



**HARINGEY COMMUNITY SAFETY PARTNERSHIP
DOMESTIC HOMICIDE REVIEW**

**Overview Report into the death of Asen
February 2016**

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Preface

1.1 Introduction

- 1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9 (3), Domestic Violence, Crime and Victims Act 2004.
- 1.1.2 This report of a Domestic Homicide Review (DHR) (hereafter ‘the review’) examines agency responses and support given to Asen, a resident of the London Borough of Haringey (hereafter simply ‘Haringey’) prior to the point of his death in February 2016.
- 1.1.3 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.
- 1.1.4 The review will consider agencies’ contact/involvement with Asen and the perpetrator Katya (who was subsequently convicted of murder) from 1st January 2015 to February 2016 (the reason these dates were selected is explained below, see 1.6.5). The review will also consider what information was known about both parties prior to this point.
- 1.1.5 The key purpose for undertaking this review 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.
- 1.1.6 This review process does not take the place of the criminal or coroner’s courts nor does it take the form of a disciplinary process.

1.2 Outline of the circumstances that led to the review

- 1.2.1 In February 2016 police were called by the London Ambulance Service (LAS) as two people were believed to be deceased at an address in Haringey. Asen was found deceased, with multiple stab wounds, and was pronounced dead at the scene. Katya was found with several stab wounds but was alive. She was treated by LAS before being taken to hospital where she underwent surgery.
- 1.2.2 Katya was arrested for the murder of Asen in February 2016. Katya was found guilty of the murder of Asen in August 2016. Later in August 2016 she was sentenced to life imprisonment, with a minimum tariff of 16 years.
- 1.2.3 The Review Panel expresses its sympathy to the family of Asen, as well as to all those affected by this tragic incident, and extends its thanks to those who directly or indirectly contributed to the review process.

1.3 Timescales

- 1.3.1 The Haringey Community Safety Partnership (the Community Safety Partnership for Haringey), in accordance with the Revised Statutory Guidance for DHRs (March 2013), commissioned this review. While the review was commissioned prior to the release of the 2016 edition of the Revised Statutory Guidance for DHRs, the chairs have been mindful of this latest guidance in both the conduct of the Review Panel and the preparation of the Overview Report and Executive Summary.
- 1.3.2 The Metropolitan Police Service (MPS) notified the Haringey Community Safety Partnership (CSP) on the 23rd February 2016 that the case should be considered as a review. The Haringey CSP decided to conduct a review, and having agreed to undertake a review, the Home Office was notified of the decision in writing on 23rd February 2016.
- 1.3.3 Standing Together Against Domestic Violence (STADV) was commissioned to provide an Independent Chair for this review on 8th June 2016. The first meeting

of the Review Panel was held on 13th September 2016. There were subsequent meetings on 6th December 2016 and the 9th February 2017. The report was not finalised until an interview could be completed with Katya, with this occurring in May 2017. The final report was agreed by the panel electronically and the report was handed to the Haringey CSP in June 2017.

- 1.3.4 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The initial delay between notifying the Home Office in February 2016 and the commissioning of STADV was because the Strategic Violence Against Women and Girls (VAWG) Lead changed at the end of March 2016. Once the new post holder was in place, the process for commissioning an Independent Chair began in April 2016, with STADV being appointed in June 2016. The delay from June to September was because of a decision to wait till after the summer holidays to ensure good attendance at the first panel.

1.4 Confidentiality

- 1.4.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.
- 1.4.2 In managing confidentiality, the Review Panel agreed that the country of origin of the subjects of the review would not be explicitly identified. This was in recognition of the complexity of the case (there is conflicting information about the nature of the relationship), as well as information shared by Katya's mother about the reasons that Katya did not want to return to her country of origin (for reasons of shame). Consequently, the report identifies both as being Turkish speaking and Muslim, but it does not identify a country of origin, noting only that both were from the same Turkish speaking community in an Eastern European (EU) country.
- 1.4.3 It has not been possible to engage family members of Asen in this review, as described below in 1.10, and as a result the decision to use a pseudonym could not be discussed with them. The Review Panel discussed this issue and agreed

to approach IMECE (see paragraph 1.6.7 for an explanation of this service) for advice on common names used in Turkish speaking Eastern European (EU) communities. To minimise the potential risk of causing offence or hurt to the families of those affected these names were cross referenced with the family trees developed by the police as part of their enquiries. Two potential names were ruled out through this process.

1.5 Dissemination

- 1.5.1 The report and findings will be disseminated to all CSP members, as well as DHR panel members. The report and findings will be published on the council's website.
- 1.5.2 The findings will also be considered, together with the actions, at the monthly meeting of the Statutory Officers' Group (SOG), which is the senior level meeting of key senior officers at the Council.
- 1.5.3 Locally, a report on the process of, and learning from, the DHRs conducted in Haringey to date (since they became a statutory requirement), as well as national learning, has been completed. This was presented to SOG in March 2017, as well as the Local Safeguarding Children Board and Safeguarding Adults Board. This report recommended that all reviews should be fed into the Training & Development Task and Finish Group of the VAWG Strategic Group to ensure that learning is reflected in local training. When this review is finalised, the recommendations will be disseminated widely amongst all partners and learning will be included within local training through this process.
- 1.5.4 It has not been possible to engage family members of Asen in this review, as described below in 1.10. However, as part of the review process, a letter was written by the chairs, translated and sent to family members, providing an update on the review process and a named contact at the Haringey CSP to whom they could direct any enquiries if they wanted to receive any further information on the

review process, receive a copy of the report, be updated in relation to publication or discuss the next steps in terms of any action plan.

1.6 Terms of Reference

1.6.1 The full Terms of Reference are included at **Appendix 1**. In summary, these were as follows:

- To review the involvement of each individual agency, statutory and non-statutory, with Asen and Katya during the relevant period of time 1st January 2015 to February 2016 (inclusive).
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

1.6.2 This review aims to identify the learning from Asen and Katya's 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.

1.6.3 The Review Panel comprised agencies from Haringey, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted in July 2016 to inform them of the review, their participation and the need to secure their records.

1.6.4 Prior to the establishment of the review, Haringey CSP undertook a scoping exercise in February 2016 to identify which agencies had contact with either Asen or Katya. The results of this scoping exercise were used to inform the constitution

of the Review Panel. The scoping exercise identified that very few agencies had contact with either Katya or Asen. Those agencies that had contact were asked to provide Individual Management Reviews (IMRs) (see 1.7.7 - 1.7.9 below), while a Review Panel was constituted with a wider range of agencies (described in 1.6.6, 1.6.7 and 1.8 below).

- 1.6.5 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved and established that the period to be reviewed would be from 1st January 2015 to the date of the homicide (this was originally noted as being in February 2016, but as Asen was last seen in January 2016, his death may have been earlier). This period was chosen because it was known that Asen and Katya had moved to the United Kingdom in 2015, with their arrival later narrowed with information shared by the police as being in August or September 2015. The review also considered what information was known about Asen and Katya prior to this point in the UK for Asen, as he had previously worked in the UK, and agencies were asked to summarise any relevant contact they had with Asen prior to January 2015. The Review Panel also considered whether to seek information about Asen and Katya during their time in their country of origin, where they had previously been residents. While agencies were asked to summarise any information from this country if this was known, it was felt that the most likely source of this information would be the families of Katya and Asen if contact could be made.
- 1.6.6 At the first Review Panel meeting the chairs and Review Panel discussed those diversity and equality issues particularly pertinent to this review, which were identified as: ethnicity and language (both Asen and Katya were from a Turkish speaking community in an Eastern European (EU) country; Turkish was their first language) and sex (Asen was male and Katya was female).
- 1.6.7 Thus, the following two organisations were invited to be part of the review due to their experience in relation in working with specific communities even though they had not been previously aware of the individuals involved:

- The first, with expertise in work with people from Black, Minority Ethnic and Refugee (BMER) communities was IMECE. The organisation supports BMER women, particularly Turkish, Kurdish and Turkish Cypriot women. IMECE assists women survivors of Violence against Women and Girls through provision of a wide range of services in a safe, secure and women only space.
- The second, with experience in work with men, was Victim Support. The organisation provides a pan-London Domestic Violence Service, enabling victims access to specialist support through both Independent Domestic Violence Advocates (IDVAs) and other support workers. In Haringey, The Mayor's Office for Policing and Crime (MOPAC) has funded an additional part-time Independent Domestic Violence Advisor (IDVA) and a part-time Domestic Violence Caseworker, supporting high risk male victims of domestic abuse and familial abuse victims (both female and male).

