HACKNEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the murder of Sarah

August 2019

Independent Chair and Author of Report: Shabana

Kausar Associate, Standing Together Against Domestic

Abuse Date of Final Version: June 2023

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"My sister was around 12 years older than me, but we were very close, she was in fact my favourite sister. Sarah was a very kind-hearted and helpful person, always wanting to offer her help in any situation. She offered much needed support to me when I left home. Sarah was a very assertive person and wasn't shy to speak her mind which was something I admired about her.

Sarah was very artistic and creative which showed in her style of dressing, she absolutely loved clothes and was always very colourful. On Valentine's Day she would be dressed in full red, she would wear Jamaican colours when it was carnival, she would always wear the colours to represent a theme or event. She was a very good cook who enjoyed cooking and feeding people. The last time the entire family were together was 6 years ago, my sister has 4 children and 3 grandchildren, 2 of whom she never got the chance to meet.

This doesn't get any easier, but we try.

She is truly missed by us all."

Pen portrait of Sarah by her sister

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1. Preface

1.1 The Incident

1.1.1 This review concerns the circumstances leading to the homicide of 44-year-old Sarah,[1] by Michael[2] who had a history of serious violence and domestic abuse. Sarah and Michael had a relatively short relationship before the homicide took place in her home. SARAH lived by herself in a flat in Hackney, where she would be regularly visited by the perpetrator after meeting him in April 2019.

1.1.2 Sarah has been described by her family as someone who faced a number of challenges, but despite this, was a strong 'fighter.' Sarah has also been described as always being a helpful person who 'wanted to do the best for the people around her. She always helped others.'

1.1.3 The perpetrator killed Sarah in her bedroom by causing significant injuries consistent with blunt force trauma to the head and torso. Before leaving the flat, he covered the body with various items found within the flat. Concerns raised by family members led to the police being called two days later, entry being forced into the

flat, and the discovery of her murder in August 2019.

1.1.4 After his arrest, Michael denied killing Sarah and instead placed blame on a former partner of Sarah's. Michael was violent and abusive to police officers whilst in detention. On the second day of his trial for murder, he changed his plea from not guilty to guilty. He was sentenced to life imprisonment with a minimum term of 23 years. Michael refused to attend court for his sentencing.

1.1.5 The Review Panel expresses its sympathy to the family of Sarah for their loss and thanks them for their contributions and support for this process.

1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').

1.2.2 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to Sarah, a resident of Hackney, prior to the point of her homicide at her home in August 2019.

1.2.3 The review will consider agencies contact/involvement with Sarah and Michael from 14th July 2017 to August 2019, which is the period that the scope of the review will be examining.

[1] Not their real name.
[2] Not their real name.

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1.2.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.2.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.6 This review process does not take the place of the criminal or coroners' courts, nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review was commissioned by Hackney Community Safety Partnership. Initially, Sarah's death had not been identified as a domestic homicide due to Michael not being identified as an intimate partner/ex-partner nor that he was living in Sarah's home. The Local Authority received notification from Victim Support in February

2020 that they were supporting Sarah's family and that her death appeared to fall within the definition of a Domestic Homicide. Following this, the Local Authority liaised with Metropolitan Police Service (MPS) colleagues to obtain their agreement that a DHR be initiated. A decision was formally made to conduct a Domestic Homicide Review by Hackney's Community Safety Partnership on 25th February 2021. Subsequently, the Home Office was notified of the decision in writing on 1st March 2021.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review on 17th March 2021. The completed report was handed to Hackney Community Safety Partnership in May 2023. In May 2023, it was tabled at a meeting of the Hackney Domestic Homicide Review Implementation Group and signed off, before being submitted to the Home Office Quality Assurance Panel on 25th June 2024 following content in all sections of the Action Plan being completed by the relevant agencies. In 18th December 2024, the completed report was considered by the Home Office Quality Assurance Panel. In 22nd January 2025, the Hackney Community Safety Partnership received a letter from the Home Office Quality Assurance Panel authorising the report for publication. The letter has been published alongside the completed report.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred due to the national arrangements to contain the spread of the COVID-19 pandemic. In addition, there was a delay in commissioning the report due to the uncertainty of the relationship

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status between the victim and perpetrator. It was initially thought that the relationship was not an intimate one, and therefore fell outside of the scope of a DHR; further discussion led to clarification and the commissioning of the DHR.

1.4 Confidentiality

1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers.

1.4.2 This review has been anonymised in accordance with the 2016 statutory guidance.

1.4.3 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Victim	Sarah
Perpetra	Michael Paul
	Emenike Alyssa
Victim's ex-p	Charlotte Elliot

These pseudonyms were agreed by the Sarah's family.
* Sarah's youngest child has been referred to as Sarah's youngest child; no pseudonym is used.

1.5 Equality and Diversity

1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process. Sarah was a 44-year-old, heterosexual, woman of Black Caribbean and South Asian heritage and a British national. Michael was a 40-year-old, heterosexual, Black man of British nationality.

1.5.2 Throughout the review, the Review Panel identified that the following protected characteristics required specific consideration:

- *Sex:* The impact of a victim's sex has been an enduring feature of domestic homicides. Analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[3] This

[3]"In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3. and Analysis of the London DHR sample (n=84) reveals gendered victimisation across both types of homicide with women representing 83 per cent (n=70) of victims (including one trans-female) and men ninety per cent of perpetrators (n=76)". Montique ,B. "*Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*" (November, 2020).

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characteristic is therefore relevant for this case as one of the victims of the homicides was female and perpetrator of the homicides was male. To date, of the nine domestic homicides that have occurred in Hackney since 2012, eight have included the homicide of a woman.

- *Ethnicity:* Both Sarah and Michael were from racially minoritised backgrounds. Research highlights the additional barriers faced by survivors from Black and racially minoritised communities in accessing services, including institutional racism, culture and religion, issues of cultural competence, and lack of diversity within frontline services.[4] The panel gave specific consideration to the potential barriers and challenges facing the victim, whilst undertaking the review. Michael is Black British, and the panel felt it was also important to consider how his lived experience and particular cultural context may have affected his help seeking patterns/perceptions or the response of services.

- *Disability:* Sarah had a number of health conditions which impacted her personal care needs. She had cirrhosis of the liver, a kidney disease, spasms in her fingers, poor standing tolerance, mobility support needs after a fall, and used a

cane when walking. She also suffered from depression and had poor mental health. Studies show that disabled women are at least twice as likely to experience domestic abuse and are twice as likely to suffer assault.[5] The panel recognised the importance of considering the impact of Sarah's health on the accessibility and responses of services.

1.5.3 In addition to the protected characteristics under the Equality Act 2010, the following have also been identified as pertinent to the lived experiences of Sarah and/or Michael:

- *Substance use and mental health needs*: Both Sarah and Michael had a long history of substance use and mental health support needs. Sarah started using substances whilst in an abusive relationship with an ex-partner at a young age. The panel felt it was important to recognise the link between experiencing trauma and using substances as a coping mechanism[6] but also to recognise any impact Sarah's substance use or mental health needs may have had on her access and engagement with services, as well as responses of services. For Michael, the panel were clear that neither substance use, nor mental health issues cause abusive behaviour but can compound existing abusive behaviours.[7] The panel, did therefore, consider how Michael's substance use and mental health needs may have compounded already abusive behaviours.

[4] Hulley J, Bailey L, Kirkman G, et al. *Intimate Partner Violence and Barriers to Help-Seeking Among Black, Asian, Minority Ethnic and Immigrant Women: A Qualitative Metasynthesis of Global Research*. Trauma, Violence, & Abuse. February 2022. [5] *https://safelives.org.uk/knowledge-hub/spotlights/spotlight-2-disabled-people-and-domestic-abuse*
[6] Herman, J *Trauma and Recovery: The aftermath of Violence from domestic abuse to political terror* Basic Books, 1992 [7] Gilchrist, G and Hegarty, K (2017) *Tailored integrated interventions for intimate partner violence and substance use are urgently needed* Drug and Alcohol Review Vol.36 Iss 1 pages 3-6.

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- *Removal of children:* The panel felt it was important to consider the impact on Sarah of the removal of her children. Evidence[8] highlights the negative impact on a parent on having children removed, and the panel considered this in relation to Sarah's perceptions of services, her substance use, and her mental health. As some racially minoritised children are statistically more likely to be removed from the care of a parent,[9]the panel considered broader structural and systemic inequalities whilst undertaking this review.

- *Socioeconomic status:* Although the panel was clear that domestic abuse can affect anyone regardless of socioeconomic status, consideration was given in this review to the accessibility and professionalisation of services engaging with Sarah, and any barriers Sarah may have faced as a result.

1.5.4 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both victim and perpetrator. This involves thinking of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community. As stated by Kimberlé

Crenshaw, “If you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be.”

- An ecological analysis considers someone’s identity and lived experiences at an individual, relational, community, and societal level. It is about how individuals relate to those around them and to their broader environment.[10]
- An intersectional analysis considers the complex ways in which differing aspect of someone’s identity and lived experience can combine or intersect in the context of structural discrimination to create heightened and persistent forms of inequality, marginalisation, disadvantage, and powerlessness.[11]

1.5.5 Taking an ecological and intersectional approach can help identify the factors that create, sustain, or exacerbate someone’s risks and needs. An ecological and intersectional approach can also identify the barriers someone may have faced in recognising or reporting domestic abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

[8] Morris L. *Haunted futures: The stigma of being a mother living apart from her child(ren) as a result of state-ordered court removal.* The Sociological Review. 2018

[9] Bywaters, P et al: *Paradoxical evidence on ethnic inequities in child welfare: Towards a research agenda.* Children and Youth Services Review, 2019 Vol. 96 PP.145-154.

[10] Further information on this approach can be found online, such as in EVAW (2011) *A Different World is Possible: A call for long-term and targeted action to prevent violence against women and girls*, https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/a_different_world_is_possible_report_email_version.pdf:

[11] Intersectionality is a term rooted in Black feminism and Critical Race Theory and coined by Kimberlé Williams Crenshaw in the 1989landmark essay “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, and furthered this in 1992 with “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color., these, amongst her other work can be accessed online for further information regarding this approach to analysis.

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1.6 Terms of Reference

1.6.1 The Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 The Review Panel was comprised of agencies from Hackney, as Sarah was living in that area at the time of the homicide. Michael was of no fixed abode but had also accessed services in Hackney. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.

1.6.3 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 14th July 2017 to the date of the homicide. This timeframe was chosen because of the length of the relationship between Sarah and Michael, the engagement with services, and the significant events leading up to the murder. Agencies were asked to summarise any relevant contact they had had with Sarah and Michael outside of these dates.

1.6.4 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance, and identified and considered the following case specific issues:

a) The individual responses of agencies to the victim and perpetrator in identification, assessment and interventions to manage the needs and risks identified for either individual and whether the responses met expected levels of practice

b) The multi-agency working involved with Sarah and/or Michael [and wider family].

c) The organisations' access to specialist domestic abuse agencies.

d) The policies, procedures, management, supervision, and training available to the practitioners involved on domestic abuse issues.

e) Particular attention was paid to:

- o How agencies identified and overcame barriers in accessing support
- o How agencies identified vulnerability and responded to individuals' experiences of multiple disadvantage
- o How agencies responded to Sarah and Michael's substance use
- o How agencies responded to Sarah's and Michael's mental health
- o How agencies responded to Sarah's and Michael's race

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- o How Sarah's previous experiences of agencies, and their responses to her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies
- o How agencies responded to Sarah's experience of domestic abuse outside of the 'traditional' intimate partner relationship
- o The effect of the loss of her children on Sarah and what assessment was undertaken, and support/interventions offered to Sarah when her children were subject to consideration by Children's Services
- o How agencies responded to concerns regarding Sarah's self-neglect
- o How agencies responded to the Michael's history of violence against women and how agencies responded to him
- o How agencies responded to Michael's self-harm

1.6.5 To address specific issues in this case (including in relation to equality and diversity as identified in 1.5) the following agencies were invited to be part of the review due to their expertise, even though they had not been previously aware of the individuals involved:

- NIA Project: a woman only service for women and girls who have been subjected to sexual and domestic violence and abuse, including prostitution.
- IMECE: a woman only community-based charity aiming to improve the lives of Black, Asian, Minority Ethnic and Refugee women.

1.7 Methodology

1.7.1 The Review applies the statutory definition[12] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse

(e) psychological, emotional, or other abuse

1.7.2 Economic abuse is defined as "any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services" (s.3: Domestic Abuse Act 2021).

[12] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

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1.7.3 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."

1.7.4 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."

1.7.5 A total of twenty-one agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, seventeen agencies had contact with Sarah and Michael, and four did not. Of the seventeen, four had only limited contact and submitted a short report. However, fifteen had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared by these agencies.

1.7.6 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned.

1.7.7 All reports received were comprehensive and enabled the Review Panel to analyse the contact with Sarah and/or Michael, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were

received.

1.7.8 In some cases, IMRs/Short Reports reported changes in practice and policies over time and thirteen made single agency recommendations of their own (these are described in section 5).

1.7.9 *Documents Reviewed:* In addition to the above information, the Review Panel and/or Chair reviewed a number of other documents during the review. Where appropriate, these are referenced in the report.

1.8 Contributors to the Review

1.8.1 The following agencies were contacted, but recorded no involvement with either Sarah or Michael:

- IMECE
- NIA Ending Violence
- Turning Point
- Kings College Hospital Sexual Assault Referral Centre

1.8.2 The following agencies and their contributions to this review are:

The National Probation Service (for Michael)	IMR and Chronology
Westminster Drug Project	IMR and Chronology

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Homerton University Hospital NHS Foundation Trust: Adult	Safeguarding IMR and Chronology
Hackney Housing Services	IMR and Chronology
Barts/Royal London Hospital	IMR and Chronology
City Road Medical Centre	IMR and Chronology
Hackney Homelessness Services	IMR and Chronology
East London NHS Foundation Trust	IMR and Chronology
Somerford Grove Surgery	IMR and Chronology
Metropolitan Police Service	IMR and Chronology
Hackney Adult Social Care	IMR and Chronology
Hackney Family Social Care	IMR and Chronology
Domestic Abuse Intervention Service	IMR and Chronology
London Ambulance Service	IMR and Chronology
Homerton University Hospital NHS Foundation Trust: Children	Safeguarding IMR and Chronology
Hackney Education Services	Short Report and Chronology
Turning Point Substance Use Service	Short Report and Chronology
Victim Support	Short

The National Probation Service (for Sarah)

1.9.1 The Review Panel members were:
Short Report and Chronology

1.9 The Review Panel Members

Mary O'Reardon	Designated Safeguarding Adults Manager NHS North East London CCG
Mary Lee	Designated Nurse for Safeguarding Children NHS Northeast London CCG

Jessica Woods GP MARAC Liaison Nurse	Homerton University Hospital NHS Foundation trust
Bunmi Shoyinka Health Visitor with Special interest in Domestic Violence	Homerton University Hospital NHS Foundation trust

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Andrea Walton	Interim Safeguarding Adult Lead Homerton University Hospital NHS Foundation trust
Roisin Gavin	Safeguarding Adults Team Barts/Royal London Hospital
Dawn Mountier	Safeguarding Officer London Ambulance Service NHS Trust
Liaqat Hussain	Safeguarding Lead Somerford Grove Surgery in Hackney

Kareen Jeremiah	Practice Manager Somerford Grove Surgery in Hackney
Philly O'Riordan	Safeguarding Partner City Road Medical Centre in Islington
John Binding	Head of Adult Safeguarding London Borough of Hackney Adult Social Care
Laura Demetriades	Service Manager Safeguarding and Reviewing London Borough of Hackney Children and Family Services
Frida Lannemyr	Service Manager: Multi-agency Safeguarding Hub London Borough of Hackney Children and Family Services
Cathal Ryan	Service Manager: Domestic Abuse Intervention Service and VAWG Lead London Borough of Hackney Community Safety Partnership
Billy Baker	Principal Officer, Pupils Out of School Hackney Learning Trust
Wayne Hylton	ASB & Estate Safety Manager London Borough of Hackney Housing Services
Carol Gayle	Operations Manager – Benefits & Housing Needs London Borough of Hackney Housing Services

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Victoria Winfield-Brown	Named Professional for Safeguarding Children East London NHS Foundation Trust
Jude Unsworth	Safeguarding Manager Turning Point
Sue Smith	Quality Co-ordinator Westminster Drugs Project
Selma Taha	Acting Director of Operations NIA Ending Violence
Rachel Nicholas	Head of Service Victim Support
Senay Dur	Director IMECE
Jim Mitchell	Detective Inspector Metropolitan Police Service
Justin Armstrong	Review Officer Metropolitan Police Service
Stephanie Salmon	Head of Probation Delivery Unit: City of London & Hackney National Probation Service (NPS)
Antony Rose	Head of Newham Probation Delivery Unit National Probation Service (NPS)
Paula Harding	Associate DHR Chair Standing Together

1.9.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.9.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 21st July 2021. There were subsequent meetings on 9th December 2021, 4th May 2022, and 5th October 2022. There were some delays in between meetings due to staff capacity.

