHS. She then developed the coordinated community response to high risk domestic abuse cases through coordinating Multi-Agency Risk Assessment Conferences (MARAC). In her current role as Senior Projects Coordinator she has a diverse portfolio of short and longer term projects including three DHRs. She brings extensive experience of working across a range of statutory and voluntary sector roles including Child Protection, homelessness and independent domestic & sexual violence advocacy.
- 1.9.2 Unfortunately, before agreement on the final version of this report, the Chair and Author had to cease her involvement due to a family bereavement. The final version was compiled by Sally Jackson Partnership Manager at Standing Together. Sally Jackson has worked in the violence against women sector for over 20 years in the local, national and international arena. Sally worked as a fully qualified nurse, before moving into the domestic abuse (DA) field, which has included co-ordinating helplines, DA service development and manager of the Hidden Violence team for Portsmouth City Council. In Portsmouth this involved setting up the first health based Independent Domestic Violence Advocate (IDVA) service and one of the first IDVA/Independent Sexual Violence Advocate services. Along with partners she developed the city's Specialist Domestic Abuse Court and Multi Agency Risk Assessment Conference. She managed the city's response to violence against women and hate crime services and supported a very active DV Forum. She has delivered training to professionals from a wide variety of sectors including doctors and international Police Commanders. She is an independent expert advisor on Gender for ODIHR on Freedom of Assembly. Sally's role at STADV is Partnership Manager which entails ensuring delivery of the operational management of violence against women services across three boroughs (not Ealing) in west London.
- 1.9.3 Standing Together against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.
- 1.9.4 STADV has been involved in conducting Domestic Homicide Reviews from their inception, chairing over 50 reviews.
- 1.9.5 **Independence Statement:** Jessica Donnellan was the Coordinator of the Multi-Agency Risk Assessment Conference (MARAC) in Ealing from May 2013 to December 2014. STADV also co-ordinate Ealing MARAC. However, as neither Kat nor Theo were known to MARAC, the Safer Ealing Partnership decided that Jessica and STADV had sufficient independence to conduct this review. A list of the current projects that STADV is working on is included in Appendix 3.

## 1.10 Methodology

1.10.1 This review has followed the 2013 statutory guidance for Domestic Homicide Reviews (issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004) as the review had already commenced prior to the publication of the refreshed 2016 guidance.

1.10.2 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total 17 agencies were contacted to check for involvement with the parties concerned with this Review:

- Three agencies returned a nil contact;
- Five agencies submitted Independent Management Reviews (IMRs) and chronologies;
- One agency submitted a summary of their engagement due to the brevity of their involvement.

## 1.11 Contributors to the review

1.11.1 The following agencies were contacted, but had no recorded involvement with Kat or Theo:

- London Borough of Ealing Education Department;
- RISE: Recovery Intervention Service Ealing (drug and alcohol misuse);
- Victim Support;
- Southall Black Sisters;
- Hestia Domestic Abuse Service and
- West London Mental Health Trust

1.11.2 The following agencies and their contributions to this Review are:

<b>Agency</b>	<b>Contribution (Chronology/IMR/Letter/Other)</b>
The Metropolitan Police Service	Chronology and IMR
The National Probation Service – London Division (formerly London Probation Trust)	Chronology and IMR
Central & Cecil Housing Trust	IMR only
Kat’s General Practice	Chronology and IMR
Theo’s General Practice	Chronology and IMR
Young Physical Disabilities Team Ealing Adult Services	Summary of Engagement only
London North West Hospitals NHS Trust Integrated Acute and Community Services	Chronology and IMR

- 1.6.7 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with V and/or P, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Both GP practices were also interviewed by the Chair. The IMRs have informed the recommendations in this report.

## 1.12 Informal Networks

### 1.12.1 Kat's Family

- 1.12.2 On the advice of the Metropolitan Police's Family Liaison Officer and Victim Support's Homicide Case Worker, the Chair of the review initially approached Kat's youngest sister to invite participation in the review. A first face-to-face meeting took place between Kat's youngest sister, the Homicide Case Worker and the Chair on 25<sup>th</sup> August 2016. At this meeting, the Chair was advised that Kat's father and brother were not in a position to contribute to the review. Home Office and AAFDA leaflets had already been provided by the Victim Support Homicide case worker, these were discussed and explained along with the Terms of reference of the DHR. However, the Chair was encouraged to make direct contact with Kat's middle sister and initial contact was made over the telephone on 16<sup>th</sup> December 2016.

- 1.12.3 The Chair kept in contact with Kat's family via email and telephone and text during the review. The overview report was shared with Kat's sisters on 16<sup>th</sup> April 2018, following further discussion by email and text, the family were happy for the report to be shared without any further amendments.

- 1.12.4 The Panel wishes to express its gratitude to Kat's sisters for their involvement in this review. Their support and input has been truly invaluable and has ensured that the process has kept a detailed and compassionate understanding of Kat at its centre.

### 1.12.5 Kat's employer

- 1.12.6 The Chair wrote to the Chief Executive Officer of Kat's workplace, seeking permission to interview her colleagues and line manager. On 21<sup>st</sup> June 2017 the Chair met with the organisations HR Manager. Further details of this meeting and its outcomes are detailed in Section 2.

## 1.13 Involvement of perpetrator and his family:

- 1.13.1 On 23<sup>rd</sup> August 2016 the Chair sent a letter to Theo in prison, requesting an interview. Theo agreed to this request and returned a signed consent form. An interview with Theo took place at HMP Belmarsh on 16<sup>th</sup> November 2016 in the presence of the seconded Probation Officer. Relevant information from this interview is contained in the body of this report. Although many important questions still remain unanswered, the Panel thanks Theo for his participation.

- 1.13.2 It was identified by the Panel that Theo's mother may have useful information and insight to contribute to the review as Kat and Theo resided with her. Consequently, an approach for an interview was made via her housing provider's Housing Officer and was agreed. An interview with Theo's mother, the Housing Officer and the Chair took place on 21<sup>st</sup> November 2016. Relevant information from this

interview is contained in the body of this report. The Panel would like to thank Theo's mother for her participation.

## 1.14 Dissemination

1.14.1 The following recipients have received copies of this report:

Panel members listed above;

Family members;

Standing Together Against Domestic Violence DHR Team;

Any other recipient, perhaps CSP provided report to;

## **2. THE FACTS**

### **2.1 The murder of Kat**

2.1.1 Theo and Kat resided with Theo's mother in a two-bedroom general needs housing association property in her sole name in the London Borough of Ealing. At 13:00 hours on a Sunday in November 2015, Theo's mother left the property to go to Church. Kat was cooking in the kitchen as she left. At 14:25 hours Kat met her youngest sister and her children and went bowling. At 17:00 hours, Kat told her sister she needed to return home in order to cook dinner for Theo.

2.1.2 At 19:00 hours Theo's mother returned to the property and asked Theo where Kat was. Theo told his mother that Kat was still out with her sister. The following day (Monday) when Theo's mother again enquired after Kat, Theo told her that she had not returned to the property from meeting with her sister. Theo's mother found this unusual as Kat would usually tell her if she was going to be away. On the Tuesday, Theo's mother telephoned Kat and left a voicemail message for her. Theo seemed to his mother to be worried and unhappy but gave no explanation as to why.