1.7 Methodology and contributors to the review

- 1.7.1 The report refers to 'domestic violence'. The cross-government definition of domestic violence and abuse (implemented March 2013) is included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:
- 1.7.2 "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
- 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 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.
- 1.7.6 The approach adopted was to seek IMRs and chronologies of contact from all organisations and agencies that had contact with Asen/Katya over the Terms of Reference time period. Whether they had contact was established through a scoping process carried out prior to the first meeting, through discussions at the first meeting, and through letters and telephone calls to those not in attendance.
- 1.7.7 The following agencies reviewed their files and notified the Review Panel that they had not been involved with Asen or Katya and therefore had no information for an IMR:
 - Adult Services – Haringey Council
 - Anti-Social Behaviour Team and Community Safety – Haringey Council
 - Barnet Enfield Haringey Mental Health NHS Trust
 - Children and Young People Service – Haringey Council
 - London Community Rehabilitation Company (CRC)
 - Haringey Advisory Group on Alcohol (HAGA) RISE
 - Homes for Haringey (including Hearthstone)
 - Integrated Offender Management
 - London Fire Brigade
 - National Probation Service (NPS)

- Nia
 - Solace Women's Aid
 - Victim Support Pan London Domestic Violence Service
 - Whittington Health NHS Trust
 - Youth Justice Service – Haringey Council
- 1.7.8 Additionally, no referral had been made for Katya or Asen to the local Multi-Agency Risk Assessment Conference (MARAC) for the highest risk victims of domestic violence. The MARAC locally is coordinated by STADV. This has a bearing on independence of and is discussed further in 1.13.7 below.
- 1.7.9 Chronologies and IMRs were requested from:
- A Medical Centre (General Practice)
 - Metropolitan Police Service
 - North Middlesex University NHS Trust (NMUHT)
- 1.7.10 IMR authors were not directly involved with the victim, perpetrator or any family members, for all agencies apart from the Medical Centre where the IMR author had some limited contact with Katya and this is considered further in 1.7.12 below.
- 1.7.11 The IMRs received from MPS and NMUHT were comprehensive and addressed the Terms of Reference, enabling the Review Panel to analyse the contact with Asen and/or Katya, and to produce the learning for this review. The IMR authors of these reviews were independent of line management of the individuals in the case.
- 1.7.12 The IMR received from the Medical Centre was adequate but there were areas where the background information or analysis were not sufficient. During the review, the Review Panel had to seek clarification and further explore several issues and questions were sent to the Medical Centre, with responses being received. In addition, the IMR author was not fully independent. The author noted: "We are a small team and most if not all of the team will have contact with our

patients at some point or another. In the case of this patient [Katya] she was seen by one GP and our Healthcare Assistant. I am the IMR author and the Practice Manager here at [the Medical Centre], I did not have direct with the patient/perpetrator but did send her a letter to confirm that her pregnancy test was positive as we were unable to reach her on the contact number we have for her. In that respect I would consider myself independent”. The Review Panel accepted this assurance as to independence in spirit (if not the letter of the statutory guidance, where section 66 of the reviewed statutory guidance states “Those conducting IMRs should not have been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR”).¹ However, the Review Panel felt this illustrated the process challenge for smaller General Practices, where it may not be possible to provide an independent the author or undertake quality assurance. This is commented on further in the analysis of the Medical Centre IMR (section 3.2).

1.8 The Review Panel Members

1.8.1 The chairs were:

- Althea Cribb, Independent Chair (Associate, Standing Together Against Domestic Violence)
- James Rowlands, Independent Chair in Training, who acted as a co-chair and was the author of the Overview Report (Associate, Standing Together Against Domestic Violence)

1.8.2 The Review Panel members were:

- Hazel Ashworth – Haringey CCG

¹ Home Office (2016) *Domestic Homicide Reviews: statutory guidance*, London: Home Office

- Feride Kumbasar – IMECE
- Claire Kowalska – London Borough of Haringey
- Fiona Dwyer – London Borough of Haringey
- Pam Chisholm – MPS
- Julie Tweedy – MPS
- Nick Langford – NHS England (London)
- Karen Ingala Smith – Nia
- Chantel Palmer – NMUHT
- Sharmeen Narayan – Solace Women’s Aid
- Eleanora Serafini – Victim Support

1.8.3 Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case. The Review Panel met a total of three times and see above 1.3.3 for dates.

1.8.4 The Chairs of the Review wish to thank everyone who contributed their time, patience and cooperation to this review.

1.9 Parallel reviews

1.9.1 *Criminal trial:* The criminal trial concluded on 12th August 2016, which meant the Review Panel did not meet prior to the conclusion of the criminal justice process and there were no issues in relation to disclosure. However, the Senior Investigating Officer (SIO) was invited to the first panel meeting to provide an overview of the criminal investigation.

1.9.2 *Coroner Inquest:* An inquest was opened by Her Majesty’s Coroner, Andrew Walker Esq from Barnet, on the 2nd February 2016 and was adjourned pending the outcome of the criminal trial. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted

contemporaneously that impacted upon this review. A copy of the report will be passed to HM Coroner following Home Office approval.

1.10 Involvement of family, friends, work colleagues, neighbours and wider community

- 1.10.1 Initially, the family of Asen were notified by the MPS Family Liaison Officer (FLO) of the decision to undertake a review on 15th September 2016, however the Haringey CSP did not formally notify the family of Asen in writing of their decision to undertake a review. In future, the Haringey CSP should ensure that such a notification is made at the earliest opportunity. No recommendation is made in relation to this point of practice because the Chairs of the Review have been assured that learning in relation to the DHR process has been captured in a report to senior officers (as discussed in 1.5.3).
- 1.10.2 The Chairs of the Review and the Review Panel acknowledged the important role Asen's family could play in the review. From the outset, the Review Panel sought to involve the family. The immediate family of Asen (his brother and father) had informed the FLO when notified about the review that they would be willing to be contacted regarding the review and that their preferred means of contact was by letter. Individual addressed letters were sent from the chairs to both Asen's brother and father, initially by email on the 11th November 2016 and then followed in writing on the 12th December 2016 when the postal address was confirmed. The letters included the Home Office leaflet for families and identified Advocacy After Fatal Domestic Abuse (AAFDA) as a support service. At the point that this report was finalised no response had been received from either the father or brother of Asen. A final letter was sent to both, providing an update on the review process and a named contact at the Haringey CSP to whom they could direct any enquiries if they wanted to receive any further information on the review process, receive a copy of the report, be updated in relation to publication or discuss the next steps in terms of any action plan.