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1.9.4 The Chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

1.10 Involvement of the Victim's Family

1.10.1 The Review Panel sought to involve Sarah's family in this review. The Terms of Reference were shared with them to assist with the scope of the review. The family were updated on progress, and they reviewed the draft report in private, with the opportunity to comment and make amendments if required.

Victim's Family:

Alyssa Daughter	Online Interview
Charlotte Mother	Online Interview

1.10.2 Once the decision to conduct the DHR had been confirmed on February 25th, Hackney Community Safety Partnership notified Sarah's sister of this decision in March 2021; a letter was sent via the police Family Liaison Officer (FLO), along with the Home Office leaflet, information on Advocacy After Fatal Domestic Abuse (AAFDA)[14] and the Victim Support Homicide Service (VSHS).[15]In May 2021, the Chair also wrote to Sarah's sister, including additional information on the DHR process. These letters were also sent via the FLO.

1.10.3 The Chair also reached out to Sarah's family via the Victim Support Homicide Case Worker to offer involvement in the review. The Chair highlighted that any participation in the review was voluntary and that they could contribute in the way they found best. Charlotte and Alyssa were keen to be take part and a meeting was arranged to go through the draft Terms of Reference and key lines of enquiry. Due to social distancing regulations, this meeting was held via Zoom, with the family and the Domestic abuse Intervention Service Manager. The meeting provided a valuable insight into who Sarah was and has helped bring her voice to this report.

1.10.4 The draft Overview Report was shared with the family in February 2023.

1.11 Involvement of the Perpetrator

[13] Not their real name
[14] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.
[15] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

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1.11.1 In November 2021, the perpetrator was sent a letter from the Chair via the probation officer with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. The perpetrator sent back the signed consent form and the Chair met him in prison for interview on 10th March 2022.

1.11.2 A summary of his interview is at section 4.2.

1.12 Parallel Reviews

1.12.1 Beyond criminal proceedings, the Review Panel were not made aware of any other parallel proceedings.

1.12.2 *Criminal trial:* Michael was charged with murder in December 2020. Michael initially pled not guilty before changing his plea to guilty and was sentenced to life in prison with a minimum term of 23 years in jail.

1.12.3 The Senior Investigation Officer (SIO) was invited to the first meeting of the Review Panel to share information about the criminal investigation and address issues in relation to disclosure.

1.12.4 *No parallel reviews:* The death of Sarah was referred to the HM Coroner, and an inquest was opened and adjourned at Poplar Coroner's Court. Following Michael's conviction, Her Majesty's Coroner decided no investigation was required and therefore closed the matter. Consequently, following the completion of the criminal investigation and trial, there were no parallel reviews that impacted upon this review.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The Chair and author of this DHR is Shabana Kausar, an Associate of Standing Together. Shabana has received Domestic Homicide Review Chair's training from Standing Together. She has extensive experience in the domestic violence sector, having worked in both statutory and voluntary sector organisations. As a Violence against Women and Girls Strategic Lead, Shabana has commissioned and led reviews on behalf of three Local Authority areas in London. She is currently undertaking a PhD on Violence against Women at University of London.

1.13.2 Standing Together 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).[16] 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. Standing Together has been involved in the Domestic Homicide Review process from its

[16] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

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inception, chairing over 90 reviews across England and Wales from 2013 until present day.

1.13.3 *Independence:* Shabana Kausar has no connection with Hackney Community Safety Partnership, or with any of the agencies involved in this case.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Hackney Community Safety Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with Hackney's Domestic Homicide Review Implementation Group and VAWG Strategic Board, and also published. There will be a range of dissemination events to share learning.

1.14.3 The Executive Summary and Overview Report will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC)/the Office of the Domestic Abuse Commissioner/the Police and Crime Commissioner for Hackney.

1.14.4 The recommendations will be owned by the Hackney Community Safety Partnership), with the Service Manager at Hackney Domestic Abuse Intervention Service being responsible for monitoring the recommendations and reporting on progress.

1.15 Previous Case Review Learning Locally

1.15.1 This is the fifth DHR commissioned locally.[17]

1.15.2 The Review Panel considered the learning and recommendations from other reviews in the analysis, and the development of recommendations for this DHR. These have identified the following learning and/or recommendations as relevant to this DHR:

- Review risk assessment processes across the partnership agencies to ensure completion, and
- Common understanding of risk and correct referral processes.

1.15.3 These issues are discussed in the analysis.

[17] To access published DHRs, go to: https://hackney.gov.uk/domestic-abuse-support

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2. Background Information (The Facts)

Referred to in report as	**Relationship to the victim**
Sarah	Victim
Michael	Perpetrator
Paul	Ex-partner
Alyssa	Daughter
Charlotte	Mother
Elliot	Sarah's Neighbour and casual partner

2.1 The Homicide

2.1.1 *Homicide:* Michael killed Sarah in the bedroom of her one-bedroom flat in Hackney in August 2019. On the day of Sarah's murder, Michael visited her at her flat at 4.52pm, and in the nineteen minutes that followed, he launched a brutal and fatal attack on her, inside her property. After fatally injuring Sarah, Michael hid her body by covering her on the floor with various items found within the flat. He can then be seen on CCTV footage leaving the flat at 5.11pm, using Sarah's keys to lock an outer metal security gate which protected the flat. Concerns were raised by family two days later, after they were unable to reach Sarah, resulting in the police forcing entry into the flat and discovering Sarah's murder.

2.1.2 When he was tracked down by police, Michael said the police had the wrong person and placed the blame on Sarah's' ex-partner, Paul, who had initially been arrested on suspicion of murder. In the period following Michael's arrest, on a number of occasions he was verbally abusive to various officers and threatened to kill officers and members of the custody staff. He continued to deny murdering Sarah and accused the police of tampering with CCTV footage.

2.1.3 *Criminal trial outcome:* The perpetrator pleaded not guilty at court, but on the second day of his trial he changed his plea to guilty after the jury had watched the CCTV of his entrance into Sarah's flat on the day of the murder. In December 2020, Michael was sentenced to life imprisonment with a starting point of 15 years, which was increased to a minimum term of 23 years due to a number of aggravating factors. These aggravating factors included, but were not limited to, a) Sarah's vulnerability due to her lack of mobility resulting from an earlier injury b) Michael's attempt to conceal the body c) his abuse of a position of trust by befriending Sarah d) blaming another man Michael knew was innocent and e) Michael's previous convictions of assaulting and injuring women.

2.1.4 *Post-Mortem*: A Forensic Pathologist conducted a Post-Mortem examination of Sarah in September 2019. The cause of death was given as blunt force trauma to the torso and head.

2.1.5 *Judges sentencing summary:* On sentencing Michael in December 2019, the Judge said:

> *"You subjected Sarah to a brutal and sustained attack in her own home. Sarah was a small woman – she was 5'1" tall and weighed a little over six stone. She used a stick to aid walking on occasions. Her injuries caused by you were numerous. The reason why you murdered her has not been explained. I am told that a trivial matter caused you to assault her. You have convictions for offences of violence towards women. I conclude that any woman was at risk if alone with you."*

2.2 Background Information on Victim and Perpetrator

2.2.1 Background Information Relating to Victim: At the time of her death, Sarah was 44 years old, a British national, and was of Black Caribbean and South Asian heritage. Sarah had physical and mental health support needs, a long history of substance use, and she had experienced domestic abuse from ex-partners. Sarah grew up in London, lived in a one-bedroom flat by herself, and was a tenant with Hackney Council.

2.2.2 Sarah had four children, three with Paul and her fourth with Emenike. Her three eldest children with Paul were cared for by their maternal grandmother and were formally made subject to a Special Guardianship Order in August 2011. Her fourth child was in the main care of his father, Emenike. Sarah was estranged from her wider family, but did have contact with some members, which increased in the last few years preceding her murder.

2.2.3 Despite these challenges, Sarah has been described as 'always being a very helpful person' who 'wanted to do the best for people around her.' Sarah was popular with her friends and known to provide support to those in her neighbourhood who were vulnerable due to substance use. She has been described as "bubbly, young-hearted, and always keen to help others."

2.2.4 *Background Information Relating to Perpetrator:* Michael was 40 years old when he murdered Sarah. He is Black British and has a history of substance use and mental health issues. He had a long history of violence within and outside of intimate relationships and had a number of previous convictions pertaining to violence against women. This includes a conviction of robbery and Actual Bodily Harm towards two women in 2002 and Actual Bodily Harm against a woman he assaulted after he refused to leave her home, in 2011. In 2013, he was accused of rape and Actual Bodily Harm of an ex-partner. He was acquitted of rape but convicted of Actual Bodily Harm and sentenced to four years imprisonment.

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2.2.5 At the time of his murder of Sarah, Michael was named as the partner, and father of an unborn child, of a vulnerable woman who was referred to a Multi-agency Risk Assessment Conference (MARAC) in September 2019.

2.2.6 *Synopsis of Relationship with the Perpetrator:* It is thought that Sarah and Michael met in April 2019. Shortly after meeting Sarah, Michael would frequently visit Sarah in her home, often staying over and leaving his belongings there. The nature of their relationship was unclear, with it initially not being viewed as an intimate relationship. However, those close to Sarah believed the relationship to be more than friendship, and Police intelligence suggested that Michael was a casual intimate partner of Sarah at the time of her murder.

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3. Chronology

3.1 Overview

3.1.1 The following chronology describes the contact that Sarah and Michael had with agencies. The time period under review is from 14th July 2017, which is the date of Sarah's hospital admission, to the date of her death in August 2019. However, there are some significant events prior to the time period under review which have been summarised below. It is important to note, that the London Borough of Hackney was subject to a cyber-attack in October 2020 which affected the following services being able to access full case notes:

- Children's Social Care
- Domestic Abuse Intervention Service
- Housing Services
- Adult Social Care

3.1.2 Whilst efforts have been made to retrieve some information from the respective systems, at the time of compiling the IMRs, these agencies do not have access to any previously uploaded documents, i.e., letters, reports, etc. However, they did have access to case chronology which provides an outline of their engagement in this case. Where the information has not been made available, this has been specified in the report.

3.2 Summary of Significant Events Prior to the Time Period Under Review: Sarah

3.2.1 Sarah began a relationship with her next-door neighbour, Paul, in 1991 when she was 16 and he was 22. They went on to have three children between 1997 and 2005. Sarah was known to the police and had a number of criminal convictions and cautions between 1995 and 2010, for theft, carrying an offensive weapon, and affray. Sarah was subjected to domestic abuse in her relationship with Paul and the police were called on nine separate occasions between 2003 and 2008. In 2008, Paul was imprisoned for three years for offenses related to threat to cause criminal damage and to bomb Sarah's home. Sarah was known to Hackney Council's then domestic abuse service in 2009, but due to the cyber-attack, the support she received there is unknown. Paul left prison and started a new relationship with another partner where he was also abusive. In 2013, the police responded to a call where he was alleged to have assaulted his girlfriend, who was referred to MARAC.

3.2.2 Children and Family Services were involved from 2006. In 2009, the three children were being cared for by their maternal grandmother, Charlotte, and were formally made subject to a Special Guardianship Order in August 2011. It is documented that Sarah moved the children to the care of their grandmother when she was fleeing domestic abuse perpetrated by Paul. In 2013, the police attended Charlotte's home after Paul was accused of being drunk and frightening the children.

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3.2.3 Sarah accessed community mental health support after an attempted overdose in 2010. In November 2011, she was seen by her GP in Somerford Grove Practice for a depressive disorder.

3.2.4 In 2012, Sarah went on to have a fourth child with Emenike. In 2013, she was the primary carer for this child and was referred to a drugs service, which she accessed until February 2015. Sarah's mental health deteriorated, and she had a number of alcohol-related physical health issues. She was recorded by Children and Family Services to be experiencing abuse by a new partner, and in August 2016 her child was placed in the care of his father, Emenike. Sarah saw her child at the weekends, but this was not always possible due to her health issues.

3.2.5 Sarah started a new drugs treatment programme with the newly commissioned

Westminster Drugs Project from June 2016. Sarah stated that she wanted her child with Emenike back but said she understood that she was struggling to meet his needs. When asked, she told her support worker that she had experienced domestic abuse, but that this was historical.

3.2.6 In April 2016, Sarah called the police to state that a male, who she was not in a relationship with but who had been living with her for two weeks, was refusing to leave and had assaulted her. Sarah did not make a statement and the male was given a harassment warning. In October 2016, Sarah contacted the police because the same male had returned and kept wanting to stay at her home. A MERLIN[18] was completed for her child with Emenike who she saw on weekends.

3.2.7 Sarah continued to receive treatment from Westminster Drugs Project and regularly attended group work for her alcohol use. She was referred to Homerton Hospital for an alcohol detox, where she was also reviewed by a psychiatrist as there were concerns for her mental health.

3.3 Summary of Significant Events Prior to the Time Period Under Review: Michael

3.3.1 Michael has a long criminal history. In 1994, having just turned 16, Michael was placed under a supervision order for robbery. He had a total of eight convictions and cautions prior to 2017. This included a history of violence against women. In 2002, he was convicted of robbery and Actual Bodily Harm towards two women and in 2011 he was convicted of Actual Bodily Harm against a woman who was a sex worker. Michael had approached her, stating that he had no money, and then went with the woman to her home. When she left, she expected him to leave with her, but he did not and when she returned in the afternoon, he was still there. She asked him to leave, whereby Michael then assaulted her.

3.3.2 In 2010, Michael visited the GP for depression. It was documented by his GP that Michael had previously become involved in gang related activity where he lived and

[18] Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason.

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that this had an impacted his well-being. It had been a desire to distance himself from this, that had been a significant factor in his depression described in 2010.

3.3.3 In July 2012, Michael started treatment with a substance use support organisation but did not attend the service and his treatment was ended in September 2012.

3.3.4 In 2013, he was accused of rape and Actual Bodily Harm by an ex-partner. He was acquitted of rape but convicted of Actual Bodily Harm and sentenced to four years imprisonment.

3.3.5 In September 2014, an Offender Personality Disorder pathway case consultation was completed with a psychologist, and the pathway plan included: residence at an Approved Premises, to attend the Building Better Relationships programme in the community, and to refer to the Mentalization Based Therapy group if the Building Better Relationships programme was not successful. He was released from custody

in December 2014 and placed in Approved Premises in the London Borough of Newham.

3.3.6 In March 2015, whilst in Approved Premises in Newham, Michael was found under the influence of illegal substances, and he attacked a female member of staff. Due to the effects of the illegal substances, Michael was taken to hospital, accompanied by the police, who had been called to restrain him. He did not suffer lasting effects and was cleared to leave. He disclosed to Probation shortly after this incident that he thought he had suffered a 'mental shut-down' and his explanation for his behaviour was that he 'felt stressed because nothing was going his way.'