2.1.3 On the Wednesday, Theo's son-in-law had grown concerned for him as he had not made the customary daily contact for three days. He decided to call at Theo's address. On arrival, Theo disclosed to his son-in-law that he had killed Kat. At 16:24 hours, Theo's son-in-law called the Metropolitan Police Service (MPS) who attended and were directed by Theo to a bedroom in the property where Kat's body was found. The London Ambulance Service (LAS) attended and pronounced life as extinct. It was later established that Kat had probably been killed four days earlier.

2.1.4 Theo was arrested and when interviewed later, made no comment to all questions. Following consultation with the Crown Prosecution Service (CPS) Theo was charged with murder and remanded in custody.

### **2.2 Criminal prosecution of Theo**

2.2.1 Theo admitted attacking Kat but denied murder on the grounds he was suffering from an 'abnormality of mental function'<sup>3</sup> at the time. However, following the resultant trial, Theo was found guilty of murder and sentenced to life imprisonment with a minimum term to serve of fourteen years.

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<sup>3</sup> Abnormality of mental functioning means a state of mind so different from that of ordinary human beings that the reasonable person would term it abnormal. It covers the ability to exercise willpower or to control physical acts in accordance with rational judgement. (Source: [http://www.cps.gov.uk/legal/h\\_to\\_k/homicide\\_murder\\_and\\_manslaughter/#manslaughter](http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/#manslaughter))

## **2.3 Information relating to Kat**

- 2.3.1 Kat was a 48-year-old British Asian woman of Sikh heritage. The eldest of four siblings (two sisters and one brother), Kat grew up in a close nuclear family in west London.
- 2.3.2 As an adult, Kat maintained particularly strong relationships with her two sisters and became a treasured aunt to her nieces and nephews as they arrived. Kat's sisters describe her as a kind and caring human being, sensitive to the needs of others and attentive to meeting those needs whenever she could. This sense of care and loyalty played a significant role in Kat's relationship with Theo and with his mother.
- 2.3.3 Kat worked for a corporate travel company in the City of London. She was a long-standing member of staff there, worked hard and loved her job.
- 2.3.4 Although Kat respected the Sikh faith that she grew up with, she did not practice it as an adult. She is variously described by those who were close to her as 'independent' and 'free spirited': she had a determination to carve out her own unique path in life. The energy with which Kat lived her life was reflected in her love of bright colours, she wore these in her clothes and in her make-up and her family requested guests at her funeral wear colourful clothes to honour this aspect of her personality.
- 2.3.5 Kat was in a relationship with Theo for approximately fifteen years. However, as Kat's parents did not want her to have a relationship with a Black man, she kept her relationship with Theo a secret from them for many years. Kat lived at home with her parents so this was a complex task. In November 2012, Kat told her parents about Theo and that she intended to move in with him. When Kat moved out of the family home, a six-month period of estrangement followed during which Kat had no contact with her parents. Although Kat reconciled with them in April 2013, Theo never had any contact with them and this was a matter which aggrieved him.

## **2.4 Information relating to Theo**

- 2.4.1 Theo was 49-years-old at the time of the murder and is a Black British African-Caribbean male. Theo is an only child and was raised by his mother in west London. His father was absent from his life and Theo has described how he missed out on having a model for how to behave in a relationship.
- 2.4.2 According to both Theo and his mother, his journey through the education system was unremarkable. Theo reports that he has dyslexia and experiences some difficulties with writing, a problem he feels has 'held him back' from achieving his full potential. Theo has spent the majority of his adult life in employment, in unskilled<sup>4</sup> roles. He has been reported to the police on two occasions for theft from employers: one incident (1997) resulted in a criminal conviction while the other (2006) was dealt with within internal disciplinary proceedings. An incident of physical violence with a colleague at work in 2008 led to Theo losing his job and a further incident of physical violence perpetrated against his supervisor at work in February 2015 again saw Theo's employment terminated. He remained unemployed from this time until his arrest for Kat's murder.
- 2.4.3 Prior to his relationship with Kat, Theo was married and had two children, a daughter and a son, with his then-wife. When Theo and his wife separated, and subsequently divorced, he returned to live with

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<sup>4</sup> Unskilled worker: a worker who does not have any special skill or training (Source: <https://www.collinsdictionary.com/dictionary/english/unskilled-worker>)

his mother. Kat would later move into the property with Theo and his mother and they remained there until the murder. Both Theo's children are now adults with children of their own.

2.4.4 There are reports to police of domestic abuse perpetrated by Theo from three women, including his ex-wife. However, none of these progressed beyond the report-making stage.

2.4.5 During the course of Theo and Kat's relationship, two and a half years prior to the murder, Theo's daughter suffered from a life changing medical condition. She was admitted to hospital for an extensive period of time and has required full-time care since being discharged. Although Theo finds it hard to articulate how these events impacted him, the Chair has surmised that it was incredibly distressing, stressful and disempowering for him, particularly during the time that she was in hospital.

## **2.5 Metropolitan Police Service**

2.5.1 Kat was not known to police and no reports of domestic abuse between her and Theo had been made during the course of their fifteen-year relationship.

2.5.2 However, Theo had come to the attention of police for perpetrating domestic abuse against three different women on three occasions over a six year period between 2000 and 2006). Details of these reports can be found in Table 1 (**below / page 16**).



Table 1: Table to illustrate allegations of domestic abuse perpetrated by Theo reported to Police

	Date	Relationship to Theo	Allegation(s) made of Theo' behaviour	Reason recorded for criminal case not progressing	Outcome
Female A	2000	Ex-partner / mother of children	Grabbed her around the neck and pushed her. Bruising caused to her elbow, knee and arm.	Victim did not wish to proceed with the allegation to court.	Advice given to victim in relation to injunctions and case closed.
Female B	2003	Ex-girlfriend	Punched her in the face. No visible injuries. However, victim complained of having a sore face.	Bystanders unable to corroborate incident and no CCTV available. Police unable to establish contact with the victim (phone / letter).	Crime report created and case closed.
Female C	2006	Girlfriend (GF)	Whilst driving with GF in the car Theo intentionally sped up and crashed into another vehicle. A child in the other vehicle sustained life threatening injuries. Post-incident, Theo contacted GF and asked her to change her account of the incident, prescribing to her what to say to police. On one occasion Theo rang GF whilst police were with her and they overheard him imply that the collision was deliberate and that he had tried to kill her. Police also recovered a number of abusive voicemail messages from Theo on GF's phone which demanded that she make contact with him: one of the messages referred directly to the collision. It was noted that GF appeared to be frightened of Theo.	N/A – case progressed to trial.	Theo found: <ul style="list-style-type: none"> <li>• guilty of dangerous driving</li> <li>• guilty of possessing an offensive weapon</li> <li>• not guilty of attempted GBH</li> <li>• case of causing GBH laid on file.</li> </ul> <p>Theo sentenced to 15 months imprisonment and disqualified from driving for 5 years and until he passed an extended driving test.</p>

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- 2.5.3 The domestic abuse reports of 2000 and 2003 did not progress through the criminal justice system, with Police citing the reasons as ‘victim not wishing to proceed with allegation’ and ‘bystanders not able to corroborate incident and no CCTV available’ respectively.
- 2.5.4 Of the four charges that were brought against Theo following the 2006 incident (dangerous driving, possessing an offensive weapon, attempted GBH and causing GBH), a jury found him guilty of only two: dangerous driving and possessing an offensive weapon. He was found not guilty beyond reasonable doubt of attempted GBH against his partner and the charge of causing GBH (to the child in the other vehicle) was laid on file.
- 2.5.5 In addition to a 15-month custodial sentence, Theo was also disqualified from driving for five years and until passing an extended practical driving test. However, on two occasions (June 2008 and December 2009) Theo was found to be driving whilst disqualified. On both these occasions, Theo advised police that he was driving his partner’s car.
- 2.5.6 Evidence in police records indicates Theo used violent and abusive behaviour outside of intimate relationships. Table 2 (below) details two incidents in which Theo was present and is both accused of using violent behaviour and alleges being subjected to violent behaviour.