- 1.10.3 Additionally, Asen's wife (Lejla) provided a statement to the MPS and gave evidence in the trial. However, she did not have a phone number or email address and contact could only be made through Asen's father. As no response was received from Asen's father the Review Panel was unable to take contact Lejla.
- 1.10.4 The FLO was also aware of a cousin, although it was not possible to contact them to confirm whether they would be willing to participate in the review.
- 1.10.5 In parallel, the mother of Katya (Aisha) was contacted. Aisha lives in Katya/Asen's country of origin and was initially contacted by the MPS and agreed to take part in the review. Subsequently a conversation took place between the Chair of the Review Althea Cribb and Aisha over the phone, through a Haringey interpreter, on the 6th December 2016. The chair made a transcript of the conversation and any direct quotes are as they were reported by the interpreter.
- 1.10.6 As part of the contact with Aisha, the chair attempted to explain that the review was not connected with the criminal justice process or the trial. It was difficult for the chair to explain her role and the purpose and process of the DHR, and the Review Panel was concerned that Aisha did not fully understand. The Review Panel agreed that ongoing support for Aisha was outside the scope of the review. However, in recognition of this unresolved issue, it was agreed that after the finalisation of the report the chair would facilitate contact with Aisha by IMECE. This would allow IMECE to explore what, if any, ongoing support Aisha wanted and which organisation was best placed to do this in either the United Kingdom or her home country. When making this contact, IMECE have agreed to provide an update on the review process and will be able to provide a named contact at the Haringey CSP to whom Aisha can direct any enquiries if she wants to receive any further information on the review process, receive a copy of the report, be updated in relation to publication or discuss the next steps in terms of any action plan.
- 1.10.7 In contacting the families of both Asen and Katya the Chairs of the Review were mindful of the potential language barrier, given the families spoke Turkish.

Arrangements were made to translate written materials and, where contact was made with the family, to facilitate this through a translator.

- 1.10.8 All letters made clear that the participation of both Asen's and Katya's family in the review was voluntary, and that they could contribute in different ways: for example, through a face-to-face meeting with the Chair of the Review, making a statement, through a telephone conversation, and Skype (not an exhaustive list). The letter emphasised that their contributions could take place at a time and place of their choosing, and that their involvement in the review would not be rushed.
- 1.10.9 Unfortunately, because it was not possible to contact the family of Asen, there was no family involvement in setting the Terms of Reference. For the same reason, the family of Asen have not had sight of or commented on this report as it was drafted or in its final form. However, as noted in 1.10.2 above, the family of Asen were provided with an update at the end of the review to ensure that they had a named contact in the Haringey CSP should they subsequently wish to engage with the review process.
- 1.10.10 Because Asen's family were not involved in setting the Terms of Reference, the Review Panel did not feel it appropriate to share a copy of the Terms of Reference with Katya's mother (Aisha). However, as described in 1.10.5, Aisha was contacted as part of the review process and her comments are reflected in the report. As with Asen's family she was also provided with an update at the end of the review to ensure that they had a named contact in the Haringey CSP should they subsequently wish to engage with the review process.
- 1.10.11 Consideration was given to involving the children of both Asen and Katya. However, given none of the children had lived with Asen and Katya as a couple and were not resident in the United Kingdom, it was agreed that they would not be involved.
- 1.10.12 The Independent Chairs of the Review also attempted contact with Katya via the prison in which she is detained in October 2016. Initially Katya's Supervising Officer responded that they felt Katya was in too "fragile" a mental state to be

informed of the review. The Independent Chair made contact three months later, and received a more positive response. On request, the letter about the review was translated into Turkish, and was then emailed to Katya's Supervising Officer on 19th January 2017. Katya's Case Worker confirmed that the letter had been given to Katya to read and consider. Although an answer was promised, and was chased on 21st February 2017, at the final drafting stage of the report, an answer had not been received.

- 1.10.13 Enquiries by the MPS, as part of the criminal investigation, did not identify any friends of either Asen or Katya.
- 1.10.14 During the criminal investigation, the MPS took several statements from witnesses including neighbours of Asen and Katya who were also resident in the same rented accommodation block. The information obtained was shared in court, and with the Review Panel in the IMRs. The MPS agreed to contact these witnesses and seek their permission to utilise their statements in the Overview Report. However, at the time of the trial the rented accommodation block had been closed and sold for redevelopment, meaning that the FLO's contact attempts were restricted to telephone calls rather than letters or a visit to the property. The outcome was as follows: messages were left but no response was received from the landlord, the manager did not wish to participate. Of the other tenants, contact attempts were made. The outcome was as follows: messages were left but no response was received, the telephone number for one was no longer in use and two indicated they were willing to participate in the review. Subsequently one of these individuals contacted the FLO again and indicated that they no longer wished to participate in the review.
- 1.10.15 The chair (James Rowlands) attempted to contact the remaining witness, and made contact on the third attempt. During a brief conversation, the witness asked to be contacted in January 2017 after the festive period. A subsequent attempt to make contact was not successful.

1.10.16 As part of their enquiries, the MPS took several statements from other witnesses including local shop keepers as well as an employer of Katya. The information obtained was shared in court, and with the Review Panel in the police IMR. The Review Panel did not feel it necessary to seek further information from these witnesses.

1.10.17 The Review Panel discussed this and concluded that the information in the statements provided important background information and that, in the interests of transparency would be utilised. However, the Review Panel agreed to keep the information used from these statements to a minimum, using only the summary of information contained in the police IMR. This information is detailed in 2.7.15 and 2.8 below.

1.11 Involvement of the perpetrator

1.11.1 The Review Panel agreed that attempts should be made to interview Katya and an initial approach was facilitated through the Prison Service.

1.11.2 The interview took place in early May 2017 and was conducted by the chair (Althea Cribb) with the support of a member of the STADV DHR team (who acted as a scribe) and a separately commissioned interpreter.

1.11.3 In the interview Katya talked to the chair about her relationship (this information is detailed in 2.9 below). However, Katya also talked about experience of the criminal justice process and her current support. The chair had, at the start of the interview, explained the limits and focus of her role in relation to the conduct of the DHR, however she agreed to provide further information on organisations supporting women in prison to Katya via her Prison Officer.

1.12 Equality and diversity

1.12.1 The Chairs of the Review and the Review Panel considered whether the protected characteristics of age, disability, gender reassignment, marriage and

civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation were relevant to this review.

1.12.2 In identifying the relevant equality and diversity issues for Asen and Katya respectively, the Review Panel noted that:

1.12.3 Asen was a heterosexual male who was 31 at the time of his death. He was from a Turkish speaking community in an Eastern European (EU) country; his first language was Turkish and he spoke limited English. He was a Muslim, but the only reference to his faith was a disclosure made by Katya to staff at the hospital during her booking appointment for maternity care. There is no information available to indicate that Asen had a disability. He was married, but his wife (Lejla) had remained living in his country of origin.

1.12.4 Katya is a heterosexual female who was 37 at the time of Asen's death. She is from a Turkish speaking community in an Eastern European (EU) country and her first language is Turkish; she does not speak English. She is a Muslim, but the only reference to her faith was a disclosure she made to staff at the hospital during her booking appointment for maternity care. There is no information available to indicate that Katya has a disability. She was pregnant and had previously had several terminations (although it is not known if Asen was the father in these previous pregnancies). She was divorced and had two children from that relationship. Her ex-husband and children remained in living in her country of origin.

1.12.5 The Review Panel subsequently identified the following equality and diversity issues in this review as being:

- Ethnicity and language (including the potential risk of so-called 'honour'-based violence);
- Pregnancy and maternity.