3.3.7 Again, in March 2015, Michael was accused of threatening a resident in the same Approved Premises. He was said to have threatened to assault the resident by taking a teaspoon, holding it close to the resident's eye and threatened to take his eye out with it. Michael was recalled to prison and remained in prison until his sentence expiry date.

3.4 Time Period Under Review

3.4.1 In May, Westminster Drugs Project reallocated Sarah to their lead for 'Hidden Harm' as she was deemed to be at high risk.

3.4.2 Sarah was admitted to hospital in June after suffering a fall caused by spasms. The spasms were due to the medication she was using for an alcohol-related liver disease. Sarah was also suffering from pain in her hip. Sarah was placed under the care of dietetics, where she missed six appointments. Sarah was also offered a referral to a substance misuse service but stated she was reducing her drinking and saw them regularly in the community and was supported by her GP. Sarah was not asked about domestic abuse.

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3.4.3 Sarah did not attend an out-patient appointment in July, but was contacted by hospital staff, when she said that her legs were swollen, she had abdominal pain and generally felt unwell. Staff called an ambulance, and she was admitted to hospital. During this admission, Sarah was reviewed by the substance misuse team and she said she did not have alcohol dependency. No alcohol withdrawal was noted by the team.

3.4.4 During this admission, Sarah told hospital staff that she struggled with bank transfers, was in rent arrears and would like some assistance. She told staff that she had a friend who would help her with a monthly shop. She was discharged with a two-week support package with Age UK for support with shopping and domestic tasks. She was supported with independence at home.

3.4.5 In August, a referral from Children and Families Services (CFS) was made to Adult Social Care (ASC), referencing Sarah as a heavy alcohol user and that this was

impacting upon her health and wellbeing. A week later, CFS made a further referral to alert ASC of an insect infestation in Sarah's home. A care and support screening was undertaken by the Occupational Therapy Team who recommended support equipment for Sarah's home due to her being at high risks of falls. Although not specifically mentioned, it is assumed that this assessment was undertaken at home via a face-to-face assessment. The assessor raised no concerns in relation to Sarah's environment and after a follow up review meeting in October, where Sarah confirmed she was able to use the equipment safely, the Occupational Therapy Team closed their involvement on behalf of ASC.

3.4.6 In September, Westminster Drugs Project noted that Sarah was less able to attend support programmes in person because of her health issues. Sarah's GP noted that Sarah had started to use alcohol again and had missed an appointment with an alcohol specialist nurse. Westminster Drugs Project discharged Sarah from treatment in November 2017 due to appointments not being attended. She was sent a letter explaining this and was provided with drop-in clinic times should she wish to engage.

3.4.7 Michael re-registered at City Road Medical Centre in October 2017 but did not visit until January 2019.

3.4.8 In April, the Housing department received an anonymous noise complaint against Sarah for loud music. As this was the first report received against her, it was sent to a Housing Officer to address. Due to the cyber-attack, there is no information available on what action was taken.

3.4.9 In the same month, Sarah was admitted to Homerton Hospital. She explained that she had been injured in a play fight with a friend whilst under the influence of alcohol and this was corroborated by the friend. Homerton Hospital do not have details of the friend. She sustained multiple injuries and required hip surgery. Prior to the surgery, she was prescribed medication to manage withdrawal symptoms. Sarah stated that she would not stop drinking and did not want the support of the community alcohol

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team on discharge. Sarah had a hip replacement on 31st April. There were post-recovery complications, and Sarah was admitted to the Intensive Therapy Unit on 6th June. Sarah's mother and sister were informed of her vulnerable state. She returned to general ward on 12th June.

3.4.10 On 19th June, Sarah spoke to a member of the Gastroenterology team where she informed them that the cause of her hip fracture was the result of being physically attacked and raped by a man, not as a result of a play fight with a friend. She stated she vaguely recalled the attacker's physical appearance and described him as wearing a hat. She did not inform the police of the attack as she was worried no one would believe her because she had been drinking. During the consultation, Sarah was also distressed by events that had happened overnight, where an unwell patient attempted to strangle herself with bedsheets. Sarah was jumpy and would not let go of the clinician's hand, asking them to not leave her. She was also noted to be having flashbacks and called for help from a man coming towards her.

3.4.11 Homerton Hospital did not follow up on Sarah's disclosure that she had been attacked,

which they attributed to delirium, and therefore no safeguarding issues were raised, or crime reported. The discharge summary notes recorded that the number of a Rape Crisis helpline was given to Sarah, but there are no notes on when this happened. Whilst at Homerton Hospital, Sarah was visited by a Consultant Liaison Psychiatrist from the Homerton Psychological Medicine (HPM) team to assess her general wellbeing and to provide medication to help with agitation and alcohol detox.

3.4.12 On 20th and 26th June further visits were made by the HPM team to assess Sarah in the general ward. The conversations focused on Sarah's medical needs and detox, and on 20 June she was asked about her drinking. Sarah stated that she 'does not binge drink' and 'doesn't drink spirits.' Sarah explained to the Consultant Liaison Psychiatrist that she had tried to get support from drug and alcohol services in the past but that she felt it 'doesn't work.' Sarah stated that she did not want to stop drinking but was aware that it could kill her, saying that 'you have to die of something' and 'everyone does some time, I could walk outside and get hit by a bus.' Although Sarah was not assessed as being suicidal at this time, she was observed to be depressed and low in mood. She stated that she would be open to talking therapies but was informed by the Consultant Psychiatrist that if she were to access talking therapies, she would be expected to address her drinking as well. She was not asked about her experience of abuse and there was no exploration of the reasons why Sarah was drinking.

3.4.13 On 26 June, Sarah was described by the Psychiatric Liaison Nurse from HPM as being more engaged, although she minimised her use of alcohol in their discussions. Sarah stated that she had friends who she spent time with 'and is looking forward to seeing them again.' She was described as being keen to be discharged and she told the nurse, 'I haven't had a drink or a cigarette since I was in here – I can't wait to get out!' Sarah was offered further support from mental health services and drug and alcohol services, but declined, stating that she would go to her GP if she needed

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support. She was not asked how supportive her friends were, nor about her general social support network.

3.4.14 Sarah was also assessed by ASC on 28th June, where she reported that she was independent with personal care tasks, was receiving support from One Hackney (floating tenancy related support), and twice declined a full assessment of need. Sarah was provided contact details for Age UK and also for community social work, should she require further assistance. ASC has no further record of contact with Sarah.

3.4.15 Sarah was discharged to stay with her mother, Charlotte, on 1st July with a referral to the Adult Community Rehabilitation Team (ACRT) Physiotherapist Team and with an appointment to return to the fracture clinic.

3.4.16 Sarah's Housing Floating Support Worker contacted the ACRT to flag that Sarah was relying heavily on friends and family and needed support with daily activities. Sarah was moved to the urgent waiting list and was seen by a physiotherapist on 17th July, who provided her with an exercise plan which included weekly visits from a physiotherapist.

3.4.17 In August, Sarah was back home, and her father temporarily moved in with her to

support her while she was less mobile, and in October, Sarah was discharged back to the Locomotor service at Homerton Hospital.

3.4.18 Michael did not appear to have been known to any other services at this time.

3.4.19 In January, Michael visited his GP for a face-to-face assessment to discuss his depression. He was started on a course of anti-depressants. He did not contact the GP for a follow up and was not seen again by the GP.

3.4.20 In January, Sarah attended A&E with hip pain. She requested morphine but was prescribed analgesia to alleviate the pain and would be seen as an out-patient for a review and scan. In March, Sarah had an out-patient appointment where she required an MRI scan of the right wrist and an ultrasound scan of the right hip. She was to be reviewed in 2 months' time. In May, Sarah visited her GP as she was not sleeping and had hip pain.

3.4.21 In February, Michael approached the Hackney Housing Advice and Homelessness team for help finding accommodation as he was sofa surfing with friends who were no longer willing to accommodate him. He stated that he had looked into renting, but that this was too expensive. The case worker tried to make some referrals, but Michael was not forthcoming with information regarding his offending history. Several attempts were made to contact Michael (on 20th February, 11th March, and 25th March) but there was no response. On 28th March, Michael went into the Greenhouse Single Homeless Project, asking why no one had contacted him. He was noted to be rude to reception staff. He left after it was explained to him that several attempts had been made to contact him and voicemails left, with no response.

3.4.22 Michael returned to the Greenhouse Single Homeless Project in April, where he was described as being calmer and apologetic for his previous behaviour. The caseworker supported Michael with a referral to Assisted Homes, which provides accommodation for people with care and support needs. The referral needed to include a range of detail around identification and proof of benefits. This was sent through to Assisted Homes and followed up by the case worker in early May. An assessment appointment with Assisted Homes was made for Michael on 24th May. On 31st May, the case worker contacted Assisted Homes to confirm whether Michael had attended his appointment and the outcome of his assessment. A response was not received from Assisted Homes and Michael made no further contact with Hackney Housing Advice and Homelessness team. His case was closed on 9th July 2020 after no contact.

3.4.23 On 15 May, Michael was stopped and searched by police at Dalston Kingsland Station, as he had been seen on CCTV threatening staff in the market with a screwdriver. He was confrontational with officers and gave his address as no fixed abode. The original informant did not wish to make any allegations of a crime, but to have Michael moved away from the area.

3.4.24 On 30th May, London Ambulance Service was called after Sarah had a significant fall outside her home. Sarah reported that she had fallen from standing but when pressed, she reported she had climbed up the building trying to get into her flat and

had fallen, possibly from the 1st floor which was a height of 20ft. Sarah was under the influence of alcohol. She was admitted to Royal London with a fracture in her leg and pelvis. Sarah was discharged on 29th June and referred to the Homerton Integrated Independence Team for support at home. Staff at Royal London did not explore further how the fall had happened or discuss any further safety issues.

3.4.25 The Homerton Integrated Independence Team undertook eight home visits with Sarah between 28th June and 7th August. These visits focused on Sarah's mobility and general well-being. On one visit, the physiotherapist reported that Sarah was outside her building socialising and walking with a stick. She was carrying a bag with two cans of beer which she said she would drink later. Sarah spoke about not being able to sleep due to the pain in her legs. She reported having been sectioned in the past and having accessed mental health and alcohol services but had not found these helpful. There are no details of Sarah being sectioned in notes from Homerton Hospital, although their mental health notes only go as far back as 2012. She informed the physiotherapist that she had suicidal ideation and had made attempts in the past but not recently. She mentioned her children and friends as her protective factors. She was appreciative of not having sustained a more serious injury and perceived her recent event as 'a sign that she might be wanted down here.' The physiotherapist reported that Sarah described her mood as 'mostly ok' although sometimes she felt low and hopeless because of low confidence and body image due to weight loss after her last operation. Sarah referred to her friends who visited her and supported her with meals, shopping, and psychological support. She was reportedly in contact with her children, an ex-partner, and her parents. She also reported a positive rapport with a support officer who supported with benefits and

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other paperwork. Sarah declined a referral to substance use support but was keen for a visit by a therapist for a mood screening. The physiotherapist made a referral to Psychotherapy.

3.4.26 On another visit, Sarah continued to speak to the physiotherapist about body image confidence. Sarah said she felt better since speaking with the psychotherapist and was hopeful for the future. It was felt that further talking therapy for emotional support and stress management would be beneficial. The physiotherapist followed up with this on 5th, 6th and 12th August.

3.4.27 During these eight visits there was no conversation about Sarah's wider social network, whether anyone was staying with her, or her experiences of abuse. Sarah was discharged from the Integrated Independence Team on 12th August and a referral made to ACRT. Sarah missed an appointment with Somerford Grove Surgery on 9th August and an appointment with the Trauma and Orthopaedics department at Royal London Hospital on 15th August.

3.4.28 On 1st July, Michael was arrested for threatening a male in Kingsland High Street with a hammer. He was searched and found to be in possession of a knife and a hammer. The original informant was found, and an account taken. Officers identified that this was a repeat victim whom Michael had threatened in a separate incident in May. While being arrested, he racially abused a number of officers. In his cell, he smeared faeces around the cell, flooded the cell with water, and wrote the word "cop killer" in faeces on the wall. He abused a female Dedicated Detention Officer, threatening to smash a glass in her face once released, and went onto racially abuse another

female Dedicated Detention Officer. Due to his behaviour, officers completed an interview through the wicket of the cell door rather than in an interview room. His solicitor was present during the interview.

3.4.29 On two separate occasions, different doctors tried to assess Michael, however he was abusive towards both of them, and they were unable to carry out a full assessment. Further attempts to assess Michael were not made. He was subsequently charged with multiple offences connected with the incidents and kept in custody to attend Thames Magistrates Court. Michael was released on court bail on 2nd July to attend East London Magistrates Court on18th November (when he was then on remand for Sarah's murder) and pleaded guilty to the offences of criminal damage and causing racially aggravated harassment.

3.4.30 On 24th August, the police were called, when Sarah reported that she was followed through her door by her ex-partner Paul, who had forced her to the floor and attempted to rape her, but she managed to fight him off. On arrival, police spoke to Elliot, Sarah's neighbour and casual partner. Elliot stated that he had been drinking for days and had just taken ecstasy. He went on to say that he had been with Sarah in her flat drinking cider, and that they had an argument. He had gone back to his flat, but later returned to Sarah's flat where, from outside, he heard talking from inside Sarah's flat, but no disturbance. He returned to find Sarah upset and questioned her as to what had happened. He looked at her body which he told police had no

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scratches. He went to call the police and when he returned, he found that she now had several scratch marks that were not there on his first inspection.

3.4.31 On police arrival, the attending officers noted a skewer next to Sarah, and suspected from what they had been told by Elliot that the scratches may have been self-inflicted by Sarah. They also noted that there was no evidence of a violent struggle within the hallway. Sarah was taken to Homerton Hospital. Paul was identified as the suspect and an attempt was made to arrest him that night at his home address. The attempt was unsuccessful, and Paul was subsequently arrested on 28th August.

3.4.32 At Homerton Hospital, Sarah told the practitioner that Paul had come for her because she had sent him to prison multiple times following his violence. She was shaken and stated she was sore. The practitioner asked Sarah if she should make a MARAC referral, which Sarah declined. No DASH risk assessment was undertaken nor referral to MARAC made by the practitioner. This is contrary practice to the training that hospital staff receive, which highlights that a MARAC referral can be made without consent, based on professional judgement. However, the practitioner did make a referral to the Independent Domestic Violence Service who was based in Homerton Hospital, a service provided by Victim Support.

3.4.33 The IDVA contacted Sarah on the same day via telephone. Sarah told the IDVA that she had moved 18 times due to domestic abuse, but her ex-partner was not letting her go. Sarah informed the IDVA that an order was in place which was issued 10 years ago, he should not make any contact with her, neither should he come near her property. Sarah did not inform the IDVA the detail of this order nor how long the order was in place. Sarah informed the IDVA that her ex-partner had told her that if he

could not have her then no one could have her. There was some indication in the notes that the IDVA thought that Sarah was distressed and offered to call her at another time. They agreed that the IDVA would call the following day.

3.4.34 Following the conversation, the IDVA contacted Hackney Domestic Abuse Intervention Service via email to see if Sarah was currently involved in their service. They confirmed that they were not involved and provided an overview of the Council's history of involvement, the last of which was with the Council's previous Domestic violence and Abuse Team in 2009.

3.4.35 On 28th August, Paul was interviewed by police and stated that he had not seen Sarah since 2017. He gave an alibi that he was in a public house at the time of the alleged offence. He also said that he wished this to be investigated as a malicious allegation. Paul was subsequently released on police bail.

3.4.36 The IDVA did not call Sarah the next day as agreed but the day after that, at approximately 2pm. During this call Sarah informed the IDVA that police had attended the previous day and had taken a statement from her. She asked police to install a panic alarm. Police advised her that they would look at the matter and would update her on the progress of the investigation. Sarah informed the IDVA that she was not feeling well and did not think Victim Support could offer her the support she was looking for. She had spoken to the police who were able to help her out and she was

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waiting for the outcome. The IDVA informed Sarah that she would contact her next week to see how things were with her. Sarah agreed to this. The IDVA did not complete a risk assessment, nor safety plan with Sarah.