**Table 2: Table to illustrate reports to Police relating to broader incidents of violence involving Theo**

	Date	Relationship to Theo	Behaviour involved in incident	Reason recorded for criminal case not progressing	Outcome
Male 1	2004	No relationship	Theo’s son had been robbed of his bicycle by two young people. In retrieving the bicycle from the young people, Theo sustained a small cut to his cheek. The young person claimed Theo had hit him on the head with two rocks and he had acted in self-defence.	Neither party wished to support a prosecution.	Case closed.
Male 2	2008	Male co-worker (CW)	Following a disagreement in the workplace, both parties make allegations that threats and violence were used.  Both parties sustained injuries: Theo a deep knife cut to his hand (the knife was a workplace tool); CW a head injury caused by being hit with a bicycle lock.	CPS deemed that the CCTV was not conclusive.	Criminal case not proceeded with.  Both parties dismissed from employment.

## 2.6 London Probation Trust (LPT)<sup>5</sup>

2.6.1 Theo was supervised by London Probation Trust following driving offences during three discreet episodes, although for inter-related offences, between 2007 and 2009. Table 1 below details these episodes:

**Table 3: Table to illustrate the episodes of LPT supervision of Theo**

	Offence	Sentence	Probation commencement date	Requirements	Probation end date
1.	Dangerous driving	Standard determinate custodial sentence – 15 months.  Disqualified from driving for 5 years and until passed extended driving test.	Following release from prison on license on 12/03/2007	Supervision	26/10/2007
2.	Driving whilst disqualified	Community Order	Sentenced on 21/07/2008	Unpaid Work – 100 hours  Training & Employment (ETE) - 20 days	Completed 23/02/2009 due to 'good progress'.
3.	Driving whilst disqualified & no insurance	Suspended Sentence Order (SSO)	Sentenced on 22/12/2009	24 months  Requirement: Unpaid Work (hours not specified)	SSO terminated on 25/04/2010

2.6.2 Due to difficulties accessing historic records, we have only been able to obtain confirmation that an OASys<sup>6</sup> assessment happened following offence 3 (2009), although the Probation representative on the panel has advised it is likely that an OASys assessment was undertaken with Theo at the commencement of each of these episodes.

2.6.3 Following offence 2, Theo's Offender Manager identified:

- Theo's offending was 'sporadic' and his record could not be described as an 'established pattern of offending';

<sup>5</sup> During the incidences relevant to this review, LPT were responsible for managing offenders. However, since June 2014, this function has been split between two providers known as the National Probation Service (NPS) and the Community Rehabilitation Company (CRC).

<sup>6</sup> **OASys:** Offender Assessment System. A general assessment tool which provides a consistent framework to Offender Managers in assessing an individual's risk of serious harm and likelihood of re-offending. Depending on the level of risk of harm and sentence type, this will trigger the completion of a risk management plan and other assessment tools (e.g. Spousal Assault Risk Assessment).

- Theo had 'inappropriate problem-solving strategies';
- Theo resided with his mother, with whom he had a 'good' relationship, although his preference was to find an independent residence;
- Theo was unemployed and in receipt of Job Seekers' Allowance<sup>7</sup>, with 'assistance' from his mother and partner (identity not known but likely to be Kat) with additional expenses;
- Theo believed his relationship with his partner to be 'stable'.

2.6.4 Although there were two instances where action was taken following breaches of the order (non-compliance), neither incident was proceeded with.

2.6.5 Following offence 3, the offender manager who completed the pre-sentence report identified:

- Theo's decision to drive was based on the fact that it was convenient and he was hoping he could do so without being detected;
- Theo was minimising the seriousness of his actions;
- Theo's claim that he not driven since his previous offence (offence 2) was not entirely honest;
- Although Theo expressed remorse, his actions were clearly not in line with his stated position and that his remorse seemed to be for having been caught rather than the seriousness of the harm he posed or the failure to comply with Court sanctions;
- This behaviour was part of an established pattern of offending behaviour, but not anti-social;
- Theo had 'inappropriate problem-solving strategies'.

2.6.6 This Order was completed without incident.

## **2.7 General Practice for Kat: Harrow area Medical Centre**

2.7.1 Following submission of an IMR and chronology, the DHR Chair undertook a visit to the GP practice for more detailed discussion.

2.7.2 During the five-year timeframe under review, Kat had 39 contacts recorded in her GP notes. Although the majority of Panel members thought this frequency to be higher than average, research conducted

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<sup>7</sup> Job Seekers' Allowance (JSA): An unemployment benefit you can claim while looking for work

by the Health and Social Care Information Centre<sup>8</sup> found that the average member of the public sees a GP six times a year (i.e. 30 visits over 5 years). The Panel representative for Ealing CCG further advised that this number of visits for a woman of Kat's age is within a normal range and would not alone have aroused concern adequate to prompt enquiry around 'personal and social history', including domestic abuse. Kat was never asked about domestic abuse at the surgery, nor did she volunteer any disclosure.

2.7.3 There are two significant and episodic themes in Kat's medical records: a range of gynaecological issues (including contraception, menstruation, urinary tract infection and routine cervical smear screening) which occur during an 18-month period between January 2011 and July 2012; and repeat presentations with unexplained pain (low back, arm, chest and shoulder) which occur over the course of a year from late 2013 until late 2014.

2.7.4 In addition to these themes, Kat sought help around hearing loss in 2015 and was referred by her GP to the London North West Healthcare NHS Trust's Ear, Nose and Throat (ENT) department who fitted her with a hearing aid shortly before she was murdered.

## 2.8 General Practice for Theo: Ealing Area Surgery

Basic Chronology and accompanying letter was received but no significant indicators that warranted further investigation

## 2.9 London North West Healthcare NHS Trust

2.9.1 **Rapid Access Chest Pain Clinic (RACPC):** Following symptoms of chest pain in July 2014, Kat's GP referred her for an assessment at RACPC. During this episode of outpatient care, records indicate that Kat disclosed to staff that she was experiencing 'a lot of pressure at work and at home'. No further details are recorded. However, a letter sent from the cardiology department back to the GP included reference to Kat's 'stress in home life' although it did not specify any further details. The letter advised that the symptoms Kat was experiencing were likely to be muscular and she was formally discharged nine days later.

2.9.2 **Vascular Department:** Kat had contact with the vascular department between February and June 2015, following a referral relating to a swelling in the left side of her neck. A scan in May returned 'normal' results and after missing an appointment in June 'due to personal reasons' the electronic system automatically triggered a discharge back to Kat's GP.