1.12.6 These issues are considered further in section 3.5.

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

- Sex is considered a risk factor because the overwhelming majority of victims of domestic violence and abuse are female, with perpetrators being overwhelmingly male. Research has also shown that intimate partner homicides are disproportionately perpetrated by men upon women (ONS, 2014).
- Recent case analysis of intimate partner homicides has been consistent with research. STADV and the London Metropolitan University² noted that the majority, 23 out of 24 of intimate homicides had a female victim and a male perpetrator. This finding is consistent in the Home Office recent analysis of intimate partner homicides.³ However, in this case Katya (a female) was found guilty of Asen's (a male's) murder. The Review Panel therefore felt it important to consider the issues related to men's experience of domestic violence and abuse, including what may help or hinder men seeking support.
- Additionally, while Katya was found guilty of Asen's murder, during the review information was shared in both IMRs and by Katya's family that described incidents where both Asen and Katya appeared to have been injured, as well as incidents where Katya was the victim. While the Review Panel is not empowered to take a view as to the circumstances of Asen's death, which is properly a matter for the criminal justice process, the Review Panel felt it important to consider the wider context of the relationship, including the fuller picture of any violence and abuse that occurred between Asen and Katya. In considering this relationship context the Review Panel therefore reflected on issues relating to the identification

² Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

³ Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office

and management of counter-allegations, or concerns about bi-directional violence, and current practice to establish 'who does what to whom' in such cases.

- The Review Panel provided special consideration to these issues throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.

1.13 Chairs of the Review and author of the Overview Report

1.13.1 The Chair of the Review was Althea Cribb, an Associate of STADV. She has received Domestic Homicide Review Chair's training from STADV and has chaired and authored eleven reviews. Althea has over nine years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

1.13.2 James Rowlands, is also an associate with STADV. James is an Independent Chair in Training: he acted as a co-chair and was the author of the Overview Report. He has been the lead council officer in eight reviews and has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations. Of relevance to this review is his experience in working with men as both victims (as an Independent Domestic Violence Advisor at the Dyn Project in Wales) and as perpetrators (on behaviour change programmes, working with the National Probation Service and a voluntary sector provider). As James was a Chair in Training the report was quality assured both by the DHR Manager with STADV and by his co-chair Althea Cribb before being presented to Haringey CSP.

1.13.3 STADV is a UK charity bringing communities together to end domestic abuse. They aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but

many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

- 1.13.4 STADV has been involved in the DHR process from its inception, chairing over 50 reviews, including 41% of all London reviews from 1st January 2013 to 17th May 2016.
- 1.13.5 Independence: Althea Cribb previously worked in Haringey as a consultant on Haringey's partnership response to violence against women and girls. This work ended in May 2014, which pre-dates the timeline considered as part of this review. Since May 2014, Althea has had no involvement with, and has been independent of, Haringey and the agencies participating in the review.
- 1.13.6 James Rowlands has had some limited contact with Haringey prior to 2013 in a previous role when he was a MARAC Development Officer with SafeLives (then CAADA). This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.
- 1.13.7 STADV does coordinate the MARAC in Haringey. However, neither the victim nor perpetrator of this review were known to Haringey MARAC. In addition, the STADV Associate DHR Chairs do not have any contact or line management responsibilities of the STADV MARAC team. Therefore, Haringey CSP deemed that STADV were adequately independent to chair and author this review.

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	Relationship	Age at time of Asen's death	Ethnic Origin	Faith	Immigration Status	Disability
Asen	The Victim	31	From a Turkish speaking community in an Eastern European (EU) country	Muslim	EU citizen	None known
Katya	The Perpetrator	37	From a Turkish speaking community in an Eastern European (EU) country	Muslim	EU citizen	None known

2.1 Opening remarks

2.1.1 In approaching this and following sections of the report, it is of note that relatively little information has been available to the Review Panel. This reflects both the limited contact that Asen and Katya had with agencies (and which was therefore available in IMRs), but also the limited information that was available from family members and friends, with most of this provided by the MPS from their enquiries, except for an interview with the mother of Katya. The Review Panel therefore found it difficult to further explore, or corroborate, the information that was available to it. Consequently, the Review Panel sought to keep an open mind and explore the potential learning from a range of perspectives, recognising Asen's death, as well as considering the implications of the conflicting information, which suggested that both Asen and Katya may have experienced and/or perpetrated

violence and abuse in their relationship. This approach is reflected in this background information section and the subsequent analysis section.

2.2 The death of Asen

2.2.1 *Homicide:* Asen lived with Katya in Haringey and, during an incident at their shared accommodation, suffered multiple stab wounds. Asen was found deceased in February 2016, but as he was last seen in January 2016, the exact time of death could not be ascertained.

2.2.2 *Post Mortem:* In February 2016, a Home Office Pathologist conducted a special post mortem examination of Asen. The cause of death was given as haemorrhage due to stab wounds to the right leg.

2.2.3 *Criminal trial outcome:* Katya was found guilty of the murder of Asen in August 2016. Later in August 2016, she was sentenced to life imprisonment, with a minimum tariff of 16 years.

2.2.4 At sentencing, the judge said:

“You deliberately failed to get any assistance in the immediate aftermath of him [Asen] sustaining his injuries. I regard this as a significant aggravating factor. Whatever your intention was at the time you injured yourself, you deployed those injuries to your advantage by blaming Asen for causing them. It is clear that Asen was attempting to defend himself by grabbing the blade of the knife you were wielding. I regard the ferocity of the attack and the multiple injuries you inflicted on him, despite Asen’s attempts to defend himself, to be a further aggravating factor. In the absence of a truthful account from you as to how things started, I am not able to determine, with any confidence, how the assaults started or what your intention was from the outset”

2.3 Outline on relationship between Asen and Katya and family makeup

- 2.3.1 *Synopsis of relationship with the perpetrator:* Based on the information collected by the MPS as part of their investigation into Asen's death, Asen and Katya met at work in 2011 in their country of origin. Their relationship was initially kept secret, with information obtained by the police as part of their criminal enquiries and subsequent interviews, indicating that this was because both were already married and there were concerns about the reaction of family and the wider community. There are contrasting accounts as to the nature of this relationship, from Asen's wife (Lejla) (see below 2.6.3), and from Katya's mother Aisha (see below 2.7.2 – 2.7.15), as well as Katya herself (see below 2.9).
- 2.3.2 In August / September 2015, Asen and Katya moved to the UK after their families in their country of origin had discovered the relationship.
- 2.3.3 During the period covered by this review, Asen and Katya lived in a rented accommodation block and their contacts with services were limited, but included some contact with health services and one contact with the police.
- 2.3.4 *Members of the family and the household:* Asen and Katya did not have any children (although Katya was pregnant at the time of Asen's death) and they lived together, living in a rented accommodation block.

2.4 Information relating to the victim (Asen)

- 2.4.1 Asen was the eldest of three children. He was born and raised in a city in his country of origin. He was married to Lejla and had three children. Lejla and the children remained living in his country of origin.
- 2.4.2 Asen had been in the UK previously, having travelled for work before returning to his country of origin. He came back to the UK with Katya in August / September 2015 and was resident in the London Borough of Haringey until his death. He was an EU citizen.

- 2.4.3 During the investigation, the police established that Asen had worked as a delivery man, with this corroborated by information shared by Katya to her midwife.
- 2.4.4 At the time of his death, Asen was 31. He was a Muslim. There is no indication that he had a disability.
- 2.4.5 Asen was not known to the police in his country of origin, following enquiries by the MPS. Asen was also not known to the police in the UK except for the contact described in this report.

2.5 Information relating to the perpetrator (Katya)

- 2.5.1 Katya was brought up in a city in her country of origin. In 1995, she married her husband. It was an arranged marriage and they went on to have two children. Based on the information available to the police in their criminal investigation and repeated by Katya's mother (Aisha), it was understood that this relationship ended in divorce in 2007 but the couple remained living together with their children. However, in the interview with Katya, she did not disclose any divorce and referred to this male as her husband.
- 2.5.2 She had come to the UK with Asen in August / September 2015 and was resident in the London Borough of Haringey until Asen's death. She is an EU citizen.
- 2.5.3 Katya had undertaken a two-week unpaid work trial (see 2.7.15), but otherwise had not been in paid employment while she was in the UK.
- 2.5.4 At the time of Asen's death, Katya was 37. She is a Muslim. There is no indication that she has a disability.
- 2.5.5 Katya was not known to the police in her country of origin, following enquiries by the MPS. Katya was also not known to the police in the UK apart from the contact described in this report.