3.4.37 On the same date in August, Michael entered Sarah's one-bedroom flat and murdered Sarah.

3.4.38 A few days later, Sarah's sister called the police stating that her father had not seen Sarah for a few days and was concerned for her welfare. Officers were subsequently despatched to check on Sarah and discovered her murdered in her bedroom.

3.4.39 The Community Support Unit who were investigating the alleged rape, were unaware of the murder and classified the rape allegation as a Domestic Abuse Common Assault on 2nd September. An investigation plan into the rape allegation was then enacted which involved the seizure of CCTV that covered the front door, and CCTV of the alibi given by the suspect, Paul. Once viewed, the CCTV proved that no one entered behind Sarah or left as she described. The only person seen was Elliot, who talked through the letter box. In a statement provided by Elliot, he stated that Sarah had been experimenting with a new drug which had caused her to be "erratic and odd."

3.4.40 The attempted rape investigation was submitted for closure, which was agreed by an Acting Detective Inspector, who closed the report as a "no crime", stating that 'significant and credible evidence exists to contradict the allegation.'

3.4.41 In September, Paul was identified as a potential suspect for the murder, given his long history of domestic abuse, and the recent allegation of attempted rape made against him by Sarah. In addition, following his release on bail for the rape allegation, he had contacted his adult daughter via text stating that he wanted to kill someone and

himself, and apologised for being a bad father.

3.4.42 Following enquiries by the investigation team, Paul was released, and Michael was arrested for Sarah's murder on 3rd September.

3.4.43

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4. Overview

4.1 Summary of Information from Family

4.1.1 Alyssa and Charlotte, Sarah's daughter and mother, were interviewed together by the Chair and the Domestic Abuse Intervention Service Manager in October 2021. They spoke of Sarah's experiences in accessing services, her history of domestic abuse, her use of substances as a coping mechanism, and about the barriers they felt that Sarah faced in getting the support she needed. They explained that Sarah was known to a number of services but none of these had been helpful to her. For example, Charlotte felt that Sarah should have been provided a ground floor flat because of her mobility needs and her vulnerability to falls. Further, Alyssa and Charlotte both explained that they felt there was an 'agenda against her [Sarah] because of the drugs.'

4.1.2 They told the Chair that Sarah kept a diary which included descriptions of her experiences of accessing services. The diary has been put somewhere safe and Charlotte and Alyssa expressed that it would be too emotionally difficult for the family to share this.

4.1.3 They also spoke about Sarah's experience of domestic abuse from previous abusive partners. Sarah's daughter, Alyssa, shared her experience of seeing her father, Paul, perpetrate abuse against Sarah. After describing a particularly violent incident that she was exposed to as a child, Alyssa told the Chair about her mother's strength and how she 'had always been a fighter.' Describing Sarah more recently, Paul shared that:

'Sarah always had fought back against abusive partners in the past but didn't appear to be fighting back this time. She didn't get enough

help and was giving up. She was struggling to give up drugs and felt weak in herself.'

4.1.4 Alyssa felt that her mother reached out for help from services but felt lonely and unheard.

4.1.5 Charlotte felt that Sarah was trying to get her life in order and was looking for work. Sarah had already lost her older children, but Charlotte explained that she was fighting for her youngest child. Alyssa felt that her mother had to fight every single day, but agencies didn't see the signs. Alyssa thought that her mother:

'Had a lot to put up with but despite this, she was always a very helpful person and wanted to do the best for the person she was with. 'The guy'[19] was homeless when he got out of prison and Sarah wanted to help him as she helped others.'

[19] Charlotte and Alyssa did not want to call Michael by his name and instead wanted to refer to him as 'the guy.'

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4.1.6 Alyssa knew that Michael was living with Sarah at the time, but didn't know what sort of relationship they were in. Alyssa described an occasion when Michael grabbed her mother and shouted at her in a busy square in Hackney:

'This was seen by some of mum's friends but as it was in a drug taking area, no-one called the police. People were frightened to talk to the police. A drug taker was living in the flat next door to Sarah who had warned all residents not to call the police to the block and they were frightened to call the police.'

4.1.7 Alyssa explained that when Michael was caught, she blamed her father, Paul. When she heard about her mum's death, Alyssa herself reported her suspicions about her dad to the police straight away. At the time that Sarah died, her dad had messaged her to apologise for his behaviour and to say that he was going away, this led Alyssa to believe that her dad may have been responsible.

4.1.8 After Sarah's death, Alyssa and Charlotte described the difficulties they continued to face as a family. After he had been convicted, Michael wrote letters to Sarah's mother and her three children, saying that they should have been more involved and helped Sarah. He wrote that "I killed your daughter for nothing". They have since burnt the letter and questioned why he was given the chance to write to them in the first place.

4.1.9 They also described having to fight to keep Sarah's flat for a month after her murder, in order to undertake the 'Nine Nights,' a Caribbean tradition which celebrates the life of a person who has died. The family were denied the opportunity to undertake this cultural practice in full. Alyssa explained to the Chair the importance of the Nine Nights celebration and what was involved. For nine nights they don't eat meat as that would be like eating the flesh of the deceased person. Family would go to Sarah's home for the nine nights. No alcohol was allowed. They would speak about their memories, both good and bad. Every night a different person would take the prayer, then, on the tenth night, they would have the funeral followed by a party. Because of

the Council needing to acquire the flat, the Nine Nights was rushed, and they were unable to have the funeral on the tenth night.

4.1.10 When asked to describe Sarah, Charlotte and Alyssa told the Chair that Sarah was a helpful person who cared for others, despite the challenges she faced. They said that Sarah was into 'Lover's Rock' music, and she played it all the time. Her favourite colour was baby blue, and in her memory, everyone wore blue to the funeral.

4.1.11 Charlotte and Alyssa expressed that they welcomed the review and wanted to know the lessons there were to learn from this terrible tragedy. They eloquently expressed, however, 'why does it have to be when Sarah was murdered that she is given a voice? Why wasn't she heard when she was alive?'

4.2 Summary of Information from Perpetrator:

4.2.1 An interview was conducted with Michael via video link in March 2022. He spoke about his upbringing and his experiences after leaving prison.

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4.2.2 Michael described how he had mostly been in prison since the age of 17 and been involved in violence all his life. He was estranged from his family and had not spoken to them after being sent to prison. He felt that there were no professionals who helped him. His main involvement with agencies was with Probation services, and he considered that they provided no help. He felt that if he had been released on license, then he may have received more support from agencies. Michael described how he had no health illnesses or drug problems so had no need to go to the GP. Housing was his only problem. He stated that they refused to help him as he was not a priority. He describes being homeless for two and a half years before he met Sarah.

4.2.3 Michael explained that he was homeless without getting into trouble. He worked on a market stall but was unable to sign onto benefits as he did not have ID. Michael felt that professionals were not listening to him but were instead making demands of him, such as asking him to live with his mother, who he had no contact with. He recognised that he came across as being aggressive or rude when frustrated. In the end, he felt that only criminals were going to help him.

4.2.4 Michael had some difficulty in speaking about Sarah but gave some background to his relationship with Sarah. They met in a secluded area of London where people who were homeless and had been in prison socialised. They had mutual friends, although as everyone was involved in criminal activity, it was hard to trust anyone. Nevertheless, people would help each other out and let each other know where soup kitchens were and where blankets could be found.

4.2.5 He explained that Sarah was established in this group of about 30-40 people. They each had their own group of friends, and some knew of their relationship, although Michael never spoke to any of his friends about the relationship, which he described as being of a sexual nature. He would stay with Sarah two-three times a week and described how she was a good person.

4.2.6 When asked about substance use, he asserted that he was not smoking and was not a drug dealer, but that he was trying to help Sarah get out of the debt that she was in

with drug dealers. He told the Chair that he had a girlfriend who was pregnant, and his plan was to help Sarah before continuing his relationship with his pregnant girlfriend.

4.2.7 When asked what would have prevented the murder, Michael explained that it was not premediated. He was trying to get Sarah out of debt by holding small amounts of drugs for her. However, on this last occasion, he was holding a larger quantity of drugs and they went missing, this caused the only argument that they had ever had. Michael said that he feared that the drug dealers would stab him, and he was going to need to carry a weapon for his self-defence. Michael told the Chair that Sarah challenged him by asking him 'what did he expect?' He reacted and this led to her death.

4.2.8 The Chairs personal reflection after the interview, was that Michael lacked accountability for his actions and instead focused on Sarah's behaviour and actions. Michael's account of his own role in the relationship, particularly in how he helped

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Sarah, does not fit with information available to the Review Panel. Lastly, in the interview he largely minimised or denied his behaviour and its impact on others.

4.3 Summary of Information Known to the Agencies and Professionals Involved

4.3.1 A range of services had contact with Sarah. Broadly this contact related to the following themes:

- Health and Social Care
- Criminal justice
- Children's services
- Substance use
- Domestic abuse
- Housing

Health and Social Care:

4.3.2 Sarah was extensively known to various health services due to her significant health needs. Between July 2017 and August 2019, which was the timeframe of this review, Sarah had a number of appointments and visits from a range of health professionals. These include, Somerford Grove Practice in early May 2021 (requesting medication
to support with hip pain), Royal London Hospital (following a fall in late May 2021), East London NHS Foundation Trust in June 2018 (in-patient mental health service provided), Adult Social Care through the Social Worker Team based in the hospital in 2017 and 2018 (for reablement package of care post hospital discharge and care and support screenings), London Ambulance service in 2017, 2018, and 2019 (seven ambulance contacts were made in this period), and Homerton University Hospital Foundation Trust across 2017, 2018 and 2019 (for a number of health related emergencies).

4.3.3 In relation to Somerford Grove Practice, Royal London Hospital, Adult Social Care, and East London NHS Foundation Trust, whilst the medical care provided was appropriate, there were missed opportunities where routine enquiry could have been undertaken about Sarah's experience of abuse, her support network, and the reasons for her substance use.

4.3.4 London Ambulance Service provided Sarah with appropriate care and support for her presenting need. However, more could have been done to explore the support Sarah was receiving and to identify any further support she may have needed for both her alcohol dependence and recovery following an assault.

4.3.5 Sarah's most significant contact was with Homerton University Hospital Foundation Trust, and can be broadly described as emergency hospital admissions, community therapy intervention, outpatient appointments, and appointments with specialist health professionals. Sarah made a number of disclosures about her experiences of abuse, the trauma she had experienced, her poor mental health, and substance use. While the medical care Sarah received was appropriate, there were missed opportunities to directly enquire about domestic abuse, make appropriate referrals

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when disclosures had been made and to gain a clearer understanding of Sarah's support network and the reasons for her substance use.

Criminal Justice:

4.3.6 In August, five days before her murder, Sarah had contact with MPS after reporting an alleged rape perpetrated by her ex-partner, Paul. This included an initial visit after the alleged rape was reported and a follow up meeting a few days later to take a written statement. The police cannot confirm, that at this second meeting any support was offered to Sarah or that further referrals to specialist support were made. While correct procedures were followed resulting in Paul's arrest, there were missed opportunities to ask about threats from others. In addition, officers suspected that the scratch marks on Sarah were self-inflicted. The panel considered the impact this may have had on Sarah in not being believed. There was also missed opportunities to link Sarah's experience with her historic experience of being exploited by a man who lived with her and would not leave.

Children's Services:

4.3.7 There was limited contact with Sarah by Hackney Child and Family Services as Sarah's child was in his father's (Emenike) care. However, as her child was with Sarah every other weekend, and in light of Sarah's deteriorating health, there were missed opportunities to ask who else was living with Sarah and to identify any risk they may have posed to either Sarah or her child. There were also missed opportunities to speak to Sarah about the impact of child removal.

Substance use services:

4.3.8 Sarah had significant contact with Westminster Drugs Project until she was discharged from their services in November 2017. Sarah accessed alcohol detox support and was referred to a Hidden Harm worker for more in-depth support. Sarah showed signs of engagement until her health deteriorated. Although attempts were made by

the service to engage with Sarah at home, more could have been done to follow up on missed sessions.

4.3.9 Sarah wanted mental health support but was told that she would need to address her alcohol use beforehand. Due to the link between poor mental health and substance use, more could have been done to support Sarah's mental health. Lastly, when Sarah was discharged from the service in November 2017, more could have been done in sharing details of other services which may have helped her once she was discharged from Westminster Drugs Project.

Domestic abuse

4.3.10 Sarah was known historically to Hackney Council's then domestic abuse service and more recently to the IDVA Service provided by Victim Support. Sarah was not known to the Domestic Abuse Intervention Service, the Council's current domestic abuse service, which has been operating since September 2016. There were shortcomings identified in Victim Support's response to Sarah. Although contact was made with Sarah on the day of the referral and arrangements were made for the next contact, a

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DASH Risk Assessment was not carried out, risks were not identified in the initial conversation between the IDVA and Sarah, and no safety advice or planning was provided.

Housing

4.3.11 There was limited contact with Hackney Housing Department, aside from an anonymous call made against Sarah for loud music in April 2018. Due to the cyber-attack Hackney Council was subjected to, the outcome of the action taken has been lost. However, as this is the only contact with Sarah during the three years of this review, consideration should be given to the support that Housing offers to their tenants, including repair visits and property checks. As an insect infestation was reported by Children and Family Service, which was not known to Housing, the Review Panel felt more contact by Housing should have been made with Sarah.

4.3.12 In contrast, the contact with Michael was more limited. These contacts are related to:

- Housing
- Health
- Police

Housing:

4.3.13 Michael approached Hackney Housing Advice and Homelessness Team in February 2019 for help to find accommodation as he was sofa surfing. A referral was made to Assisted Homes in May 2019, but there was no response from either Michael or Assisted Homes, so his case was closed in July 2020.

Health:

4.3.14 Michael presented once for a face-to-face appointment with his GP at City Road Medical Centre for support with his depression. He was started on a course of medication but did not make contact for a follow-up. There was a missed opportunity

to ask if he felt he was at a risk to himself or others.

Police:

4.3.15 Michael had more contact with MPS than any other service during the timeframe of this review. In May and June of 2019 police were called to two separate incidents of threatening and abusive behaviours, with the one in June 2019 resulting in his arrest and conviction for criminal damage and causing racially aggravating harassment. There were missed opportunities to identify whether he was a risk to others.

4.4 Any Other Relevant Facts or Information:

4.4.1 No other additional facts or information have been identified.

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5. Analysis

5.1 Domestic Abuse

5.1.1 Taking into account the government definition of domestic abuse in section 1.7.1, information gathered by the police as part of the murder investigation, information provided by other agencies, and accounts shared by the family, it is clear that Michael exerted abusive behaviour towards Sarah.

5.1.2 Tragically, Sarah's death means that it will never be possible to know the full extent of her experiences. Although Michael claimed that he had never been violent or abusive, the Review Panel concluded that Sarah was subject to a range of violence and abuse by Michael. This included:

- *Physical abuse:* At least one assault was witnessed by Sarah's friends, whereby Michael was observed to have violently grabbed and shouted at Sarah in a busy square in Hackney.
- *Coercion, threats, and intimidation:* Sarah was aware of at least some of Michael's violent past, and according to court notes, she had spoken to her friend about Michael and described him as being, in her words, a "nutter." Information gathered by police and other professionals described Michael as being abusive and violent to a number of previous partners. Research shows that previous acts of abuse and violence against others can be used by perpetrators to intimidate and control victims.[20]
- *Emotional abuse and isolation:* Sarah was very isolated due to being estranged from her family and also due to her disabilities. We know that perpetrators deliberately target disabled women in the first place and then further isolate them from friends, family, and sources of support.[21]
- *Economic abuse:* Economic abuse involves tactics used by abusers to affect someone's economic self-sufficiency (e.g., access to education or training,

sabotage to work efforts, or the use of accommodation or property).[22]In this case, Michael was staying with Sarah two-three nights a week. Sarah had previously called the police in 2016 to remove a man who had been living with her and had assaulted her when asked to leave, this man kept returning and harassing Sarah despite having received a police warning. It is possible, that Sarah may have had similar concerns with Michael.