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<sup>8</sup> Health and Social Care Information Centre, Trends in consultation rates in general practice.

2.9.3 **Ear, Nose & Throat (ENT) Department:** Kat had contact with ENT services throughout 2015 which resulted in the fitting of a hearing aid. There is no indication of enquiry or disclosure of domestic abuse during this contact.

## 2.10 Central & Cecil Housing Trust (C&C)

2.10.1 Kat moved out of the owner occupied family home in Harrow in November 2012, to move in with Theo in Ealing.

2.10.2 Theo resided at his mother's flat: a 2 bedroom general needs tenancy owned by Central & Cecil Housing Trust. When the tenancy began in 2000, Theo was named on the CORE<sup>9</sup> return. C&C was therefore aware that he was living at the property, although he was not named on the tenancy agreement.

2.10.3 In 2014 C&C introduced an annual tenancy audit policy. These audits are usually carried out within the tenant's property so the Trust can assess the condition of the property, identify any concerns and establish who is living there. There is no record of such an audit being undertaken for this property and C&C were not aware that Kat was living there from November 2012. In fact, the designated Housing Officer had never had contact with the tenant, Theo or Kat.

2.10.4 There were no reports of anti-social behaviour from the property and the tenant (Theo's mother) was never in rent arrears. A small number of minor repairs were reported and work to rectify these was undertaken by C&C contractors. A record of these repairs has been provided to the Review panel and none can be linked to domestic abuse taking place in the property.

2.10.5 Although the flat was shared Kat and Theo's bedroom was at the end of a long corridor well away from his mother's living accommodation and bedroom affording them privacy. Theo's Mother had no reason to access their bedroom.

## 2.11 Informal Networks

### 2.11.1 Family

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<sup>9</sup> **CORE** (COntinuous REcording) is a national information source funded by the Department for Communities and Local Government that records information on the characteristics of both Private Registered Providers' and Local Authorities' new social housing tenants and the homes they rent and buy. Policy makers and practitioners regard the system as an essential tool for monitoring housing costs, assessing affordability and developing policy. (Source: <https://core.communities.gov.uk/public/LearnAboutCORE.html>)

- 2.11.2 During the earlier phase of Kat's relationship with Theo, when Kat was living in the family home and keeping the relationship a secret from her parents, her sisters describe thinking of the dynamic as 'fiery': they would overhear Kat on the phone to Theo, sometimes raising her voice or shouting.
- 2.11.3 In November 2012, Kat moved out of the family home and in with Theo. Both Kat's secrecy about the relationship and Theo's race caused considerable upset to her parents and there was a six-month period of estrangement between them and Kat. Although they would ultimately reconcile six months later, Kat told her sisters, almost immediately after moving in with Theo, that she regretted the decision: she was not as happy as she thought she would be. Kat kept in touch with her sisters.
- 2.11.4 In summer 2013, Theo's daughter was hospitalised, for an extended period of time, with a very serious medical condition. This was incredibly stressful for the whole family. The demands on Kat increased as she was driving Theo to the hospital every day (he was banned from driving) and, in Theo's consequent absence from the home, took on more responsibility for supporting Theo's mother who was fairly frail and needed help to walk.
- 2.11.5 In November 2014, Kat told her sisters that things in her relationship with Theo needed to change if she were going to remain with him. She talked about a twelve-month timescale for this to happen.
- 2.11.6 During 2015, Kat's sisters noted the following:
- A swollen lip which Kat said had happened in play fighting with Theo;
  - Burns on her arms which didn't seem consistent with the explanation that they had happened whilst cooking;
  - Using a darker shade of foundation which, in hindsight, may have been used to cover up facial bruising
- 2.11.7 In February of that year, Theo lost his job and remained unemployed up to the point of the murder. Kat's sisters describe Theo being very reliant on her to complete job applications for him during this period and noted a jealousy of Kat's success and independence.
- 2.11.8 Two weeks before the murder took place, Kat had told her sisters that she was saving money and looking for a place to rent as she wanted to move out and get away from Theo.
- 2.11.9 **Employer**
- 2.11.10 In 2015, a year before she was murdered, Kat spoke with her employer about several factors she felt were negatively impacting on her: a need for more support with work assignments, the medical condition suffered by Theo's daughter, and 'emotional pressure' from Theo. Her employer responded

by giving her some leave from work and providing some additional support to meet the demands of her workload.

2.11.11 When Kat returned from the agreed period of leave, she made further disclosures of 'arguments' and 'relationship strains' with Theo, describing one particular incident in which Theo physically shoved her with such force against a wardrobe that it broke. Colleagues occasionally noted marks, scratches and bruises on Kat's hands and face but she explained all of these away as 'accidents' although she did confide that she was in the process of saving money so that she could leave Theo and move into accommodation of her own.

2.11.12 Following Kat's murder, her line manager advised Police that he had not known how to respond to the disclosures made by Kat about her relationship. As Kat was older than him, he did not believe that he could offer any useful advice about how to deal with the situation.



## 3. Analysis

### 3.1 Metropolitan Police

3.1.1 A significant period of time has passed since the last reports of domestic abuse perpetrated by Theo (although not against Kat) were made to police (16, 13 and 10 years respectively). The panel are agreed that the contemporaneous policies and procedures, which would have guided the Metropolitan Police's response to these reports of domestic abuse, have been subject to substantial change over the last decade. There is also therefore agreement that we are not able to elicit meaningful learning through measuring the effectiveness of these considerably historic responses against now defunct guidance. However, relevant aspects of progress in Police practice are detailed below.

#### 3.1.2 Serial Perpetrators

3.1.3 In 2014, the College of Policing (COP) adopted the term 'serial perpetrator':

'...someone who has been reported to the police as having committed or threatened domestic abuse against two or more victims. This includes current or former intimate partners and family members.'<sup>10</sup>

3.1.4 By this definition (which was not in place at the time of any of the domestic abuse reports relating to Theo), Theo's behaviour would now lead him to be identified as a 'serial perpetrator'.

3.1.5 The COP goes on to describe how there is no evidence base to time limit the monitoring of serial perpetrators:

*'There is currently no evidence base to support the use of a set time-period, e.g., a rolling three-year period, over which to measure serial offending [emphasis added]. Monitoring serial perpetrators can help to identify the known highest-risk offenders and to make decisions locally, but the overriding consideration must always be public safety. The focus in individual cases should be on up-to-date risk assessment, based on any relevant history. Relevant incidents should not be limited to those that have occurred with a set time period [emphasis added]. There are many reasons why a perpetrator may not offend in a given period, including being in prison for a significant period of time. Forces are responsible for keeping track of offenders in their area, including by being aware of those with a known history of domestic abuse offending, whether involving a current or previous partner or family member.'*<sup>11</sup>

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<sup>10</sup> <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/context/>