2.6 Information from the victim's (Asen's) family

2.6.1 Prior to the first meeting of the Review Panel, the FLO from the MPS had been in contact with Asen's father (who lives in Asen's country of origin) and his brother (who lives in Germany).

2.6.2 The FLO provide the following precis of his contact with the family:

"Asen's family claimed that in early January 2016 the couple were due to fly back to [country of origin] however, before they could travel Katya destroyed Asen's passport. On 22/01/2016, Asen went to the Embassy [of his country of origin] and obtained a temporary passport. On 30/01/2016, Asen purchased two one-way tickets to [country of origin] and visited a cousin living in London. He told him he would be returning to the UK after visiting family, but would not be returning with Katya".

2.6.3 Asen's wife (Lejla) provided a statement to the MPS and gave evidence at Katya's trial.

2.6.4 A summary of Lejla's account of her relationship with Asen as follows:

- Lejla told the police that her relationship with Asen had been very good. She said he could be quick to get angry but was also quick to calm down.
- Lejla told police that any information about Asen being violent to her was a lie.
- She disclosed one occasion in their relationship when Asen had hit her. Lejla reported that she had been shouting at their younger child in a loud voice (this was after the child had smeared lipstick on the bed). Asen hit Lejla "very lightly on the shoulder using the back of his open hand". Lejla said she responded to this by smiling at Asen and was not concerned or upset.

2.6.5 Lejla also told the police the following information about Asen and Katya's relationship:

- Lejla, when pregnant with her third child with Asen, become aware that Asen was involved with another woman. She had become suspicious as Asen's phone would ring in the middle of the night. Lejla called the number once and a female answered, who claimed not to know Asen. Over time Lejla felt the female was "leaving clues" i.e. scratches on Asen, lipstick on clothes.
- Lejla reported that she had put a voice recorder in Asen's pocket on one occasion and heard him and a female shouting about why she had a termination without telling him. Lejla heard a bang and thought maybe Asen had hit the woman. Lejla was not there to see whether he had done so and described this as a banging noise, not a slapping noise. She also heard the female talk about Asen being jealous, although Lejla told the police that she did not know Asen to be jealous. Lejla identified the other women as Katya, telling the police that she had challenged Katya once shortly before she left her country of origin for the UK.
- Lejla told the police that she had been in contact with Asen every weekend by Skype, and that she had noticed scratch marks on Asen's neck / chest during these conversations. Lejla described the scratches as red and long and that they looked like they had been caused by nails. She said Asen tried to hide them but could not. Lejla also said that Asen told her that Katya had smashed his phone to stop him talking to her. Asen was also reported to have told her that he was unhappy in the relationship and that Katya "tried to provoke him into hitting her, regularly threatened him with the police and that they argued all the time".

2.6.6 Lastly, Lejla told the police about what Asen had said about returning to his country of origin:

- Lejla had told him that his leaving for the UK had affected their eldest daughter

- Lejla said she had told Asen to leave Katya in the UK, as she did not want to return to their country of origin, but Asen told her that he could not leave Katya alone. Lejla said she told him not to tell Katya that he was bringing her back and to just take her to the airport and let her decide what to do but to call the police if Katya started to scream.
- Lejla reported that Asen had told her that that “he was bringing Katya back ... and was going to finish the relationship”.
- Lejla said that Katya had torn up Asen’s passport.

2.7 Information from the perpetrator’s (Katya’s) family

2.7.1 Katya’s mother (Aisha) was not a witness at Katya’s trial, however she was interviewed by a Review Panel Chair. Her account is based on information she had been told by Katya and it is unclear what, if any, of the account below was the result of contact she directly witnessed.

2.7.2 A summary of Aisha’s account is as follows: Aisha was predominantly concerned with the criminal justice process following Asen’s death, and was angry about the outcome. She felt that Katya had been let down by the criminal justice process and her solicitor, who she claimed had told Katya that she had done nothing wrong, and that she would be out of prison in just a few years if she admitted to killing Asen. Aisha believed her daughter had acted in self-defence after Asen had “cut her throat” and stabbed her in the leg. She felt that this had occurred because Asen wished to return to his country of origin, while Katya had wanted to stay in the UK.

2.7.3 Aisha outlined that Asen and Katya had worked together [in their country of origin], and that Asen was always “chasing” Katya and was “after her”. Aisha had complained to the manager at their workplace about Asen’s behaviour and in the end Katya had to leave the job. Katya was divorced from her husband but they remained living together with their children. Asen had a partner and children he

lived with. Aisha did not want Katya to break up her family; she wanted her to stay with her children. Aisha described Asen as “chasing after other women and then he went after Katya”. She felt that Katya had felt it necessary to leave her job and stay at home because of this contact by Asen.

- 2.7.4 Despite leaving her job, Aisha stated that Asen continued to pursue Katya, sending text messages, making phone calls, and to Katya’s ex-husband as well, including abusive messages, and visiting Katya’s home and threatening her and her ex-husband. Aisha spoke to children’s services and/or police in her country of origin (it was unclear which) about what she could do about Asen’s behaviour towards her daughter. They said that Katya needed to keep the text messages, and fill in a form to make a complaint (it was not clear whether a complaint was subsequently made). Aisha’s cousin spoke with Asen about this, and Asen responded, “let’s see what she’s going to do about me”.
- 2.7.5 It is not known if Aisha subsequently made a complaint, but during investigation by the MPS, the MPS was not informed of any criminal investigation(s) that had taken forward (neither Asen or Katya were known to the police in their country of origin).
- 2.7.6 Shortly after that Asen came to the UK on his own – without Katya and without his own family. Just before he left, he “hit” Katya, “beat her up”. He said “I’m going to take you to England as well” and, Aisha said, “my daughter begged him please, I’m living with my family, you’re going to separate me from my family”.
- 2.7.7 18 months later, Asen returned to his country of origin for a holiday, and started to phone and text Katya, “disturbing her all the time”. Aisha’s son-in-law (Katya’s ex-husband) overheard some of the conversations and threw Katya out. Aisha said that Katya had “begged [him] please don’t believe them, he’s trying to separate us, please don’t do that”. After that Asen “took” Katya to the UK.
- 2.7.8 Once in the UK, Katya had contact with her sister, and told her that Asen’s mother and his partner (who the Review Panel believes is Lejla) (in their country of origin) did not leave them alone, and were constantly pressuring Asen to return home.

Aisha stated that Katya did not want to return, but encouraged Asen to do so, to “sort out your problems in [country of origin] with your kids, and your wife, you can stay there as long as you like, one month, two months, I am staying here”. Aisha stated that Katya had said Asen’s response to this was that Katya wanted to “stay here to find yourself a different boyfriend”, and if she stayed in the UK while he went back to their country of origin “then one and a half months later how am I going to accept you as a partner?”