- *Sexual violence:* Although no direct evidence was shared with the Review Panel in relation to Michael perpetrating sexual violence against Sarah, she did make a rape allegation against a previous partner shortly before her murder. The review

[20] Ganley, Anne L. "Understanding domestic violence." Improving the health care response to domestic violence: A resource manual for health care providers (1995): 15-42.
[21] Thiara, K and Bashall, R: *Addressing Domestic Violence and Abuse against Disabled Women* in *Working with domestic abuse across the lifecourse* Ed. Radford, L. 2021, Jessica Kingsley Publishers
[22] Judy L. Postmus, Sara-Beth Plummer, Sarah McMahon, N. Shaanta Murshid, Mi Sung Kim (2012) 'Understanding Economic Abuse in the Lives of Survivors', Journal of Interpersonal Violence, 27(3), pp. 411 - 430

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panel considered Sarah's mental health in the context of her previous experience of trauma and abuse. The work of van der Kolk (1994) established that trauma can interfere with the conscious recall of experience, but not the memory system that controls emotional responses. This results in traumatic memories continuing to exist in dissociative states that might be re-experienced.[23]In this way, the panel considered the rape allegation may have been the result of a previous incident of abuse.

5.1.3 In his interview, Michael stated that he was not a drug dealer but was holding drugs for Sarah. He claimed that he was trying to help Sarah get out of debt with drug dealers, by holding small amounts of drugs for her. He went on to say that just before he murdered Sarah, he had been holding a larger quantity of drugs for her which had gone missing, and this caused their argument. The Review Panel considered how Michael's control of these substances could have been used in turn to control Sarah.

5.1.4 The relationship between substance use and domestic abuse is complex, but crime surveys tend to focus on the behaviour of victims more often than offenders.[24] Michael's role in holding drugs for Sarah illustrates how substance use can be implicated in the perpetration of coercive control. Research reveals that some victims self-medicate to manage the depression that the daily anticipation of violence engenders, but that some perpetrators control victims by increasing their dependence on substances before restricting their access to them.

5.1.5 Sarah was not accessing substance use support when she met Michael, having been discharged from Westminster Drugs Project in 2017. On 29th July 2019, Sarah declined a referral to a substance use service, but she was keen for her Psychotherapist to refer her for mental health support. The last time she sought mental health services she was told that she would need to address her substance use beforehand. Both Michael's potential control of substances and her concerns on being denied access to mental health services could have been barriers to Sarah reaching out for support.

It is important to continue to raise awareness of the relationship between substance use, trauma, and domestic abuse, to address the barriers facing victims in accessing support. In adopting an approach which focuses on the way that victims use substances as a coping mechanism, the way that perpetrators use substances to control their victims, and the barriers substance use creates in the accessibility of support, it is possible to challenge any victim blaming which may see the victim's use of substances as the problem.

Recommendation 1: The Hackney Community Safety Partnership to identify how it can better raise awareness and improve responses to people impacted by multiple disadvantage who have experienced domestic and sexual abuse.

[23] van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review of Psychiatry, 1, 253–265.

[24] Gadd, D et al T*he dynamics of domestic abuse and drug and alcohol dependency* The British Journal of Criminology, Volume 59, Issue 5, September 2019, Pages 1035–1053

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5.1.6 Sarah faced significant barriers to accessing support which were exploited by Michael. As discussed above, perpetrators are known to deliberately target disabled women in the first place to exert control over them. Information from professionals showed that Michael was also staying with Sarah two-three nights a week, often leaving his clothes at her home which he used as a base. This befriending and use of Sarah and her home shows signs of Sarah being exploited. Research by McCarthy highlights that:

> *Where people with disabilities are befriended by those who are intent on abusing and exploiting them, its dynamics are very similar to the relationships many women with disabilities in our study find themselves in, that is, meeting someone who appears to like them, who then very quickly inveigles into their life and home and starts to exert power and control, through intimidation and violence.'*[25]

5.1.7 When speaking to her psychotherapist in July and August 2019, Sarah often referred to her friends who visited her and supported her with meals, shopping, and psychological support. Although Sarah did have friendships with members of the local drinking peer group, the Review Panel are aware that Michael would regularly visit her. Police footage show that in the week preceding her murder, Michael visited three times on the Monday, six times on the Tuesday, four times on the Wednesday where he stayed overnight, and on the day of her murder, he left early and returned on two occasions, with the second visit being when he fatally attacked and killed Sarah.

5.1.8 The Review Panel identified this behaviour as 'Cuckooing' which refers to when a perpetrator takes over the home of a vulnerable person and treats it as their own.[26] The victims of such crimes often do not perceive what is happening to them as abuse, because of their strong desire for friendship and acceptance.[27] At this time, it is documented that Sarah was in pain because of her hip, her mental health was low, and she expressed to her psychotherapist that she had body image concerns. McCarthy argues that there are strong links between domestic abuse, disability hate crime, and targeted abuse against women with disabilities, and that there is a need for professionals to make a connection across all three rather than treating them as discrete forms of violence and abuse in disabled women's lives.[28]

5.1.9 Sarah's vulnerability to exploitation and professionals' lack of awareness of her social and support networks was exploited by Michael. In the interview with Michael, he presented himself as helping Sarah. Once in prison, he contacted Sarah's family and maliciously accused them of not being involved or helping her. His actions show,

[25] McCarthy, M: *"What kind of abuse is him spitting in my food?" Reflections on the similarities between disability hate crime, so called 'mate crime' and domestic abuse against women with intellectual disabilities* Disability and Society 2017 32, 4, PP: 227. [26] Thiara, K and Bashall, R: *Addressing Domestic Violence and Abuse against Disabled Women* in *Working with domestic abuse across the lifecourse* Ed. Radford, L. 2021, Jessica Kingsley Publishers PP: 171.
[27] McCarthy, M: *Reflections on the similarities between disability hate crime, so called 'mate crime' and domestic abuse against women with intellectual disabilities* PP: 598.
[28] Ibid.

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despite pleading guilty to Sarah's murder, he still did not hold himself to account by first blaming Sarah's ex-partner and then her family for her treatment.

There is a need to better understand the impact of domestic abuse on disabled women, particularly for victims who are not seen to be in 'traditional' relationships. Furthermore, links need to be made between domestic abuse and 'cuckooing.'

Recommendation 2: The Hackney Community Safety Partnership to identify how to better raise public and professional awareness of the impact of domestic abuse on victims who have a disability.

Recommendation 3: The Hackney Community Safety Partnership to identify how to raise awareness of the relationship between domestic abuse and 'cuckooing.'

Recommendation 4: The Hackney Community Safety Partnership to identify how to raise awareness of domestic abuse experienced outside of a 'traditional' intimate relationship.

5.2 Analysis of Agency Involvement

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference in section 1.6.4.

Analyse the individual responses of agencies to the victim and perpetrator in identification, assessment and interventions to manage the needs and risks identified for either individual and whether the responses met expected levels of practice

Health

5.2.2 Health services had the most contact with Sarah. There is clear evidence that the medical support provided to Sarah was appropriate across all the services included in this review. There are also specific examples of good practice in health services' individual responses to Sarah's needs. For example, after being admitted into Homerton hospital in July 2017, Sarah expressed that she struggled with bank transfers and was in rent arrears, so was referred to floating support, which she engaged with. She was also referred to ACRT for regular support at home from the community physiotherapy team after being moved to the urgent waiting list in July 2018. After the rape allegation in August 2019, Sarah was rightly referred to the co-located Independent Domestic Violence Service provided by Victim Support. After Sarah's admission to Royal Hospital London in May 2019, a referral was made to

children's safeguarding in relation to her youngest child, and she was reviewed by the Alcohol and Drugs Team who offered a package of care on discharge, although she declined this

support. While being assessed by the Consultant Liaison Psychiatrist with East London NHS Foundation Trust, time was spent trying to understand how her detox was going in June 2018.

5.2.3 However, there were considerable missed opportunities to provide Sarah with the support she needed. In June 2018, she disclosed to Homerton that she had been raped. Despite this, there was no follow up and no referrals made to either the police or to specialist services. As Sarah was presenting as being jumpy and having

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flashbacks, the clinician assumed the disclosure to be the result of delirium. It is concerning that correct procedure was not followed in this instance. It is also important to highlight that research shows that sexual violence is significantly higher among those with mental illness than the rest of the population. Many mental health professionals report lacking skills and confidence to respond to patient disclosures of sexual assault, even those that are coherent and supported by evidence.[29] There is a need to improve awareness between the experience of sexual violence and mental health.

5.2.4 There were also considerable missed opportunities to look beyond Sarah's presenting issue and to see her needs more broadly. The Review Panel found that there was an over emphasis on medicating Sarah without exploring the impact that her trauma and experience had on her substance use. Across her involvement with Homerton Hospital, Royal London Hospital, and with the Consultant Liaison Psychiatrist with East London NHS Foundation Trust, Sarah was regularly asked to address her substance use. On a number of occasions, it was noted that she was downplaying her alcohol use or refusing support, telling health professionals that she had the support that she needed from her GP.

5.2.5 We now know that Sarah had disengaged from Westminster Drugs Service in November 2017. We also know that she stated to Consultant Liaison Psychiatrist with East London NHS Foundation Trust that she would be open to talking therapies but was informed that if she were to commence this, they would expect her to address her drinking as well. The emphasis on addressing her alcohol use, without providing Sarah with the wider support needed led to her minimising her alcohol use. There was also a missed opportunity by the Consultant Liaison Psychiatrist to identify specialist services in the community which could have supported Sarah, without her having to go through formal mental health pathways.

5.2.6 The City and Hackney Mental Health Strategy 2019-23, was launched after Sarah's murder, but there is a welcome emphasis on addressing the barriers that she faced, including to:

- *Develop open access and low threshold services;*
- *Jointly develop a new substance misuse contract that better integrates substance misuse and mental health services, including: the integration of substance misuse into psychiatric liaison; a seamless pathway between*

mental health services and substance misuse services and ensuring that people with substance misuse problems have access to support for their mental health needs

● *Invest in Multiple Needs Service for those with multiple and complex need* ● *Develop assessment, referral, and integrated care pathways to diagnose and address the mental health needs of people presenting with physical illness; and*

[29] Ashmore, J *et al* (2015) *'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities* International Journal of Mental Health Nursing, 24.2 PP139-148.

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● *Target action to reduce numbers of frequent users of A&E, ambulance, and mental health services by addressing undiagnosed mental health need.*[30]

5.2.7 Across Sarah's experience of health services, there was also little professional curiosity regarding her wider support networks. The Consultant Liaison Psychiatrist with East London NHS Foundation Trust identified that Sarah had a network of friends but there was no further information gained on who they were or the role they played in her life. The Homerton hospital physiotherapist attended a number of home visits. In none of these appointments were questions raised on the nature of Sarah's support network, despite Sarah often referring to her friends who visited and supported her.

5.2.8 Both East London NHS Foundation Trust and Homerton hospital have included recommendations in their IMRs to address these issues, which the Review Panel welcomed.

5.2.9 London Ambulance Service had contact with Sarah on seven occasions during the time period of this review. There is no evidence on these occasions to suggest the ambulance staff explored the support Sarah was receiving or what support she may have needed. In August 2019, the ambulance was called after Sarah reported a rape. Although a safeguarding referral was completed for Sarah's children, there is no evidence that a discussion took place with her with regards to support mechanisms following an assault.

5.2.10 Michael's experience with health services was less frequent, but he did attend his GP at City Road Medical Centre in January 2019 for support with his depression. A case analysis of DHRs undertaken by Standing Together highlights that domestic abuse perpetrators will often visit their GP for support.[31] There is no indication that he was asked about risk he posed to either himself or others.

It is vital that professionals follow protocol and make referrals when a disclosure of abuse is made. Professionals need to be trained on understanding the relationship between sexual abuse and mental health, so that disclosures are fully addressed. It is also important that service users who are using substances as a coping mechanism, but who also have mental health issues, are not turned away from services.

Recommendation 5: Homerton Hospital to ensure that staff are trained on the correct referral procedure in responding to domestic and sexual abuse.

Recommendation 6: East London NHS Foundation Trust to ensure that the City and Hackney Mental Health Strategy 2019-23 is used to move away from a medicated model and instead holistically support service users, especially those experiencing domestic and sexual violence and abuse.

Recommendation 7: East London NHS Foundation Trust to provide assurance to the Hackney Community Safety Partnership that an appropriate response is adopted to the needs of service users who have multiple needs such as substance use.

[30] https://www.cityoflondon.gov.uk/assets/Services-DCCS/ch-joint-mental-health-strategy-2019-23.pdf Page.11
[31] Sharp-Jeff, N and Kelly, L (2016) Domestic Homicide Review Case Analysis. Page 27

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Recommendation 8: City Road Medical Centre to improve their routine enquiry to establish if a patient may be a risk to themselves or others.

Criminal Justice

5.2.11 Michael had more contact with MPS than with any other service during the timeframe of this review. This included police call outs and an arrest. Historically, Michael was known to the police for mental health issues, robbery, offensive weapon use, and multiple violent assaults including domestic abuse and the alleged rape of a girlfriend. In July 2017, when Michael was arrested after threatening a male with a hammer on a high street, he displayed abusive and problematic behaviour. On two separate occasions, unsuccessful attempts were made by doctors to undertake an assessment due to his behaviour. Despite the way in which he presented and the fact that police had opposed bail, Michael was released on bail by the magistrates.

5.2.12 Sarah was known to MPS as a result of the historic domestic abuse she experienced from Paul. She was also known for her vulnerability to being exploited by a man who would stay with her in 2016 and then refused to leave. When MPS responded to the rape allegation in August 2019, Michael was staying overnight with Sarah and was regularly visiting her during the day, as shown by CCTV. Before she was taken to hospital, Sarah was asked about the incident. She was not asked who else was staying with her, nor did the police assess who else may have been a risk to her. This was a missed opportunity.

5.2.13 The attending officers also had misgivings about Sarah's allegations of rape. Although the case was eventually closed due to lack of credible evidence, the Review Panel considered Sarah's interaction with the police and her possible feelings about not being believed. As discussed earlier, traumatic memories continue to exist in

dissociative states that might be re-experienced if the survivor is triggered. Sarah's disclosure of rape was met with scepticism, which may have had an impact on how safe she felt to disclose further harm or fear of others.

5.2.14 However, the Review Panel were pleased to learn of new guidance issued by MPS to support officers to better identify and respond to domestic abuse, published in June 2021.

There are concerns that procedure is not being followed if a perpetrator presents as volatile and uncooperative. It is vital that agencies ensure that processes are followed so that risk to themselves and others is understood. It is also important that survivors of sexual violence who have mental health support needs are believed. It is vital that statutory services, and the police in particular, understand the relationship between mental health and domestic abuse to better support survivors.

Recommendation 9: The MPS Mental Health Toolkit to be updated to include guidance on safely and appropriately undertaking an assessment of a non-compliant individual is in custody.

Recommendation 10: The Hackney Community Safety Partnership to identify how to improve services' responses to violent offenders.

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Recommendation 11: MPS to monitor the impact and changes resulting from the publication of the new domestic abuse guidance on undertaking risk assessments and referrals to specialist services, and to share any findings with the Hackney Community Safety Partnership.

Recommendation 12: MPS to ensure that frontline police officers are trained on understanding the relationship between sexual violence and mental health.