<sup>11</sup> Ibid

- 3.1.6 The Metropolitan Police Service has a working group on serial perpetrators which is defining, monitoring and evaluating how to respond to these individuals across London, both to hold them accountable for their behaviour and to safeguard victims from harm. The Panel has acknowledged the responsibility of the Police to monitor serial perpetrators in a proportionate way and the consequent limitations that this brings. One of the particular challenges discussed by the Panel was whether it would be proportionate to identify and monitor an individual like Theo as a serial perpetrator when he has never been proven to be guilty of the three reported acts of abusive behaviour in a criminal court.
- 3.1.7 Progress made in Police practice, requiring the completion of risk assessments<sup>12</sup> with all victims reporting domestic abuse, goes some way towards answering this question. The risk assessment process supports police to establish where a perpetrator's behaviour sits on the spectrum of risk: low / medium / high. An assessment of 'high risk' to two or more victims (and in a case like this there would be risk assessments from three victims), even without criminal caution or conviction, would meet the proportionality threshold to trigger the monitoring of the perpetrator, as described by COP above.
- 3.1.8 It is important to note that the high volume of domestic abuse cases that the MPS deals with means that decisions around monitoring not only take account of proportionality, but also resources.
- 3.1.9 Whilst present practice focuses on serial perpetrators currently coming to police attention, Kat's case demonstrates the equal importance of also targeting those with more historic records of serial perpetration (the last report of Theo perpetrating domestic abuse was ten years ago). The Panel debated whether historical cases like this could be identified, flagged as 'serial perpetrator', and monitored accordingly. There was agreement that this was neither proportionate nor possible.
- 3.1.10 **Domestic Violence Disclosure Scheme (DVDS)**<sup>13</sup>
- 3.1.11 A further progression of note is the introduction of the DVDS in 2014 (also known as 'Clare's Law'):  
'This gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner.  
  
This information may be disclosed via a request from a member of the public ("right to ask") or by an agency where a proactive decision is made to consider disclosing the information in order to protect a potential victim ("right to know").'<sup>14</sup>

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<sup>12</sup> DASH Risk Checklist: <http://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf>

<sup>13</sup> <https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance>

<sup>14</sup> <http://www.gmp.police.uk/content/section.html?readform&s=903BB34BE34EDA3180257A71002DE9EE>

- 3.1.12 The scheme enables current victims of domestic abuse, along with their family members, friends and colleagues, to obtain information about a partner's history and make more informed decisions about the relationship. We do not know whether Kat was aware of this scheme. The issue of agencies reaching Kat is an important one.
- 3.1.13 The information collated for this review indicates that Theo not only had a pattern of abusive behaviour in intimate relationships (see Table 1) but also used violent behaviour in a broader context (see Table 2). The two incidences of driving whilst disqualified only add to the concern about his disregard for the welfare of others, the law and its sanctions.
- 3.1.14 The Panel has considered whether the information known to Police about this broader context of Theo's behaviour presented missed opportunities to consider the potentially harmful impacts of this type of behaviour on intimate partners. It has concluded that these were not appropriate opportunities due to the time passed since the last offence.

## **3.2 National Probation Service & the CRC**

- 3.2.1 The verdict in the trial of 2006, specifically the finding of Theo not guilty beyond reasonable doubt of attempted GBH against his then-partner, removed any duty for the criminal justice system to take action to hold Theo accountable for his abusive behaviour in intimate relationships. This outcome renders the issue of domestic abuse invisible in subsequent interactions between the service and Theo. Although the panel discussed whether benefit would be drawn from Offender Managers using supervision mandated for other offences to pursue accountability for suspected perpetrators of domestic abuse, the majority of the Panel concluded that this would not be appropriate as it would infringe the human rights of the person found 'not guilty'.
- 3.2.2 The further two disqualified driving offences presented further opportunities to the Probation service to explore the dynamics of Theo's relationships which they duly undertook through the mandatory OASys process. As these offences had no connection to domestic abuse, the evaluation of Theo's relationships relied solely on his own assessment of them. Although it would have been useful for the Offender Managers to directly engage Theo's mother and partner to contribute to this aspect of the assessment, it is not within the power of the Probation service to reach out to partners / family of those on license to engage them in the assessment of relationship dynamics unless the index offence is related to domestic abuse.
- 3.2.3 Following the split in providers in 2014, there are now private and public Probation Services. The Community Rehabilitation Companies (MTC Novo in London) supervise medium and low risk of harm offenders (including numerous domestic violence cases), the National Probation Service manage high

and very high risk of harm cases, including domestic violence. A lot has improved since 2006 with NPS involved in Multi-Agency Safeguarding Hubs (MASHs) across London - sharing information on safeguarding etc, and NPS and CRC's contribution to MARAC and conversations around Clare's Law, (eg in MAPPA). The Spousal Abuse Risk Assessment tool (SARA) has been developed further around domestic violence and is used in the assessments at court. There are now dedicated domestic violence courts./teams/officers in NPS that provide information to for sentencing.

- 3.2.4 To ensure that these changes are meeting the needs of survivors and identifying and addressing risk in perpetrators, recommendation **(1)** is made that Ealing Community Safety Partnership ask both the CRC and NPS to reassure them that offenders without an index offence of domestic abuse but with evidence of domestic abuse in their background are assessed around risk.

### **3.3 General Practice for Kat: Harrow area General Practice**

3.3.1 Kat's contact with the GP surgery accounts for the vast majority of her interactions with public services. Indeed, her only other interactions with such services came following referrals that were made by the GP to activate more specialised components of the healthcare system. An individual such as Kat, who has such limited visibility within the broad community of public services (housing, social services, police, probation etc.), therefore requires GP practices to undertake a more active role, not only in the identification of domestic abuse, but also in activating help and support from the wider system.

3.3.2 Consequently, a recommendation **(2)** is made in this report for the practice to review their domestic abuse policy to ensure all staff at the practice understand the crucial role they each play in tackling domestic abuse and will guide them through safe and effective practices to identify and respond to survivors. The IRIS<sup>15</sup> project provides a robust evidence base from which the Medical Centre can develop a policy which should include (but is not limited to):

- A process of routine screening for domestic abuse at the registration of each patient;
- A commitment to raising the visibility of domestic abuse and relevant support services amongst patients attending the surgery (e.g. posters / leaflets in the waiting area and in consultation rooms, messages on electronic screens).

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<sup>15</sup> IRIS: Identification & Referral to Improve Safety (<http://www.irisdomesticviolence.org.uk/iris/domestic-abuse-and-health/introduction/>)

- A plan to support the implementation of the policy in operational practice through regular training;
- Clear and up-to-date referral pathways to specialist domestic abuse support services.

3.3.3 The two episodes of Kat's presentation to the GP (gynaecological issues and unexplained pain) provided opportunities for active enquiry about domestic abuse. However, staff at the practice did not make the links between the nature / patterns of these presentations and the possibility that they were indirect manifestations of domestic abuse. Subsequently, the opportunities to enquire were missed.