- 2.7.9 The chair asked if Aisha felt that Katya could have gone to anyone for help about the relationship. Aisha stated that Katya was isolated in the UK – she had no friends or family. She had worked briefly at a hairdresser, but had left because “she always had bruises on her face and arms”. Aisha thought that the hairdressers had not tried to help Katya, just asked her why she stayed with Asen. Aisha also said that Katya would have found it difficult to ask for help, or receive information or advice, because she did not speak English.
- 2.7.10 The chair asked if Katya might have accepted help if it was offered by a Turkish speaking organisation. Aisha replied that she would “definitely” have taken that support.
- 2.7.11 Aisha talked about the incident in which Asen had been arrested for assaulting Katya. She did not understand why Asen had only stayed in the police station one night: “in the street he kicked her, he hit her, and then he was in for one night”. [This was the incident in October 2015, which is described in 2.10.34 - 2.10.39 below. It is of note that Asen was not held in custody overnight as stated by Aisha, as he was released from custody the same day as he was arrested].
- 2.7.12 Aisha felt that Katya was unlikely to make a complaint in that situation, she wouldn’t know how to protect herself, and even with Asen in the police station she wouldn’t have thought “I’m over him”.
- 2.7.13 The chair asked if Katya wanted the relationship to continue at that point.
- 2.7.14 Aisha answered: “things happen I’ll tell you something, she wanted to stay in England, she wanted to have a life in England, she didn’t want to come back to

[country of origin] because lots of things happen here, was shameful for her as well, and then for family, everyone, it was a bit shame. That's why she didn't want to come If Asen wanted to go back ... he could have gone back on his own, he should have stayed in [country of origin], and then Asen cut Katya's throat, he stabbed her, because Asen wanted Katya to come back to [country of origin]" (as a matter of record, the court did not accept this defence).

- 2.7.15 The only other account related to Katya is provided by her former employer's statement to the MPS. She stated that she had provided an unpaid trial period for two weeks at a hairdressing salon and stated that, during the second week, she had noticed old bruising on Katya's upper arms and Katya disclosed that her husband had hit her. Katya was told to report to the police but refused. In the information available to the Review Panel it is not clear whether this reference to a her "husband" was a term of convenience that Katya was using to describe Asen, or whether it related to her husband in her country of origin. However, this contact was after Asen and Katya's arrival in the UK (the exact time frame is unclear, but based on information shared by the police, this was soon after their arrival in August or September 2015).

2.8 Information from neighbours of Asen and Katya

- 2.8.1 The landlord, manager and other residents were spoken to as part of the initial enquiries by the MPS.
- 2.8.2 Two residents stated they heard Asen and Katya arguing regularly. On occasion, one of these residents heard banging, which made them think the arguments were physical. A third resident regularly heard Asen and Katya arguing and things being thrown / broken. About two weeks before Asen's death this resident saw Asen with scratches to his face and neck. This same resident also told the police that he knew they were going back to their country of origin and that Asen planned to return to the UK alone. A friend of one of the residents provided evidence of hearing Asen and Katya arguing on more than one occasion when he was visiting.

- 2.8.3 The manager informed the MPS that shortly after Asen and Katya had moved in, he had heard a serious disturbance coming from their room. When he knocked on the door it was opened by Asen who had several scratches on his chest. Katya looked dishevelled but uninjured. The manager also indicated that other residents had complained about Asen and Katya arguing. They were given several warnings about their behaviour. Around Christmas 2015, Asen and Katya were heard arguing again and were given notice to quit the room. They were due to leave on 1st February 2016.
- 2.8.4 The only other account related to Asen is provided by two local shop workers, who provided a statement to the MPS. The workers reported seeing Asen with scratches on his face and neck a couple of months before his death. They also stated that Asen told them he was returning to his country of origin with Katya.

2.9 Information from the perpetrator (Katya)

- 2.9.1 The following information is taken from the MPS IMR:

“Following her arrest, Katya provided a prepared statement to the MPS in interview in which she said she was attacked and defended herself. She stated that, following the fight with Asen, she lost consciousness and woke to find him dead and tried to stab herself”.

“When interviewed for psychiatric reports, Katya said Asen had been violent to both her and his wife previously in [country of origin] and that this violence continued when they moved to the UK. She described that Asen was persistent in pursuing the relationship and obsessed with her. Asen moved to the UK for about 18 months before returning to [country of origin] in July 2015. They both came to the UK in August 2015 and when she began working as a hairdresser in London, Asen became jealous and controlling, on occasion not allowing her to leave the flat. He would not allow her to take English lessons and controlled what clothes she wore. Katya described a number of different occasions when Asen

had assaulted her, including an incident when he did not allow her to go to work and punched her several times on her arms causing bruising”.

- 2.9.2 The Review Panel agreed that, to supplement this information, Katya should be offered the chance to participate in the review, and Katya subsequently agreed to this, as described in 1.11 above.
- 2.9.3 The interview with Katya lasted about 1.5 hours and covered the following areas:
- The background to Katya’s relationship with Asen
 - The period when Katya and Asen were living in the United Kingdom.
- 2.9.4 Katya explained that her relationship with Asen started in 2011, stating that Asen had approached her as a friend and then “began telling me that he wanted me”. Katya said that she had “... told him not to talk to me like this”. After this conversation, she said that Asen did not contact for a few days but that soon after she would “see [him] hanging around my house around the time I would leave work”. When she asked him why he was doing this, Katya said that Asen had told her “he was concerned about me as it was dark [when she went to work] ... and there were a lot of bad people around at that time” and “he wanted to protect me”.
- 2.9.5 At the time both Asen and Katya were married and Katya talked about the anxiety she experienced about Asen’s initial approaches, fearing that this would make people talk. Katya said that, when they subsequently got together, she remained anxious that people would find out about their relationship. Katya described this eventually happening about 8 months after they first met and talked about the reaction of family and the wider community; this initially took the form of “gossip” but Katya said that it subsequently became very negative, leading to conflict with some family members.
- 2.9.6 Katya was positive about her relationship with Asen, saying for example “he cared about me so no one would cause me harm”. Although Katya did not disclose any violence or abuse in their country of origin, she did describe Asen as being jealous of other men who she had contact with at work.

- 2.9.7 Katya was aware of Asen's wife (Lejla) and said, in contrast to Lejla's description above, that "they had a lot of fights.... He used to beat her up".
- 2.9.8 When talking about their time in the United Kingdom, Katya was very positive about aspects of their relationship saying this was "good" and "initially things were great and we couldn't believe we were finally together".
- 2.9.9 Katya said that her relationship with Asen changed over time, and she credited this to pressure on Asen from his family in their country of origin. She said that this led to arguments and Katya said that "he (Asen) would hit me frequently". Katya also said that Asen wouldn't allow me to "do my makeup or my hair or dress nicely".
- 2.9.10 When asked about whether she would have sought help, Katya said that "I didn't know that there were places to could go to seek help. In my culture, most men beat up their wives, it was something you couldn't get away from".
- 2.9.11 Katya also referred to those occasions she had been offered help. She talked about the time at the salon when her manager had told her to report to the police. She said she did not do so because "I loved him". Katya also said that she would not necessarily have wanted help to leave Asen, but that instead she wanted him to be able to get help as she wanted the abuse to stop.
- 2.9.12 Katya also talked about other contacts, including with the police, and said of these that "no one gave me clear information. If someone had given me clear information on where I could have gone to be protected I would have gone".
- 2.9.13 Katya was asked specifically about her pregnancy when in the United Kingdom and whether she felt should could have asked for help. She stated: "when I fell pregnant he began treating me better so I didn't feel the need to mention anything to anyone".
- 2.9.14 Finally, Katya also explained why she did not want to go back to her country of origin. She said that "going back would be me walking into trouble with two

families” and “going back would mean losing everything that was going well for me”.