Children's services:

5.2.15 Although there was limited contact with Sarah by children's services during the timeframe of this review, the Review Panel considered the impact on Sarah of having her children removed. As discussed earlier, extensive research has been undertaken looking at the impact on mothers, which includes mothers being silenced through the stigma and shame of being judged to be a deeply flawed mother, the justifiable fear of future children being removed, and court-ordered reporting restrictions.[32] Significantly, research by Morris highlights that

> '*Children's Services do not remain involved as there is no longer a child of concern, and the Court does not monitor the provision of any of the services recommended during the proceedings, be these mental health or drugs related services…the women involved in these cases tend not to meet the stringent criteria to access mainstream Community Mental Health services. Thus, they are left to deal with the trauma and loss of a child on their own, particularly as they may be ostracised by family and friends due to the stigma and shame of state-ordered removal.*'[33]

5.2.16 As discussed earlier, some racially minoritised children are statistically more likely to be removed from the care of a parent.[34] The panel considered the implicit bias that Sarah may have historically experienced and the impact this may have had on her

engagement with services. A recommendation has been made to address this point.

5.2.17 At the time that Sarah's children were removed, she did not have access to support from services. Since 2013, the Pause Service in Hackney provides this vital support. The Pause Service is an intensive, trauma-informed, and relationship-based model that works with women who have experienced, and are at risk of having children removed from their care:

> *The Pause Programme supports women to break the traumatic cycle of repeat pregnancies and removals. Pause is an 18-month, individually tailored package of support for women. It is delivered by dedicated Practitioners working intensively with women, to address a broad range of emotional, psychological, practical, and behavioural needs.*

[32] Morris L. *Haunted futures: The stigma of being a mother living apart from her child(ren) as a result of state-ordered court removal.* The Sociological Review. 2018

[33] Ibid, p.818.

[34] Bywaters, P et al: *Paradoxical evidence on ethnic inequities in child welfare: Towards a research agenda.* Children and Youth Services Review, 2019 Vol. 96 PP.145-154.

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5.2.18 Sarah was not referred to Pause when her youngest child was placed in his father's care in 2016. This was because he was not removed under a formal process and so a referral to Pause was not considered. With hindsight, Children's Services have informed the panel that they will consider a referral to Pause outside of formal processes of removal.

5.2.19 The panel welcomed the good practice of having a substance misuse team embedded within Children and Family Service which can provide advice and guidance to social workers in relation to issues of substance misuse.

In light of research which emphasises the disproportionate impact of children being removed from mothers of colour; it is important that Children and Family Services undertake implicit bias training in order to adopt a more anti-racist approach in their practice.

Recommendation 13: The Hackney Community Safety Partnership to obtain from Hackney CFS an update on the work being done to address disproportionality in the social care system.

Recommendation 14: The Hackney Community Safety Partnership to identify the training offer for statutory services to address implicit bias and to adopt an anti-racist approach in partnership practice.

Substance use:

5.2.20 Sarah had significant contact with Westminster Drugs Project until she was discharged from their services in November 2017. During this time, Sarah attended a number of programmes, and her vulnerabilities and needs were identified, leading to her referral to the Hidden Harm worker, the member of staff responsible for working with parents who use substances. She was also asked about domestic abuse as part of her assessment, which was reviewed every 12 weeks, where Sarah reported there had

been abuse but that it was historical.

5.2.21 However, the Review Panel felt that there were missed opportunities to offer Sarah the support she needed and to support her to continue to use the service. This is particularly in regard to the following issues:

- Although Sarah engaged with treatment, she did have periods of missing appointments. This was followed up by offering other appointment dates, but it is not documented if the reasons for her absence were explored with her during keywork sessions. Understanding what prevented Sarah from coming to appointments would have enabled her keyworker to support her during those times. There was also no attempt to alter the service to better meet her needs, rather than offering the same service at another date.
- Towards the end of her treatment episode, Sarah experienced a number of health issues which resulted in a hospital stay. Although the service carried out a home visit and completed a treatment review, Westminster Drugs Project should have explored with Sarah what support she might have needed to help assist her attending service-based appointments or could have shaped the adoption of a more assertive outreach approach, where the emphasis wasn't placed on Sarah attended the service's premises.

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- Although the service was aware that a referral to Adult Social Services had been submitted, there was no evidence of follow up regarding the outcome of
the assessment. It would have been beneficial to have gained a full understanding of what services may have been offered to Sarah prior to discharge.

5.2.22 In 2020, Turning Point replaced Westminster Drugs Service as the substance use service in Hackney. Turning Point deliver a number of services in Hackney, including: a criminal justice team who provide a pathway from prison to community services; a rough sleeper team who support people who are homeless or in temporary accommodation; a family, friend and carers service that supports families involved with children's social services and also offers support to those affected by another's substance misuse. The panel welcomed this enhanced service offered in Hackney.

Substance use services must focus more on the root cause of substance use and better partner with service users in supporting them. Recognising that services need to be flexible to meet the complex needs of service users, a more needs led approach, which centres the voice of the service user, would support engagement.

Recommendation 15: The Hackney Community Safety Partnership to identify how the voices of service users who have experienced domestic or sexual violence and abuse can better inform substance misuse service delivery through co-production and co-design.

Recommendation 16: Westminster Drugs Project to ensure that the root cause of the substance use is explored with service users and pathways to mental health services identified.

<u>Domestic abuse services:</u>

5.2.23 Sarah was known historically to Hackney Council's domestic abuse service in 2009, before it was replaced by the Domestic Abuse Intervention Service in 2016, and, after her rape allegation, she was referred to Victim Support by Homerton Hospital. Victim Support demonstrated some good practice in contacting Sarah on the day of the referral and making arrangements for the next contact.

5.2.24 However, the Review Panel noted significant concerns with the response from the IDVA from Victim Support where standard procedure was not followed. After making contact with Sarah, the Victim Support procedure should have included:

- Establishing victim safety and risk issues, and addressing any immediate safety concerns
- Completing a risk assessment as soon as practically possible
- Discussing and providing immediate safety planning
- Completing a needs assessment

5.2.25 Although the IDVA was aware that Sarah was distressed, she did not call her back on the following day as arranged. By the time they called her another day later, Sarah informed them that she was not feeling well and did not think Victim Support could

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offer her the support she was looking for. The IDVA informed Sarah that she would contact her next week to see how things were going with her. Sarah agreed to this.

5.2.26 The IDVA was the last professional to speak to Sarah, which was on the same day that she was murdered by Michael. There is no record of a DASH Risk Assessment being carried out, and no summary of risks highlighted in the initial conversation between the IDVA and Sarah. Further, the Review Panel concluded that the IDVA appeared not to have offered any safety advice or planning, nor to have explored the incident which Sarah reported to the police. Neither is it clear what additional services, if any, were offered. The IDVA could have been more forthcoming in explaining the service they and other services could have offered to Sarah.

5.2.27 Information made available to the Review Panel highlights that the IDVA was an accredited Safe Lives trained IDVA in March 2019 and prior to that she had completed the Victim Support in-house 4-day Domestic Abuse training in March 2018. Whilst the IDVA had a line manager, the supervision records the most recent line management supervision at the time of the IDVAs involvement with this case was in February 2019. Whilst Managing Performance Policy clearly states that supervision for staff should be held at least every 8 weeks as an absolute minimum, this did not routinely happen with this IDVA.

5.2.28 Victim Support has a Domestic Abuse and an IDVA Operating procedure which is reviewed regularly and follows Safe Lives case management best practice. It states that Case reviews of all IDVA work will be routinely undertaken by the line manager every 4 to 6 weeks. However, the Review Panel learnt that if no service is delivered to a victim, the records are deleted from the Case Management System. Because of this, the Review Panel were unable to check to see if a case review had been completed for this case. The Review Panel welcome the fact that the policy has now been changed to retain all domestic abuse records regardless of whether any

services were delivered for the client for a period of 7 years for London.

5.2.29 The following recommendations have already been implemented by Victim Support or are on track:

- Senior management dip sampling of 121 notes and Case Reviews every six months to ensure quality case work and effective support is being offered to survivors in line with the Victim Support IDVA Operating protocol.
- Service-wide internal audit based on Safe Lives Leading Lights Standards. The audit programme is important in raising standards and ensuring adherence to the Victim Support IDVA operating procedures. This is undertaken every 3-4 years and was most recently completed in 2021.

Domestic abuse services must see interactions with victims as being the one chance to provide support and risk assess. It is vital that services adhere to commitments and are risk and needs led.

Recommendation 17: Victim Support to ensure that staff are regularly trained and supervised, and case reviews are undertaken.

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Housing:

5.2.30 Sarah's interaction with Hackney Housing was limited and the availability of information from this period has been impacted by the cyber-attack Hackney was subjected to. However, the Review Panel were made aware that an anonymous call was made against Sarah for loud music in April 2018. As this was the first report received against her, the matter was referred to a Housing officer. The result of this referral is unknown due to the cyber-attack. However, in light of Alyssa (Sarah's daughter) highlighting that 'a drug taker was living in the flat next door to Sarah who had warned all residents not to call the police to the block and they were frightened to call the police,' the Review Panel were keen to know what checks and visits were undertaken by Hackney Housing to ensure the safety of their tenants. Unfortunately, the cyber-attack has meant this information is unavailable, but Hackney Housing will be reviewing their support to tenants through the adoption of the Domestic Abuse Housing Alliance accreditation.

5.2.31 In August 2017, contact was made from Children's Services to Adult Safeguarding alerting them of an insect infestation in Sarah's home. There is no detail of this in the information made available to the Review Panel from Hackney Housing. Again, the Review Panel were keen to know that checks and visits were undertaken to ensure the safety and upkeep of properties.

5.2.32 The Review Panel welcomed that Hackney Housing would undertake the Domestic Abuse Housing Alliance accreditation, which supports local authority housing teams to achieve and embed standards of good practice for responding to domestic abuse.

5.2.33 Michael's contact with Housing services was also limited, with him presenting at Hackney Housing Advice and Homelessness Team in February 2019 seeking help to find accommodation as he was sofa surfing. During the initial assessment, Michael was reluctant to share details of his offending history. The caseworker tried to make

referrals to housing providers, but they required more details on his offending history. The case worker contacted Michael on three separate occasions requesting for him to make contact, but he did not return the calls.

5.2.34 Michael presented at the Greenhouse Single Homeless Project three days after the last attempt the homelessness team made to contact him. He was described as being hostile to staff in his demands to ask why no one had made contact with him. It was explained to him that several attempts had been made to contact him and voicemails left, with no response. He next presented at Greenhouse in April, where he was apologetic, and agreed to a referral to Assisted Homes. The housing case worker attempted to follow up with both Michael and Assisted Homes to determine the outcome of the referral, however, no response was received from either. A decision was made in July 2020 to close his case, by which time he was in custody for Sarah's murder.

Domestic abuse often takes place in the home and so the role of Housing is vital in identifying and supporting victims. Housing officers must be trained to connect the

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dots between rent arrears, condition of a property, who lives in a property, and experiences of domestic abuse.

Recommendation 18: Hackney Housing Advice and Homelessness Service to ensure follow up with agencies to determine the outcome of referrals.

Recommendation 19: The Hackney Community Safety Partnership to identify how housing partners can better be incorporated into the wider partnership approach to domestic abuse.

Multi-agency working involved with Sarah and/or Michael:

5.2.35 There are examples of good multi-agency working in this review which would have provided support for Sarah. This has been referenced elsewhere in this report and includes referrals from health services to substance use services, to the Adult Community Rehabilitation Team, and to the co-located IDVA based within Homerton Hospital.

5.2.36 However, there were a number of services supporting Sarah that the Review Panel felt lacked multi-agency working and streamlining of support offered to her. This is particularly when considering the lack of robust substance use support available to Sarah despite a number of agencies flagging the impact this had on her health and wellbeing. On a number of occasions, substance use services were offered to Sarah. However, Sarah had negative experiences of previously accessing the service and she would decline referrals by downplaying her alcohol use or informing professionals that she was accessing support from elsewhere. This was not followed up by professionals, nor was there any multi-agency working to understand the barriers Sarah faced in accessing this support.

5.2.37 Further, there are agency specific examples of referrals not being made between agencies to support Sarah:

Royal London Hospital:

- Psychiatry referral: Sarah presented due to an injury sustained while intoxicated, She had a fall from a height and a review from psychiatry should have been considered to ensure this was not with suicidal intent
- Self-Neglect referral: Sarah demonstrated alcohol dependency and drug seeking behaviours although declined support. A safeguarding adult referral may have been appropriate given her care and support needs and risk of self-neglect via alcohol misuse

Homerton Hospital:

- Police referral: Sarah made a rape allegation which was not followed up in 2018.
- MARAC referral: A domestic abuse risk assessment should have been undertaken and a referral to MARAC should have been made based on

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professional judgement. Instead, Sarah was 'offered' a referral to MARAC which is concerning practice.

East London Foundation Trust:

- Talking therapies: Sarah was offered mental health support but was told she would need to address her substance use at the same time. No further support from other services was offered.

Adult Safeguarding:

- Age UK: It is unclear if there was any follow-up with Age UK following the two referrals made to them (2017 and 2018). Furthermore, when Sarah was admitted to hospital in 2018, there had been no contact made with Age UK prior to the second referral that was made to them, to establish the level of engagements that they had with Sarah in 2017, specifically whether she had fully engaged or if services had been cancelled. There is a contractual obligation for Age UK to notify the local authority of any issues of access or other concerns. However, an information gathering conversation may have assisted in confirming or identifying any informal care arrangements for Sarah.
- Children services: Contact was made from Children's Services to Adult Safeguarding in August 2017 alerting them of an insect infestation in Sarah's home. There appear to have been no follow-up calls or email communication between either the hospital social work team or the community ASC team and the CFS referrer to gather further information and/or clarity on the concerns. There was also no contact made with housing upon receipt of the concern relating to 'insect infestation' to understand if there were other environmental or self-neglect related concerns.

Westminster Drugs Project:

- Sarah was discharged in November 2017 which no full exploration of her support needs nor an offer of wider support that was available to her. This information was not shared with her GP.

Housing:

- There is no detail on the outcome of the noise complaint received by Hackney Housing against Sarah in April 2018. There is no evidence of referrals being made to other services from Housing.
- The Hackney Benefits and Housing Needs Team supporting Michael, did not make referrals to other support available to him when he presented as homeless in January 2019.

MPS:

- There is no evidence of Michael being offered support after his arrest in July 2019. Doctors were unable to undertake an assessment due to his behaviour, but no further plans were made to assess Michael and to determine if he was

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a risk to himself or others. Michael was not referred to other services and a Multi-agency public protection arrangement (MAPPA) was not undertaken to manage violent sexual offenders.
- Sarah was known historically to the police as a result of the abuse that she experienced from Paul. Despite this, the last contact Sarah had with specialist domestic abuse support was in 2009. The Review Panel were not made aware of any risk assessments or referrals made by the police for domestic abuse support for Sarah.

5.2.38 There were also instances of limited information sharing between agencies. MPS had historic detail of Sarah being exploited by a man who stayed with her and refused to leave. This was not shared with other professionals, despite the police concerns of Sarah's vulnerability.

Domestic abuse victims can only be supported if professionals appropriately share each puzzle piece to build a picture of need. In addition, no one agency can solely address domestic abuse. A coordinated approach, with robust referrals pathways between agencies, is needed to ensure that victims receive the support they need.

Recommendation 20: The Hackney Community Safety Partnership to identify how to adopt a stronger coordinated community response to domestic abuse.

Organisations' access to specialist domestic abuse agencies.

5.2.39 Sarah was known to a number of statutory services, but her involvement with specialist domestic abuse agencies and wider specialist services is limited. She was known historically to the Council's previous domestic abuse service in 2009.

5.2.40 There are a number of specialist services which were operating in Hackney during the timeframe of this review. However, as Sarah was unknown to them, it is clear that no referrals were made to any of them between 2017-2019, until August 2019 when Sarah was known to Victim Support.