3.3.4 Practice improvement in this area will require: firstly, the development of clear guidelines on triggers for targeted domestic abuse enquiry (e.g. gynaecological issues, UTIs, unexplained pain); and secondly an on-going programme of training to equip staff to fulfil this part of their remit and respond safely and effectively to any resultant disclosures. Recommendations (**3 and 4** respectively) are made in this report to reflect these requirements. Achieving good practice in this area will mean that survivors will be identified earlier on, preserving resources invested in inappropriate investigations (e.g. unexplained pain), and be offered appropriate help:

*'...healthcare professionals not trained to identify domestic violence and abuse may mislabel and misdiagnose people's problems, leading to inappropriate plans or ineffective remedies. (For example, specialists may be ordering unnecessary and expensive investigations and GPs may be prescribing inappropriate anxiolytics and antidepressants.)'<sup>16</sup>*

3.3.5 The overwhelming pressure on GPs to respond to the huge volume and broad scope of patient needs is well documented. Limited appointment times may create additional barriers for BME women to feel comfortable to disclose personal issues. A 2016 study by The King's Fund<sup>17</sup> to understand the pressures in general practice describes the profession as being 'in crisis':

*'General practice is in crisis. Workload has increased substantially in recent years and has not been matched by growth in either funding or in workforce. [...] Pressures on general practice are compounded by the fact that the work is becoming more complex and more intense.'<sup>18</sup>*

3.3.6 In order to support the Medical Centre to effectively meet the needs of domestic abuse survivors, within the recognised pressures of the current fiscal environment, a recommendation (**5**) has been

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<sup>16</sup> <https://www.nice.org.uk/guidance/ph50/chapter/4-considerations>

<sup>17</sup> Understanding pressures in general practice, 2016: [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf)

<sup>18</sup> Ibid, page 3

made for Harrow CCG to commission the IRIS programme. The programme would ensure that adequate and specialised resources be delivered to this area of work.

### **3.4 General Practice for Theo: Ealing Area General Practice**

3.4.1 Consent from perpetrator to view medical records not received.

### **3.5 London North West Healthcare NHS Trust**

3.5.1 The Trust recognises that Kat's disclosure of 'stress at work and at home' was a missed opportunity to explore the dynamic of her relationship with Theo and create an opportunity for domestic abuse enquiry / disclosure. It is important that staff within the Trust feel adequately skilled and confident to discuss and probe with patients the dynamics of their relationships. The need for direct enquiry from professionals (rather than an expectation of spontaneous disclosure from survivors) is well documented.

3.5.2 The Trust already has a domestic abuse policy to structure and support its workforce's approach to the issue. The Panel has reviewed this document and made a recommendation (6) to consult with staff across the Trust on the utility and practicability of the policy in its current form and use any information gathered to support the current refreshment process. As described above (par 3.3.2) the evidence base provided by IRIS would also support the evolution and improvement of this document.

3.5.3 Through this Review, the Trust has recognised a need for further training and supervision in order for staff to be adequately equipped to practice safely, effectively and consistently around domestic abuse. Recommendations (7 and 8 respectively) are made in this report to reflect these needs.

3.5.4 The Trust can be commended for its sharing of the important 'stress'-related information disclosed by Kat within the letter it sent back to her GP.

### **3.6 Central & Cecil Housing Trust (C&C)**

3.6.1 Through this Review process, C&C have identified the need to comply with their annual tenancy audit policy Recommendation (9). Had an audit taken place, it is likely that Kat's residence at the property would have been identified. Although we cannot make any linear link between the identification of Kat as a resident and the prevention of her murder, it is now clear that there would have been benefit to the Housing Officer making contact with Kat and identifying themselves as a source of information

and support. We cannot know whether Kat would have called on them for domestic abuse support but by creating the opportunity for disclosure and to receive subsequent help, the Trust may safeguard future survivors from harm.

- 3.6.2 A recommendation (10) is made in this report for C&C to expand the tenancy audit policy to include the requirement for Housing Officers to make direct contact with all identified residents as early as possible and to identify themselves as sources of information and support. In order to support staff to receive any subsequent domestic abuse disclosures, a further recommendation (11) is made for C&C to separate domestic abuse from its Anti-Social Behaviour policy and create a stand-alone domestic abuse policy that makes clear to its workforce how to respond safely to disclosures, activate a coordinated multi-agency response to protect survivors (and any children), and hold perpetrators to account. This policy should include measures to generate greater awareness of domestic abuse amongst tenants (whether as direct survivors or agents to support the safeguarding of others) and make sources of support visible, including local and national specialist domestic abuse support services and what to do if you are concerned about a neighbour. A very simple strategy that was identified when the Review Chair visited Theo' mother and met with the designated Housing Officer, was the display of support service / concern raising information in communal areas of the buildings.
- 3.6.3 To ensure effective, safe and consistent implementation of the above, C&C will additionally need to commit to undertaking regular training (which should include good practice around intersectionality) with staff and a recommendation (12) has been made to reflect this.
- 3.6.4 It is notable that during the period of Kat's residence at the flat, the only professionals to access the property were contracted repairs personnel. It is vital that these workers are adequately equipped to recognise the signs of domestic abuse and have a clear process through which to alert the landlord to take safeguarding action:
- Protecting vulnerable children and adults is one of the most challenging and important roles that frontline housing staff perform. Because they regularly enter people's homes – for example, to carry out repair work or talk about benefit reform – they are one of the few agencies capable of spotting the early signs of abuse and making sure something is done about it.<sup>19</sup>*
- 3.6.5 A recommendation (13) is made in this report for C&C to ensure that contracted personnel are appropriately trained to recognise signs of abuse. A further recommendation is made (14) to ensure

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<sup>19</sup> Spotting the Signs by Martin Hildith. Inside Housing – 26<sup>th</sup> November 2014. <http://www.insidehousing.co.uk/spotting-the-signs/7006995.article>

that contracted personnel have and utilise an effective channel through which to alert the landlord to concerns requiring action / investigation.

- 3.6.6 C&C's Safeguarding Vulnerable Adults policy is due to be updated and a recommendation **(15)** has been made in this report to incorporate current legislation and best practice evidence around domestic abuse into this policy. For example when a person is identified as using abusive behaviour and they have a caring responsibility is intimate partner violence considered and enquired about and vice versa?

## **3.7 Informal Networks**

### **3.7.1 Family**

- 3.7.2 Perceptions of relationships by friends and family, such as 'fiery', 'volatile' or 'passionate', can sometimes obscure what professionals would describe as abusive. It is vital that we equip friends, families and communities with adequate awareness and knowledge of domestic abuse because they play such a vital role in reaching victims, like Kat, who may otherwise not come to the attention of services. These informal networks can play a vital role in supporting victims to name abuse in relationships and developing the confidence to reach out to specialist support services for help. The CSP may wish to discuss how to increase community education about domestic abuse.

## **3.8 Employer**

- 3.8.1 It is important to recognise the achievement of Kat's employer in creating a space that felt safe enough for her to disclose and discuss the dynamic of her relationship with Theo. The commitment to their duty of care to Kat is clear through the leave and additional workload help they offered her. However, the opportunity to connect her with specialist domestic abuse support services was not maximised and as a result, a recommendation **(16)** is made for a domestic abuse policy to be developed for the organisation. This will support staff to enquire, recognise signs, feel confident to respond safely to disclosures and activate specialist support pathways.
- 3.8.2 A further recommendation **(17)** is made for the organisation to develop at least one member of staff as a domestic abuse champion. This individual will receive training on domestic abuse so that they can lead on raising and maintaining the profile of domestic abuse within the organisation and be a point of contact for those looking for information, whether those are concerned colleagues / line managers or survivors.



3.8.3 The Women's Aid *Change that Lasts*<sup>20</sup> approach recognises the powerful role that the broader (non-statutory) community, including employers, can play in tackling domestic abuse. One particular strand of the approach, the *Ask Me*<sup>21</sup> scheme, calls on local authorities to engage their local businesses in taking an active role in getting survivors to the right help at the earliest opportunity. Recommendations (18) are made for both the City of London and Ealing to consider adopting this scheme.