2.10 An overview of each agency’s involvement

Organisation Name	Contact with Asen (Y/N)	Contact with Katya (Y/N)
<i>Medical Centre (General Practice)</i>	<i>N</i>	<i>Y</i>
<i>North Middlesex University Hospital Trust</i>	<i>Y</i>	<i>Y</i>
<i>Metropolitan Police Service</i>	<i>Y</i>	<i>Y</i>

2.10.1 Medical Centre (General Practice)

2.10.2 The Medical Centre in this review is a partnership of two General Practitioners in Haringey, London.

2.10.3 Contact with Asen

2.10.4 There is no record for Asen being registered at the Medical Centre, or any other General Practice.

2.10.5 Contact with Katya

2.10.6 Katya registered at the Medical Centre on the 10th November 2015 and she was seen for a new patient health check on the 16th November 2015. At this initial contact Katya requested a pregnancy test and a blood test was taken. She was seen again on the 23rd November 2015, by a healthcare assistant to discuss the results of the blood test; the test was inconclusive and was marked to be

repeated. Katya requested to see a General Practitioner (GP) and an appointment was booked.

- 2.10.7 On the 25th November 2015, the surgery attempted to contact Katya, but could not make contact by telephone. On the same day, a letter was sent to Katya advising her to contact NMUHT to book herself in for maternity care directly or to get in touch with the Medical Centre.
- 2.10.8 Katya saw a GP on 1st December 2015, where a positive pregnancy test result was shared. A referral was made to maternity care at the NMUHT, as well as to the early pregnancy unit to have a scan.
- 2.10.9 The Medical Centre's records are electronic and are limited; reflecting the short period Katya was registered. The IMR author notes that there was "no mention of mental health/relationship problems", repeating this later when asked to consider effective practice and lessons learnt, referring to "no indication of mental distress or disharmony in the relationship".
- 2.10.10 At two of these four contacts (the 23rd November 2015 and 1st December 2015) the record noted that a telephone interpreter was used through Language Line. On the other contracts, it is not recorded whether an interpreter was used.
- 2.10.11 **North Middlesex University Hospital Trust (NMUHT)**
- 2.10.12 NMUHT is an acute hospital, located in the London Borough of Enfield. The Trust serves the local populations of Enfield and Haringey and other surrounding boroughs due to patient choice. The services provided at NMUHT encompass specialist outpatient and inpatient services for both adults and children, which include an Accident and Emergency Department, Maternity Service, Paediatric Services and many other specialities.
- 2.10.13 The services that were accessed by Asen and Katya during the period of this review were the Accident and Emergency Department, Maternity Services and Ultrasound Department. In the period from April 2015 to March 2016, there were

171,850 patients that attended the Accident and Emergency Department and 5,286 babies born in the Maternity Services.

2.10.14 Contact with Asen

2.10.15 Asen had a single contact with NMUHT, specifically the Accident and Emergency Department.

2.10.16 On the 29th of June 2015 at 22:28, Asen presented to the Accident and Emergency Department. Asen registered with the reception, where staff took an initial history. Reception staff recorded that Asen had “post fall, right hand injury pain”. There is no record in relation to Asen and whether any language barrier was noted, although reflecting the information from the police, the Review Panel is aware that Asen had limited English.

2.10.17 Asen’s presentation was such that he was not flagged to triage staff as requiring urgent assessment. When Asen was subsequently called by a practitioner to be assessed in triage, he was found to have left the department prior to being seen.

2.10.18 As there were not safeguarding or life-threatening concerns that had been identified during his presentation, or observed by staff, there was no follow up with Asen.

2.10.19 Contact with Katya

2.10.20 Katya attended a booking appointment with the maternity service as well as two scans in the ultrasound department.

2.10.21 On the 2nd December 2015, Katya attended the Ultrasound Department, having been referred by her GP due to abdominal pain. Katya had an ultrasound scan performed and was found to be six weeks pregnant and her expected due date was confirmed to be the 26th July 2016. The diagnosis following the scan was an early intrauterine pregnancy with uncertain viability. The scan was performed by a consultant obstetrician. There were no disclosures documented at this appointment regarding domestic abuse (it would not be routine for someone to

be questioned about domestic violence at a scan appointment, unless there was a cause for concern which would trigger a selective enquiry).

2.10.22 A further scan was recommended in two weeks on the 16th December 2015. Katya also submitted her GP referral to the maternity service and a booking appointment for maternity care was arranged for the 30th December 2015 and an ultrasound appointment was arranged on the 26th January 2016 for a Nuchal Translucency Scan (see explanation below, 2.10.31).

2.10.23 Katya did not attend her scan appointment on the 16th December 2015.

2.10.24 Katya did not attend her maternity booking appointment on the 30th December 2015; a further appointment was booked for the 7th January 2016.

2.10.25 On the 7th January 2016, Katya attended her booking appointment for maternity care. She was accompanied by Asen and there was a Turkish interpreter present.

2.10.26 At the appointment, Katya did not tell the midwife she had any significant medical history, but told her about her family history of hypertension. Katya said she had not been involved with mental health, social care or other health services and that she felt well. No current health concerns were highlighted with the pregnancy by the midwife. Katya had her booking blood test taken and was given pregnancy advice by the midwife.

2.10.27 During the appointment Katya was recorded as having disclosed the following information:

- She was unable to speak or read English.
- She was a housewife.
- Asen was a delivery man.
- Both Katya and Asen identified their religion as Muslim.
- She had seven previous pregnancies, of which five were terminated and two had resulted in live birth. Both children were with family in her country

of origin. There was no commentary on the father of these children or why they were residing there.

2.10.28 Katya was asked, on her own, regarding domestic violence and abuse and she did not disclose any past or current abuse. It is of note that, in Katya's account, at this contact she did not feel the need to mention anything or ask for help because she felt Asen was "treating me better" (see 2.9.13 above).

2.10.29 The risk factors that the midwife identified were: language issues, previous caesarean section and maternal age.

2.10.30 Katya was booked for consultant led care, shared with the midwife, due to her obstetric history of a previous caesarean section.

2.10.31 Following the booking assessment Katya had a letter generated to advise the GP of the pregnancy and risk factors that had been identified.

2.10.32 Katya attended the ultrasound department on the 26th January 2016 at 14 weeks of pregnancy for a Nuchal Translucency Scan. This scan is to check for abnormalities in pregnancy such as Downs Syndrome or Neural Tube defects. Katya had the scan performed and a further scan booked for anomaly at 20 weeks of pregnancy on the 24th March 2016.

2.10.33 **Metropolitan Police Service (MPS)**

2.10.34 The MPS is the territorial police service responsible for law enforcement in Greater London, excluding the 'square mile' of the City of London.

2.10.35 **Contact with Asen and Katya**

2.10.36 The MPS (Enfield Borough) had contact with Asen and Katya on one occasion prior to the incident that led to Asen's death.

2.10.37 On the 15th October 2015, an independent witness called police after Asen was seen to grab Katya's handbag, search through it and then kick her left leg. He tried to kick her again but she got away before he grabbed her wrist and tried to

drag her into a nearby road. Police located Asen and Katya and he was arrested at 13:20 for common assault.

- 2.10.38 With the assistance of a Turkish-speaking officer Katya was spoken to. She told police Asen was her partner and that nothing had happened; he had been joking as he wanted to go to the shops, so he grabbed her arm. Katya was described by officers as “laughing” throughout most of the DASH Risk Assessment (RA) questions in the 124D booklet.⁴ She answered ‘no’ to all questions and had no visible injuries. Katya denied that she had been kicked; declined referral to the Victim Support Scheme (VSS); was unwilling to provide a statement and could not supply any contact details.
- 2.10.39 When cross referencing this information to the account provided by Katya of her contact with the police, it is of note that her account of this contact is very different. She stated that “no one gave me clear information. If someone had given me clear information on where I could have gone to be protected I would have gone” (see 2.9.12).
- 2.10.40 The independent witness provided a statement. CCTV enquiries near the alleged incident were conducted but no relevant footage was found / identified.
- 2.10.41 A crime report was completed and the DASH RA questions and answers were copied onto the MPS crime recording system (which is called CRIS). The risk was assessed as ‘standard.’ The report was flagged as being ‘Domestic Violence’ related and intelligence checks were completed, which highlighted there was no previous contact with police. No address was recorded for Katya and in the notes section on the Victim Informant Witness (VIW) page it was recorded that she did not know her address or have a telephone number. A Haringey address was recorded for Asen.