5.2.41 This is significant, as this review has found that Sarah regularly did not feel supported

by a number of statutory services. Sarah also had negative experiences with statutory services from previously being arrested by the police through to her children being removed by Children's Service, which may have negatively impacted her feeling safe to access statutory services. Sadly, we are unable to hear directly from Sarah on her relationship with statutory services. However, we know from research that victims of domestic abuse have a mistrust of statutory services.[35] As Sarah often withdrew from statutory service support, it can be strongly suggested that she too had these concerns.

5.2.42 Further, we know that there are additional barriers that women experiencing multiple disadvantage face in getting the support they need from statutory services. As a disabled woman of colour who was using substances as a coping mechanism, Sarah

[35] Evans, M and Feder, G.S Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support Health Expectations, 19 (1) (2014), pp. 62-73

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could have benefitted from specialist services from a 'by and for' agency who would be able to adopt a more intersectional approach to understanding Sarah's challenges and the support that she needed.

5.2.43 There is extensive research which supports this approach.

- A national online survey of over 400 survivors of sexual abuse found that among survivors who had used both sectors, over 70 per cent were more satisfied with voluntary sector services than with statutory services.[36]
- Eighty-nine percent of women accessing a Black and Minority Ethnic (BME) led 'by and for' ending VAWG organisation reported improvements in their mental health and well-being[37]
- Ninety-nine percent of women responding to a research study in London with survivors of violence said that the BME led women's organisations made them feel safe and protected. Women pointed to the understanding held by specialist workers in regard to the intersecting impact of interpersonal and structural forms of violence, their language, cultural context, racism and immigration issues.[38]
- The report of the Independent Mental Health Taskforce to NHS England entitled the Five Year Forward View on Mental Health (2016) stated that

  'More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.'

5.2.44 The Review Panel have found that statutory services needed to do more to connect Sarah with the specialist support available in Hackney. Instead, Sarah received an overly medicated model of support which emphasised her substance use as the "issue" rather than recognising her holistic needs.

5.2.45 Michael was also unknown to specialist services. The Review Panel have been made aware that Michael's behaviour was considered a barrier to services being able to engage with him. However, there is no evidence that he was referred to a Respect

accredited domestic abuse perpetrator service.

Specialist services provide a vital role in supporting victims from minoritised background and/or those who feel unsupported by statutory services.

Recommendation 21: The Hackney Community Safety Partnership to identify how to centre the offer of specialist services to promote their work to statutory services.

[36] Smith, N., Doganru, C. & Ellis, F (2015) Hear Me, Believe Me, Respect Me. Focus on Survivors: A survey of adult survivors of child sexual abuse and their experiences of support services. University Campus Suffolk & Survivors in Transition.

[37] Imkaan (2012) Vital Statistics 2: Key findings report on Black, Minority Ethnic and Refugee Women's and Children's experiences of gender-based violence. London: Imkaan

[38] Imkaan (2013) Beyond the Labels: Women and girls' views on the 2013 mayoral strategy on violence against women and girls. London: MOPAC

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Recommendation 22: The Hackney Community Safety Partnership to identify how to promote sexual violence services across the partnership.

The policies, procedures, management, supervision, and training available to the practitioners involved on domestic abuse issues.

5.2.46 Agencies involved in this review have a range of policy, procedures, and training in place in relation to domestic violence and abuse and these were described in each agency's IMR.

5.2.47 A summary of the agencies with domestic abuse policies and their training is outlined in the table below:

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Agency	Domestic Abuse policy and review date at time of this report	Domestic Abuse Training
Children and Family Services	No specific policy, but adhere to Domestic Abuse Intervention Service Protocol	● Safe and Together training Together Consultations ar specific issues within a fa ● Domestic Abuse Awarenes for staff.
Domestic Abuse Intervention Service	Domestic Abuse policy in place which was last reviewed in 2021	● Staff providing a direct serv ● Training across Children a is located) on Anti Racist
Probation Service	Domestic Abuse policy in place which was last reviewed in April 2020.	● Mandatory training is provid Domestic abuse, and Adu

Westminster Drug Project	Domestic Abuse policy in place which was last reviewed in August 2021.	● A one-day training course is recently outsourced the tra abuse provider and will be
Hackney Housing	Domestic Abuse policy in place which was last reviewed in 2022.	● Domestic abuse e-learning is offered to staff
Hackney Homelessness Services	Domestic Abuse policy in place which is being reviewed as part of DAHA accreditation.	● There are 3 training course 1 E-learning, and Level 2 & 3
Victim Support	DA and an IDVA Operating procedure which is reviewed regularly and follows Safe Lives case management best practice.	● Victim Support IDVAs are e complete Safe Lives accredite Induction includes training on assessment, safety planning,
London Ambulance Service	Domestic Abuse policy in place which was last reviewed in October 2021	● All clinical staff attend a Saf 3 mandatory training day.
Adult Social Care	No specific domestic abuse policy	● Training is not mandatory, b workshop help by the Dom ● Domestic Abuse is also incl training and referenced in

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Royal London Hospital	Domestic Abuse policy in place which was last reviewed in March 2019.	● A hospital IDVA from Sol Safeguarding Adults Level 3 Domestic Abuse- Level 3
City Road Medical Centre	No specific domestic abuse policy	● Level of training is depende by NHS England. ● IRIS training is voluntary for
East London Foundation Trust	Domestic Abuse policy in place which was last reviewed in March 2020.	● Domestic abuse is discusse Statutory and Mandatory train 3. ● ELFT provides stand-alo services.
Homerton hospital	Domestic Abuse policy in place which was last reviewed in 2022.	● Domestic abuse is included Safeguarding training deli external trust is shared ac ● Bespoke training is delivere other services within the c ● Plans have been made for t specific training to AE, Se
Somerford Grove Practice	Domestic Abuse policy in place which was last reviewed in November 2020.	● Mandatory yearly E-learning the practice ● The IRIS service offers yea sessions and reviews of s
Metropolitan Police BCU (name here)	Domestic Abuse policy in place which was last reviewed in 2022.	● Between the 2 July and delivered Domestic Abuse M

Turning Point	No specific domestic abuse policy	● There is no standalone dom complete mandatory safeg children training. ● The Safe and Together n have attended the one-day w
Hackney Education	No specific domestic abuse policy	● Domestic Abuse is covered but not offered as a stand

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Having a clear and robust domestic abuse policy in place which is regularly reviewed can provide an organisation with the support and guidance to best respond to domestic abuse. It is also important that this policy is accompanied by regular and stand-alone domestic abuse training, which is mandatory for any appropriate professional to attend.

Information provided by the Review Panel shows inconsistencies across agencies in having a policy and/or domestic abuse training. In addition, much training that is delivered is through wider safeguarding training. To ensure staff get a nuanced understanding of domestic abuse and an awareness of the availability of local specialist service, it is important that a move is made towards commissioning and attending training delivered by specialist and ‘by and for’ services.

Recommendation 22: The Hackney Community Safety Partnership to ensure that all agencies’ policies are up to date, or, for those without one, to ensure a policy is developed. The policy must be accompanied by regular and mandatory training on domestic abuse.

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6. Conclusions and Lessons to be Learnt 6.1

Conclusions

6.1.1 Sarah was tragically murdered by a man she had recently met and who she offered support to. Michael had an extensive history of violence, particularly against women, and was known to target and abuse vulnerable women. Despite this history, and the many services supporting Sarah, the risk to her went unidentified and resulted in her tragic murder.

6.1.2 But Michael's actions must not be allowed to overshadow Sarah's life. The conversations the Chair has had with Sarah's family has shed a light on her strong character. Despite the many challenges she experienced in her life, Sarah was always ready to help others. It is this memory of Sarah which endures and will be missed.

6.1.3 The Review Panel extends its sympathy to all those affected by Sarah's death and

thanks all those who have participated in the review

6.1.4 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.

6.2 Key Themes and Learning Identified

6.2.1 The most substantive learning in this case has related to five areas: not seeing beyond Sarah's presenting needs, the limited understanding of multiple disadvantage, the lack of assessment of domestic abuse outside of a 'traditional' intimate relationship, the lack of involvement of specialist services in supporting the needs of a minoritised woman, and the lack of management of dangerous offenders:

Not seeing beyond Sarah's presenting needs:

6.2.2 Despite Sarah being known to many different services in the two years preceding her death, it is clear that agencies focused on addressing Sarah's presenting need rather than looking beyond and understanding her wider vulnerabilities and needs. Sarah primarily had frequent contact with health agencies and this review shows that more needed to be done to understand the root cause of these contacts. Although it is important to highlight that positive attempts were made to meet Sarah's immediate health needs, these were often taken at face value and a lack of professional curiosity meant that Sarah was not supported holistically.

6.2.3 Further, the review has found that there was limited multi-agency working between partners. Different agencies held information on Sarah, which, if shared effectively through a broader partnership working approach, could have put the pieces together to build a clearer picture of Sarah and her needs.

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6.2.4 This would have been particularly helpful considering that Sarah often minimised her vulnerabilities or would give different agencies different information, due to her previous negative experience of accessing services. We know that no one agency can single handily tackle domestic abuse and that a coordinated community response is needed to provide victims with the support they need. Recommendations have been made to address these points.

Limited understanding of multiple disadvantage:

6.2.5 This review has also found that there was a limited professional awareness of the intersection of experiencing abuse, substance use, and mental health. As discussed earlier, experiencing abuse can have a significant impact on the mental wellbeing of victims and can result in them using substances as a coping mechanism for managing the trauma. Tragically, across her life course, Sarah experienced significant abuse and we see her using substances to manage this trauma. We also see her mental health being impacted. She would often reach out for mental health support but would be told

she would need to address her substance use first. We also see instances where professionals did not believe Sarah's disclosures of abuse due to either her substance use or her poor mental health. The separation of these three intersecting issues meant that Sarah was not able to get the support she needed.

6.2.6 Fortunately, Hackney has since published a multi-agency health strategy which assesses the needs of the population, maps the challenges, identifies the opportunities, and explains how they will work collaboratively with partners and with service users to deliver the priorities, as well as how they will monitor their progress. In particular, the strategy's emphasis to jointly develop a new substance misuse contract that better integrates substance misuse and mental health services. This includes psychiatric liaison, access to therapy and specialist support, which is especially welcome.

6.2.7 However, addressing multiple disadvantage must go further, and the response must include an understanding of domestic abuse in the relationship between mental health and substance use. Recommendations have been made to address these points.

<u>The lack of assessment of domestic abuse outside of a 'traditional' intimate relationship</u>

6.2.8 The review found that professionals did not consider domestic abuse because Sarah and Michael were not connected in a, what is generally understood to be, 'traditional' intimate relationship. Indeed, this view of the relationship also resulted in delays in this review being undertaken, as clarification was needed to understand if the criteria of a domestic homicide review was met.

6.2.9 Instead, the Review Panel understands that Sarah and Michael were casual intimate partners, and the relatively short relationship was underpinned by power and control. This was not identified by agencies, despite the police having a historic record indicating that Sarah had experienced similar circumstances with another male a few years prior to her murder.

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6.2.10 There is a growing awareness of wider experiences of domestic abuse in relation to familial abuse and parental abuse, but there is a need to make sure that professionals are identifying and responding to risk in a broader domestic abuse context.

<u>Lack of involvement of specialist services:</u>

6.2.11 We know from research that women who experience domestic abuse may have a mistrust of statutory services and may find it difficult to engage with them. In particular, we know that victims from a minoritised background face additional barriers in accessing mainstream services, including institutional racism, issues of cultural competence, implicit biases in the workforce, and lack of diversity within frontline services.

6.2.12 As a disabled woman of colour, Sarah may have found the support of a specialist service more helpful in meeting her holistic needs. However, this review has found that there was a lack of engagement of specialist services, particularly of 'by and for' services, which could have supported Sarah, especially when she took a step back from statutory services.

6.2.13 Fortunately, Hackney has a well-developed VAWG strategy for 2019-2022, which places particular emphasis on the role of specialist services and the need to improve pathways between them and statutory services. Many of the recommendations made in this review will build on, or add to, the initiatives that are already underway to develop local processes, systems and partnership working. The new and refreshed VAWG strategy has been published in October 2022.

The lack of management of dangerous offenders:

6.2.14 This review has highlighted the challenge facing services in managing and responding to dangerous offenders. Michael presented to Housing, Probation, and the Police in a confrontational and even abusive way. Services described the difficulty they faced in trying to engage Michael and to undertake routine practice, which impacted being able to hold him to account, and also in offering him support.

6.2.15 Additionally, a range of studies note the challenges associated with the invisibility and/or lack of interventions aimed at domestic abuse perpetrators.[39] Support for victims is vital, but we know that a lack of engagement of the perpetrator is problematic, as this results in the root cause not being addressed. This is especially true as research also shows that perpetrators will and do continue to be violent in future relationships.[40] This was indeed the case with Michael. Therefore, engaging perpetrators, despite how they present, is key to holding them to account for their abusive behaviour and to be able to offer them the right support to change.

6.2.16 Hackney offers perpetrators the opportunity to change their behaviour through the Domestic Abuse Prevention Programme, a 26-week group programme for men who have been violent or abusive towards a partner or ex-partner. The programme only

[39] Westmarland, N., and L. Kelly, 'Why Extending Measurements of 'Success' in Domestic Violence Perpetrator Programmes Matters for Social Work', The British Journal of Social Work, 43.6 (2013), 1092.

[40] Ibid. 1093

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provides support to those who wish to address their behaviour and who are willing to accept accountability for their actions. Recognising that this would not have been appropriate for Michael, there is a need to ensure that violent offenders like Michael are both held to account and referred to appropriate support. Recommendations have been made to address these points.

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7. Recommendations

7.1 Single Agency Recommendations (Identified by Individual Agencies)

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

7.1.2 These recommendations are also presented by agency in the single agency recommendation action plan template in Appendix 3. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to Hackney Community Safety Partnership.

Adult Safeguarding

7.1.3 Hospital Social Work Team to audit hospital discharges where the individual has declined an offer of support from ASC in order to test out if there is “sound” rationale for non-progression, particularly where there are known vulnerabilities.

7.1.4 To work with the City & Hackney Safeguarding Adults Board to complete and circulate a “Professional Curiosity” briefing, as this has featured in a number of Safeguarding Adults reviews.

7.1.5 To liaise with Turning Point to arrange a training / awareness raising session to assist ASC to better understand the services and support available to people who may have addiction issues.

Royal London Hospital

7.1.6 To ensure routine psychiatry and self-neglect referrals are made when assessing patients, or to make an adult safeguarding referral where appropriate.

7.1.7 To improve attendance on domestic abuse training as there has been low numbers since the pandemic.

7.1.8 To identify dedicated clinical staff working with substance misuse expertise to advise hospital staff.

City Road Medical Centre

7.1.9 To be vigilant to the additional needs of ex-offenders by linking up with external partners and specialist services.

7.1.10 To ensure that IRIS training is regularly delivered to staff.

East London NHS Foundation Trust

7.1.11 To ensure staff remain up to date with domestic abuse and substance misuse training.

7.1.12 Explore more around support networks that service users have by ensuring that staff attend Care Act training, focusing on Section 42 enquiry.

7.1.13 A question around domestic abuse to be included in routine enquiry in assessments with service users.

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7.1.14 Ensure patient’s capacity is recorded in progress notes where there are questions around someone’s cognition and insight.

Homerton University Hospital Foundation Trust

7.1.15 To complete a Think Family Audit for publication in January 2023.

7.1.16 HUHFT SAT and SCT to target departments where there is a high prevalence of

domestic abuse reported to improve referrals and risk assessments through targeted training.

7.1.17 HUHFT SAT and SCT to update the Domestic Violence Policy to reflect any recommendation from the DHR.

7.1.18 To liaise with Turning Point to arrange a training / awareness raising session to assist staff to better understand the services and support available to people who may have addiction issues.

7.1.19 To set up a panel to discuss and better respond to complex cases.

7.1.20 To produce a 7-minute briefing and case reflection on Professional Curiosity. 7.1.21 To discuss the case with the Patient Safety Team and produce a spotlight on learning.