### 3.9 Equality and Diversity

- 3.9.1 The Review Panel identified the following protected characteristics of Kat and Theo as requiring specific consideration: ethnicity and the inter-racial relationship, a caring responsibility and sex.
- 3.9.2 *Ethnicity*: Kat was British Asian and was born in the UK, Theo was a British African- Caribbean man and the difference of backgrounds was an issue for Kats family. Although Kat had repaired her relationship with her family before the murder occurred so it is unlikely that this would have prevented her seeking help or support. The Asian community represents 29% of the local population and the Black African 10.9% according to the 2011 census.
- 3.9.3 To inform the discussion of BMER victim/survivors experience of domestic violence specifically, the Review Panel benefited from being able to draw on the experience of the representative from Southall Black Sisters.
- 3.9.4 While there is no evidence to indicate that Kat accessed help and support from a domestic violence service the Review Panel felt that, given the potential barriers to access to help and support that she might have faced because of their ethnicity, it is in scope of the review to consider the issue of provision for BMER victim/survivors.
- 3.9.5 A recent report by Imkaan<sup>22</sup> defines specialist BME led organisations as “independent, specialist and dedicated services run by and for women from the communities they seek to serve”, which:
- Work in ways that are not only about individual women and girls' safety, and/or the safety of their children, but are also about BME women's autonomy, freedom and self-determination.
  - Recognise the continuum of violence against women and girls and seek to offer support around every aspect of women's needs, ensuring a holistic, needs led response.

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<sup>20</sup> <https://www.womensaid.org.uk/our-approach-change-that-lasts/>

<sup>21</sup> <https://www.womensaid.org.uk/our-approach-change-that-lasts/askme/>

<sup>22</sup> Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*, London: Imkaan. [<http://imkaan.org.uk/resources>]

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- Work across the spectrum of risk and need, understanding the fluctuating nature of risk and are adept at recognising 'hidden' risk indicators.
- Are skilled in identifying indicators and experiences of specific forms of Violence Against Women and Girls (VAWG) that may be missed within a mainstream domestic violence organisation.
- In offering a range of services, are able to access women who may not even recognise their experiences as violence.
- Create flexible and diverse support systems, sensitive to the fact that for many BME women, refuge and support services may be unfamiliar and/or stigmatised.<sup>23</sup>

3.9.6 It is positive therefore that there is such provision in Ealing, provided by SBS. However, the same Imkaan report noted that BME specialist services are under considerable pressure in London with implications for the sustainability of such specialist provision. The report concludes that it "*is important that this support covers all areas of VAWG and that it includes the protection of specialist BME ending VAWG organisations*".

3.9.7 It is beyond the scope of this review to make a recommendation as to how to sustain BME specialist services, but the Review Panel identified the importance of individual areas being aware of their local population, including the level of need and the requirement for specialist BME led provision. In considering how to achieve this, it is important to recognise that some of those BME victim/survivors will be men.

3.9.8 However, the Review Panel recognised that for individual London boroughs it is neither possible nor desirable for areas to work alone in this regard, and that there is therefore a wider regional importance to ensure that BME led specialist services are sustained in order that BME victim/survivors can access help and support in an environment where staff have the knowledge and expertise in providing support to those affected by various forms of violence in specific individual, family and community contexts.

3.9.9 Although Theo's Mother may not have met the threshold for a carers assessment both Kat and Theo supported her in her activities of daily living. There are two important issues to consider, did the need to care for her prevent or postpone Kats decision to leave and possibly seek help.

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<sup>23</sup> Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*, London: Imkaan. [<http://imkaan.org.uk/resources>]

- 3.9.10 Was any risk to Theo's mother considered bearing in mind his previous violence and abuse. It is unlikely that any caring agency (bearing in mind that his daughter also used carers) was aware of his offending past so it's difficult to see how they could have reacted to it. However, it is worth considering what action may have been taken if it had of been known.
- 3.9.11 As already described Kat being female increased her risk of domestic abuse and although her employer was aware of issues his gender and age prevented him from feeling confident to talk to her about it.

### 3.10 Lessons Learnt

- 3.11 *Serial Perpetrators:*** Some themes emerge for the learning that has taken place throughout this review. The issue of serial perpetrators especially when there is not an index offence of domestic abuse may present a risk but be hard to track, especially if any reported incidents are many years ago.
- 3.12 *Employers:*** Employers have an important role to play in supporting staff who are experiencing abuse, but it is important that they receive training to feel confident and competent to address issues if they arise
- 3.13 *Wider Community:*** It is important that the wider community knows where to seek help, so that if a friend or family member experience abuse they feel able to offer appropriate support
- 3.14 *General Practice:*** General practice and especially at routine appointments are an ideal opportunity to enquire about relationships and safety.
- 3.15 *Housing Providers:*** Housing providers also have an excellent opportunity to provide support to tenants who may be experiencing domestic abuse if they have been trained to notice signs and feel confident to talk with tenants safely.

## 4. Conclusions and Recommendations

### 4.1 CONCLUSIONS

4.1.1 It is a deeply uncomfortable conclusion that, despite Theo coming to the attention of the criminal justice system on several occasions, and at various levels, this review has found no proportionate changes that could better hold perpetrators like him to account to reduce the likelihood of these known behaviour patterns escalating to murder and protecting the lives of women like Kat.

4.1.2 However, it is positive to have identified some ways in which services could better reach those surviving abusive relationships, as we now know Kat did for many years. Until we develop more robust mechanisms through which to hold perpetrators to account for their abusive behaviour, and ultimately prevent domestic abuse from happening in the first place, we will continue to need to develop innovative strategies to educate communities, reach survivors and disrupt perpetrators in order to achieve safety.

### 4.2 REVEIEW PANEL RECOMMENDATIONS

#### 4.2.1 Ealing Community Safety Partnership

4.2.2 **Recommendation 1** Ask both the CRC and NPS to reassure them that offenders without an index offence of domestic abuse but with evidence of domestic abuse in their background are assessed around risk.

#### 4.2.3 Harrow Area General Practice

4.2.4 **Recommendation 2:** Review the current domestic abuse policy to ensure it incorporates learning from this review

4.2.5 **Recommendation 3:** Develop a guideline for triggers for targeted domestic abuse enquiry. abuse (e.g. gynaecological issues, UTIs, unexplained pain) this would be achieved by implementing recommendation 6

4.2.6 **Recommendation 4:** Continue annual domestic abuse training programme, which includes information on use of personal/social information and links to local specialist provision

#### 4.2.7 Harrow CCG

4.2.8 **Recommendation 5:** Consider the option to commission the IRIS programme.

#### 4.2.9 London North West Hospitals NHS Trust

4.2.10 **Recommendation 6:** Consult with staff across the Trust on the utility and practicability of the domestic abuse policy in its current form and use any information gathered to support the refreshment process.

4.2.11 **Recommendation 7:** Domestic abuse training programme to be enhanced.

- 4.2.12 **Recommendation 8:** Supervision around domestic abuse cases to be enhanced.
- 4.2.13 **Central & Cecil Housing Trust (C&C)**
- 4.2.14 **Recommendation 9:** Audit compliance with annual tenancy audit policy.
- 4.2.15 **Recommendation 10:** Expand the tenancy audit policy to include the requirement for Housing Officers to make direct contact with all identified residents as early as possible to identify themselves as sources of information and support.
- 4.2.16 **Recommendation 11:** Develop and implement a stand-alone domestic abuse policy. This policy should include measures to generate greater awareness of domestic abuse amongst tenants and make sources of support visible, including local and national specialist domestic abuse support services.
- 4.2.17 **Recommendation 12:** Create access to domestic abuse training for staff.
- 4.2.18 **Recommendation 13:** Ensure that contracted personnel are appropriately trained to recognise signs of abuse.
- 4.2.19 **Recommendation 14:** Ensure that contracted personnel have and utilise an effective channel through which to alert the landlord to concerns.
- 4.2.20 **Recommendation 15:** Update the Trust's Safeguarding Vulnerable Adults policy to incorporate current legislation and best practice evidence and cross-reference the above with a domestic abuse policy.
- 4.2.21 **Informal Networks:**
- 4.2.22 **Recommendation 16:** Kat's employer to develop and implement a domestic abuse policy and consider joining the Employers Initiative for Domestic Abuse
- 4.2.23 **Recommendation 17:** Kat's employer to identify and support the development of at least one domestic abuse champion.
- 4.2.24 **Recommendation 18:** City of London/Westminster and Ealing to consider adopting the *Ask Me* scheme.

# Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Kat and Theo following the death of Kat. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

## Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Kat and Theo during the relevant period of time.
3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
6. To commission a suitably experienced and independent person to:
  - a) chair the Domestic Homicide Review Panel;
  - b) co-ordinate the review process;
  - c) quality assure the approach and challenge agencies where necessary; and
  - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

8. On completion present the full report to the Ealing Community Safety Partnership.

### **Membership**

9. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

10. The following agencies are to be on the Panel [amend as appropriate]:

- a) Clinical Commissioning Group
- b) General Practitioner for the victim and perpetrator
- c) Hospital
- d) Local Authority Adult Social Care Services
- e) Local Authority Community Safety
- f) Local Authority Housing services
- g) C&C Housing
- h) Local domestic violence specialist service provider e.g. Women's Aid / IDVA
- i) Mental Health Trust
- j) NHS England
- k) Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
- l) Probation Service

11. The Panel recognise that the particular issues in this case are gender and ethnicity and therefore Southall Black Sisters will be invited to act as experts on this area to advise the Panel.

12. [If there are other investigations or inquests into the death, the panel will agree to either:

- a) run the review in parallel to the other investigations, or
- b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.]

### **Collating evidence**

13. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

**FINAL VERSION FOR publication**

14. Chronologies and IMRs will be completed by the following organisations known to have had contact with Kat and Theo during the relevant time period, and produce an Individual Management Review (IMR):
- a) Metropolitan Police Service
  - b) National Probation Service
  - c) C&C Housing
  - d) GPs for Kat and Theo
  - e) London North West Healthcare NHS Trust
15. Further agencies may be asked to completed chronologies and IMRs if their involvement with Kat and Theo becomes apparent through the information received as part of the review.
16. Each IMR will:
- a) set out the facts of their involvement with Kat and/or Theo
  - b) critically analyse the service they provided in line with the specific terms of reference
  - c) identify any recommendations for practice or policy in relation to their agency
  - d) consider issues of agency activity in other areas and review the impact in this specific case.
17. Adult Safeguarding will produce a Summary of Engagement to capture any involvement with Theo's mother and/or daughter.
18. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Kat and Theo in contact with their agency.

**Analysis of findings**

19. In order to critically analyse the incident and the agencies' responses to Kat and/or Theo, this review should specifically consider the following points:
- a) Analyse the communication, procedures and discussions, which took place within and between agencies.
  - b) Analyse the co-operation between different agencies involved with Kat / Theo [and wider family].
  - c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
  - d) Analyse agency responses to any identification of domestic abuse issues.
  - e) Analyse organisations' access to specialist domestic abuse agencies.
  - f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.



- g) [Add specific issues to the case]

*As a result of this analysis, agencies should identify good practice and lessons to be learned. The Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.*

### **Development of an action plan**

20. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Community Safety Partnership on their action plans within six months of the Review being completed.
21. Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

### **Liaison with the victim's family and perpetrator**

22. Sensitively attempt to involve the family of Theo in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Victim Support Homicide Service.
23. Invite Theo to participate in the review, following the completion of the criminal trial.
24. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
25. [Coordinate with any other review process e.g. those concerned with the child/ren of the victim and/or perpetrator.]

### **Media handling**

26. Any enquiries from the media and family should be forwarded to the Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

27. The Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

### **Confidentiality**

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents to be password protected.

### **Disclosure**

31. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

32. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:

- a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
- b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
  - i) It is needed to prevent serious crime
  - ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

## Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<i>What is the overarching recommendation?</i>	<i>Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)</i>	<i>How exactly is the relevant agency going to make this recommendation happen?  What actions need to occur?</i>	<i>Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?</i>	<i>Have there been key steps that have allowed the recommendation to be enacted?</i>	<i>When should this recommendation be completed by?</i>	<i>When is the recommendation and actually completed?  What does the outcome look like?</i>

## Appendix 3: Standing Together Against Domestic Violence Projects

Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. It is currently involved in delivering the following projects:

MARAC Team – Co-ordinate Ealing, Haringey, London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea and Westminster Multi-Agency Risk Assessment Conference's.

Health Team – We bring together those providing health services including mental health and maternity in our local area into an operational group. Through the group we start conversations about domestic abuse within and between different agencies and different sectors. We inform, guide, and monitor the activity of the group to ensure that their work is safe, effective, and responds to the shifting needs of domestic abuse survivors and their children.

National Pathfinder project – Funded through the Tampon Tax, the Pathfinder Consortium brings together domestic abuse systems leaders from Safe lives, AVA, IRISi, and IMKAAN to establish comprehensive health practice in relation to domestic abuse in acute hospital trusts, mental health trusts and community health trusts. The Consortium is working with three selected Pathfinder sites over three years to enhance and bring new approaches to existing activity. The consortium contributes time and expertise to support the Pathfinder sites to develop a sustainable health response.

Domestic Abuse Housing Alliance – Standing Together is one of 3 agencies leading change for cohesive policies and strategies for tackling domestic violence and housing globally.

Courts – In 2002, Standing Together was instrumental in the development of one of the UK's first Specialist Domestic Abuse Court at Hammersmith Magistrates' Court, London in 2002. In 2012, Standing Together established another SDAC at Westminster Magistrates' Court. Our team track cases, coordinate support agencies from all sectors, produce resource packs, produce data reports and conduct annual reviews of the SDACs.

Housing First – The Housing First and Homelessness project aims to develop the Housing First approach in the tri-borough to support homeless women affected by domestic abuse and multiple disadvantage. We also

work to improve cross sector understanding between the homelessness and domestic abuse sectors, and provide training on domestic abuse and multiple disadvantage tailored for homelessness providers.

Safety Across Faith and Ethnic (SAFE) Communities Project - The SAFE Communities project will ensure that domestic abuse and violence against women and girls are tackled holistically by targeting support to those in the tri-borough area who are likely to be approached first by survivors for help. Grassroots communities and faith groups have the power and potential to make a real difference in the lives of survivors and hold perpetrators to account.

DHR - Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 40 reviews, including 41% of all London DHRs from 01/01/2013 to 17/05/2016. We share the learning from DHR's nationally to spread the learning from these tragic events.