7.1.22 To review the impact of the 7-minute briefing on Domestic Abuse, Self-Neglect and Mental Capacity published in November 2021.

Somerford Grove Practice

7.1.23 To strengthen communication between GPs and the social worker team by inviting social services teams to the monthly Primary Care multi-disciplinary meetings.

7.1.24 To hold regular multidisciplinary meetings to discuss vulnerable patients.

7.1.25 Patients with moderate to severe alcohol dependence issues should have more care worker support, or systems to help them not fall between the cracks of care, through discussing these cases at the Primary Care multi-disciplinary meetings and monitoring patients who are not attending appointments and liaising with Care Support Workers.

Hackney Housing Department

7.1.26 To achieve Domestic Abuse Housing Alliance accreditation.

London Ambulance Service NHS Trust

7.1.27 To ensure staff are trained to understand and assess safeguarding risks of someone who meets adult at risk criteria, when undertaking emergency visits.

Victim Support

7.1.28 To ensure quality case work and effective support is being offered to survivors in line with the Victim Support IDVA Operating protocol. Through randomly selecting a sample of open and closed cases per service for quality assurance every 6-8 weeks; monitor the quality of the audit process through dip sampling of 121 notes and case/ quality reviews at least 3-6 monthly; and liaising with the relevant staff to discuss outcomes and ensure learning and improvement.

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7.1.29 Continue to conduct service-wide internal audit (every 3-4 years) based on Safe Lives Leading Lights Standards to raise standards and ensure adherence to Victim Support's IDVA operating procedures through: caseload reviews; being compliant with Safe Lives Leading Lights Standards; applying due diligence for all onward referrals; and positive stakeholder engagement.

7.1.30 To repeat delivery of MARAC induction workshop for all new IDVAs and to strengthen

training programme to ensure regular MARAC training is delivered to IDVAs.

Westminster Drugs Project

7.1.31 To ensure a full exploration of a service user's vulnerabilities and needs is undertaken to ensure continued engagement with a service.

7.1.32 To ensure that information sharing practices are in place and up to date, and that multi-agency meetings are called to provide a handover at the point of discharge of a vulnerable service user.

Hackney Child and Family Services

7.1.33 To ensure that referrals are made to 'Pause' so that mothers who have children removed are supported.

7.1.34 To review and offer training to staff on substance use, trauma-informed practice, and multiple-disadvantage.

7.1.35 To review how the Family Group Conference offer is being utilised by social workers. These can be offered to families to help explore and understand their wider support network, including friends and social supports.

Probation

7.1.36 To ensure that high risk offenders are seen weekly in Approved Premises by a named Probation Officer.

7.1.37 Address substance misuse use with service users leaving custody by completing referral to substance use service at point of initial sentence plan; arranging a three-way meeting in the event of disengagement; and through regular exchange of information throughout course of licence.

7.1.38 Addressing mental health / personality disorder needs by identifying key agencies involved at point of initial sentence plan, and if none involved, proceeding with a vulnerable adults' referral; if engaged with services, arrange three-way meetings and/or regular exchange of information throughout course of licence/order; and if sectioned, Probation Practitioner to ensure attendance and or update from ward rounds and Clinicians involved.

Hackney Education Service

7.1.39 To review and update the training offer to staff to raise awareness of domestic abuse.

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7.2 Multi Agency Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.

7.2.2 These recommendations are also presented in the multi-agency recommendation action plan template in Appendix 4. The Hackney Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan.

Recommendation 1: The Hackney Community Safety Partnership to identify how it can better raise awareness and improve responses to people impacted by multiple disadvantage who have experienced domestic and sexual abuse.

Recommendation 2: The Hackney Community Safety Partnership to identify how to better raise public and professional awareness of the impact of domestic abuse on victims who have a disability.

Recommendation 3: The Hackney Community Safety Partnership to identify how to raise awareness between domestic abuse and 'cuckooing.'

Recommendation 4: The Hackney Community Safety Partnership to identify how to raise awareness of domestic abuse experienced outside of a 'traditional' intimate relationship.

Recommendation 5: Homerton hospital to ensure that staff are trained on the correct referral procedure in responding to domestic abuse.

Recommendation 6: East London NHS Foundation Trust to ensure that the City and Hackney Mental Health Strategy 2019-23 is used to move away from a medicated model and instead holistically support service users, especially those experiencing domestic and sexual violence and abuse.

Recommendation 7: East London NHS Foundation Trust to provide assurance to the Hackney Community Safety Partnership that an appropriate response is adopted to the needs of service users who have multiple needs such as substance use.

Recommendation 8: City Road Medical Centre to improve their routine enquiry to establish if a patient may be a risk to themselves or others.

Recommendation 9: The MPS Mental Health Toolkit to be updated to include guidance on safely and appropriately undertaking an assessment of a non-compliant individual is in custody.

Recommendation 10: The Hackney Community Safety Partnership to identify how to improve services' responses to violent offenders.

Recommendation 11: MPS to monitor the impact and changes resulting from the publication of the new domestic abuse guidance on undertaking risk assessments and referrals to specialist services, and to share any findings with the Hackney Community Safety Partnership.

Recommendation 12: MPS to ensure frontline police officers are trained on understanding the relationship between sexual violence and mental health.

Recommendation 13: The Hackney Community Safety Partnership to obtain from Hackney CFS an update on the work being done to address disproportionality in the social care system.

Recommendation 14: The Hackney Community Safety Partnership to identify the training offer for statutory services to address implicit bias and to adopt an anti-racist approach in partnership practice.

Recommendation 15: The Hackney Community Safety Partnership to identify how the voices of service users who have experienced domestic or sexual violence and abuse can better inform substance misuse service delivery through co-production and co-design.

Recommendation 16: Westminster Drugs Project to ensure that the root cause of the substance use is explored with service users and pathways to mental health services identified.

Recommendation 17: Victim Support to ensure that staff are regularly trained and supervised, and case reviews are undertaken.

Recommendation 18: Hackney Housing Advice and Homelessness Service to ensure follow up with agencies to determine the outcome of referrals.

Recommendation 19: The Hackney Community Safety Partnership to identify how housing partners can better be incorporated into the wider partnership approach to domestic abuse.

Recommendation 20: The Hackney Community Safety Partnership to identify how to adopt a stronger coordinated community response to domestic abuse.

Recommendation 21: The Hackney Community Safety Partnership to identify how to centre the offer of specialist services to promote their work to statutory services.

Recommendation 22: The Hackney Community Safety Partnership to identify how to promote sexual violence services across the partnership.

Recommendation 23: The Hackney Community Safety Partnership to ensure that all agencies' policies are up to date, or, for those without one, to ensure a policy is developed. The policy must be accompanied by regular and mandatory training on domestic abuse.

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Appendix 1: Glossary

A&E	Accident and Emergency

AAFDA	Advocacy After Fatal Domestic Abuse
AFV	Adult Family Violence
BAMER	Black, Asian, Minority Ethnic and Refugee
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CPS	Crown Prosecution Service
CSP **CSU**	Community Safety Partnership Community Safety Unit
DAHA **DASH RIC** **DHR** **DI** **FSW** **FLO**	Domestic Abuse Housing Alliance Domestic Abuse Stalking and Harassment Risk Indicator Checklist Domestic Homicide Review Detective Inspector Family Support Worker Family Liaison Officer
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IO	Investigating Officer
LAS	London Ambulance Service
LGBT	Lesbian, Gay, Bisexual and Trans
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MPS	Metropolitan Police Service
RASSO	Rape and Serious Sexual Offences

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SCRG	(MPS) Specialist Crime Review Group
SIO	Senior Investigating Officer

SOIT	Sexual Offence Investigation Technique
SPOC	Single Point of Contact
VAWG	Violence against Women and Girls
VSHS	Victim Support Homicide Service

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Appendix 2: Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Sarah and Michael following the death of Sarah in August 20219. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Sarah and Michael during the relevant period of time 14th July 2017 to August 2019. To summarise agency involvement prior to 14th July 2017.

2. To 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. 3. To 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.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6. To contribute to a better understanding of the nature of domestic violence and abuse.

7. To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

8. The Independent Chair of the DHR will:

a) Chair the Domestic Homicide Review Panel.

b) Co-ordinate the review process.

c) Quality assure the approach and challenge agencies where necessary.

d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. The Review Panel:

a) Agree robust terms of reference.

b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

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c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.

d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.

e) Agree and promptly act on recommendations in the IMR Action Plan.

f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.

g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:

o The purpose of the review has been met as set out in the ToR;

o The report provides an accurate description of the circumstances surrounding the case; and

o The analysis builds on the work of the IMRs and the findings can be substantiated. h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

i) On completion present the full report to Hackney Community Safety Partnership.

j) Implement your agency's actions from the Overview Report Action Plan.

Hackney Community Safety Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan. b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.

c) Forward Home Office feedback to the family, Review Panel and STADV.

d) Agree publication date and method of the Executive Summary and Overview Report.

e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will make reference to the terms domestic abuse and coercive control. The Review applies the statutory definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

    (a) physical or sexual abuse

    (b) violent or threatening behaviour

    (c) controlling or coercive behaviour

    (d) economic abuse

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    (e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[41]

11. Economic abuse is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[42]

12. 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."

    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Sarah and Michael (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
14. The Review Panel identified the following protected characteristics of Sarah and of Michael as requiring specific consideration for this case: Sex, Race, and Disability
15. The following issues have also been identified as particularly pertinent to this homicide: Substance use, Mental health, Class and Removal of children.

16. Consideration will be given by the Review Panel as to whether either the victim or the perpetrator could be considered to be an 'Adult at Risk' under the following definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."
    Abuse is defined widely and includes domestic and financial abuse.

[41] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted
[42] ibid

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Expertise: The Review Panel will therefore invite the following organisations to the panel as an expert/advisory panel member to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.

- Sistah Space, a community-based organisation created to bridge the gap in domestic abuse services for African heritage women and girls
- IMECE Women's Centre, a woman only charity whose aim is to empower Black, Minority Ethnic and Refugee women

17. The CSP/Chair of Review/other panel member will make the link with relevant interested parties outside the main statutory agencies.
18. The Review Panel agrees it is important to have an intersectional framework to review Sarah and Michael's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Membership

19. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
20. The following agencies are to be on the Review Panel
    a) NHS North East London CCG
    b) Homerton University Hospital NHS Foundation Trust: Community Health Services
    c) Homerton University Hospital NHS Foundation Trust: Hospital Services
    d) East London NHS Foundation Trust
    e) City Road Medical Centre

f) Somerford Grove Surgery

g) Hackney Adult Social Care

h) Hackney Family Social Care

i) Hackney Community Safety

j) Hackney Learning Trust

k) Hackney Housing Services

l) Domestic Abuse Intervention Service

m) NIA Ending Violence

n) Imece Charity

o) Victim Support

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p) Sistah Space

q) Metropolitan Police Service

r) The Probation Service

s) Turning Point Substance Use Service

t) London ambulance Service

Role of Standing Together Against Domestic Abuse (Standing Together) and the Panel

21. Standing Together have been commissioned by Hackney CSP to independently chair this DHR. Standing Together have in turn appointed their DHR Associate Shabana Kausar to chair the DHR. The DHR team consists of two Support Officers and a DHR Manager. The DHR Support Officer (Helene Berhane) will be the main point of contact and will coordinate the DHR and the DHR Team Manager (Hannah Candee) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

22. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
23. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Sarah and Michael during the relevant time period: a) NHS Northeast London CCG

    b) Homerton University Hospital NHS Foundation Trust: Community Health Services

    c) Homerton University Hospital NHS Foundation Trust: Hospital Services

    d) East London NHS Foundation Trust

e) City Road Medical Centre

f) Somerford Grove Surgery

g) Hackney Adult Social Care

h) Hackney Family Social Care

i) Hackney Community Safety

j) Hackney Housing Services

k) Domestic Abuse Intervention Service

l) Metropolitan Police Service

m) The Probation Service (for Michael)

n) London ambulance Service

24. Chronologies and a short report will be completed by the following organisations: **72**

a) Local Authority Education Services and/or School(s)

b) The Probation Service (for Sarah)

c) Turning Point Substance Use Service

d) Victim Support

25. Further agencies may be asked to completed chronologies and IMRs if their involvement with Sarah and Michael becomes apparent through the information received as part of the review.

a) Imece Charity

b) Sistah Space

c) NIA Ending Violence

26. Each IMR will:

o Set out the facts of their involvement with Sarah and/or Michael.

o Critically analyse the service they provided in line with the specific terms of reference. o Identify any recommendations for practice or policy in relation to their agency. o Consider issues of agency activity in other areas and review the impact in this specific case.

Key Lines of Enquiry

27. In order to critically analyse the incident and the agencies' responses to Sarah and/or Michael, this review should specifically consider the following points:

a) Analyse the individual responses of agencies to the victim and perpetrator in identification, assessment and interventions to manage the needs and risks identified for either individual and whether the responses met expected levels of practice

b) Analyse the multi-agency working involved with Sarah and/or Michael [and wider family].

c) Analyse organisations' access to specialist domestic abuse agencies.

d) Analyse the policies, procedures, management, supervision, and training available to the practitioners involved on domestic abuse issues.

e) Analysis should pay particular attention to:

- How agencies identified and overcame barriers in accessing support
- How agencies identified vulnerability and responded to individuals' experiences of multiple disadvantage
- How agencies responded to Sarah and Michael's Substance use
- How agencies responded to Sarah's and Michael's Mental health
- How agencies responded to Sarah's and Michael's race
- How previous responses to Sarah's experiences of agencies, and her reports of abuse to them (concerning previous intimate partners), may have affected her confidence in agencies.

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- How agencies responded to Sarah's experience of domestic abuse outside of the 'traditional' intimate partner relationship.
- The effect of the loss of Sarah children on her and what assessment was undertaken, and support/interventions offered to Sarah when her children were subject to consideration by Children's Services
- How agencies responded to concerns regarding Sarah's self-neglect
- How agencies responded to the Michael's history of violence against women and how agencies responded to him
- How agencies responded to Michael's self-harm

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review 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

28. 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 Hackney Community Safety Partnership on their action plans within six months of the Review being completed.
29. Hackney 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 and other informal networks

30. The review will sensitively attempt to involve the family of Sarah 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 the Victim Support Homicide Service.

31. The Review Panel discussed the involvement of children in the DHR at the 1st Panel Meeting and have decided it is inappropriate for this review. The panel has considered the following factors; age, proximity to the homicide and view of Children's Social Care of child/children's needs. 32. Michael will be invited to participate in the review.

33. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information. 34. The Review Panel will consider the involvement of other informal networks of Sarah and/or Michael.

Media handling

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35. Any enquiries from the media and family should be forwarded to Hackney Community Safety Partnership who will liaise with the Chair. Panel members are asked not to comment if requested. Hackney Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.
36. Hackney Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

37. 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.
38. 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.
39. 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 will be password protected.
40. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.
41. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when

it has been verified as the work address for an individual or charity.

42. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

43. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

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

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a) The Data Protection Act 2018 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

b) The Guidance and the Explanatory Notes to the Domestic Violence, Crime and Victims Act 2004 paragraph 7 of Section 2, states that the purpose of a DHR is to safeguard victims (see Section 2, paragraph 7(a)) and to prevent domestic violence and homicide (see Section 2, paragraph 7 (d). Therefore, the legal power to share with the Review is created by Section 7(2) of Part 2 of Schedule 2 of the Data Protection Act 2018.

c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

o The review team should be informed about the existence of information relevant to an inquiry in all cases; and

o The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or o partial redaction of record content.

d) 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).

e) 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) **76**

Appendix 3: Single Agency Recommendations – Action Plan Template *Agency Name*

Recommendation

Scope : local / regional	Action to take	Lead Agency	Key mil the rec

Appendix 4: Multi Agency Recommendations – Action Plan Template

Recommendation

Scope : local / regional	Action to take	Lead Agency	Key mile the reco
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