⁴ The 124D booklet is a tool to assist officers in the initial investigation of domestic incidents. The booklet provides questions to be asked to identify risk and to enable officers to intervene effectively and contains a tear-off slip to be handed victims; giving them contact numbers for support agencies and information on how police will continue with the investigation.

2.10.42 On the custody record for Asen a different address was recorded, also in Haringey. The matter was referred to the Community Safety Unit (CSU)⁵ and Asen was interviewed with a solicitor present; he made no comment and was described as having limited English. Following an evidential review of the case, no further action was taken and Asen was released from police custody at 20:11. A Domestic Violence Closing Supervisory Checklist was completed on 16th October 2015 by a CSU Detective Sergeant and the crime report was closed.

⁵ CSU's are part of the MPS' Safeguarding Teams. They have overall responsibility for the investigation and management of cases involving Domestic Abuse, Hate Crime or Safeguarding Adults at Risk.

3. Analysis

3.1 Domestic Abuse/Violence

- 3.1.1 Information gathered by the police as part of the murder investigation, as well as information provided by other residents of the rented accommodation block where Asen and Katya lived, other witnesses, and third party accounts from the members of Katya and Asen's family, present a complicated picture. Asen and Katya clearly had regular arguments, indeed the frequency of these led to a notice of eviction from the rented accommodation block where they had resided. The Review Panel has considered whether these arguments were disputes or could be symptomatic of domestic violence.
- 3.1.2 The definition of domestic violence and abuse refers to “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality”.
- 3.1.3 If the review considers the first part of this definition (“any incident”), then Asen was clearly the victim of domestic violence and abuse. He died because of stab wounds inflicted by Katya and his death is the reason that this review was initiated.
- 3.1.4 However, when considering the second part of this definition which, in its broader sense, refers to a pattern of incidents, the picture is less clear:
- In relation to Asen: there is information to suggest he was the victim of domestic violence by Katya. This includes reports of injuries including scratches on his chest (seen by the manager of the rented accommodation block), and scratches to his face and neck (seen by a resident, as well as two workers in a local shop). Additionally, Lejla (Asen's wife in his country of origin) stated that Asen was unhappy, as well as telling police that she had seen scratches and that Katya had destroyed his phone and torn up his passport to stop his return to country of origin. Tragically, it is not

possible to speak with Asen about his relationship and experiences with Katya and, unfortunately, in the absence of contact with his family, the review cannot further explore these issues.

- In relation to Katya: there is information that she was a victim of abuse from Asen. She was seen looking dishevelled but uninjured (by the manager of the rented accommodation block) and was also seen with old bruises (by the hairdressing salon owner) to whom she made a disclosure that her "husband" had hit her (this may have been Asen, see 2.7.15 for a description of this disclosure). In addition, there was the incident reported by an independent witness in October 2015, when she was kicked in public (while Katya denied this at the time, it is of note that, if she was the victim of domestic violence, it is not uncommon for victim to minimise incidents for their own safety). Further to this Katya's statements during the criminal justice process, and in her interview as part of this review, as well as information provided by her mother (Aisha), also serve to suggest she was the victim of domestic violence abuse from Asen. Finally, Lejla also references one occasion where she may have heard Asen hit Katya.

3.1.5 The review is therefore left at an impasse. Asen was certainly the victim of a single incident of domestic violence which led to his death, and Katya has been found guilty of his murder.

3.1.6 Yet, considering the information available to the Review Plan, there is a more complicated picture, with conflicting evidence about whether Asen or Katya experienced domestic violence and abuse in a broader sense of an ongoing pattern of behaviour. Based on this information available either Asen or Katya could have been the victim of domestic violence and abuse. On this basis, considering the specific incident that led to Asen's death, it is possible that Katya may have been a victim who used 'violent resistance' (i.e. violence utilized in response to domestic abuse) against a perpetrator (Asen). Yet equally it is possible that the relationship between Asen and Katya featured bi-directional violence and that this may have been assessed as 'situational couple violence'

(i.e. violence that is not embedded in a general pattern of power and control, but is a function of the escalation of a specific conflict or series of conflicts). These definitions for types of intimate partner violence are most commonly ascribed to the work of Michael Johnson.⁶

3.1.7 Following considerable discussion, the Review Panel felt that this issue could not be resolved. It therefore sought to consider the learning from this set of circumstances regarding practice more broadly. This is because a DHR is by its very nature an unusual event, but the challenge of counter-allegations or concerns about bi-directional violence is not uncommon in practice.

3.1.8 There are specific tools available to manage counter-allegations or concerns about bi-directional violence and to establish 'who does what to whom' (although it is of note that such tools are most commonly used by specialist domestic abuse services; they are not for example used by the MPS). The most well-known version of this tool has been published by Respect, and is part of a Toolkit that has been designed to support and inform work with male victims of domestic violence.⁷ In this toolkit, the issue is summarised as follows:

"In some couples, both parties are using violence. However, it is often the case that one is using violence to defend themselves or the children, or as a means of resistance. In any case, there are risks for both adults and for children witnessing the violence. The appropriate responses will be more effective if the practitioners understand who is doing what to whom and with what consequences. For example, responding to a victim who has used violence in self-defence will not be the same as responding to someone who is the perpetrator. It is therefore very important, when both parties are using violence, to assess clearly who is the

⁶ Johnson, M. P. (2008) *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence*. Boston: Northeastern University Press.

⁷ The Respect Toolkit can be accessed at: <http://www.mensadviceline.org.uk/help-and-information/frontline-workers-and-male-domestic-violence-victims/toolkit-for-work-with-male-victims-of-domestic-violence/> (last accessed 12.02.18)

perpetrator and who is the victim using violent resistance, self-defence or some other form of violence, in the interests of all adults and children involved”.⁸

- 3.1.9 The toolkit includes assessment resources to help practitioners listen to what someone says about their experiences and identify what is going on, to provide the most appropriate help and to make best use of scarce resources. It also enables practitioners to identify any behaviours that someone may themselves be using, which may include identifying if they are in fact a perpetrator.
- 3.1.10 In the guidance for the toolkit, the following categories of client following an assessment are identified:
- Victim/survivor of domestic abuse
 - Perpetrator of domestic abuse
 - Victim who has used violent resistance against the perpetrator
 - Perpetrator whose victim has used violent resistance
 - Mutual violence
 - Unhappy relationship with no abuse or violence
- 3.1.11 Consequently, the Review Panel identified the importance of ensuring that professional training includes information on the typologies of domestic violence, as well as the identification and assessment of counter-allegations and bi-directional violence, including for more specialist practitioners, the ability to undertake an assessment of ‘Who Does What to Whom’.
- 3.1.12 In Haringey, the Review Panel was informed that the delivery and content of training is currently being scoped by the Training & Development Task and Finish Group. There is therefore an opportunity to ensure that local training addresses this practice issue as part of that process. In completing this process, Haringey

⁸ Respect (2013) *Respect Toolkit: Work with male victims of domestic violence (2nd Edition)*, London: Respect. <http://www.mensadvice.org.uk/help-and-information/frontline-workers-and-male-domestic-violence-victims/toolkit-for-work-with-male-victims-of-domestic-violence/> (last accessed 12.02.18)

will also need to identify how it will feed into single agency training, including those agencies that operate across London, such as the police.

Recommendation 1: The Training & Development Task and Finish Group of the VAWG Strategic Group ensures that training around typologies of domestic abuse is included in the minimum training standards that are currently being developed.

- 3.1.13 As the Review Panel was unable to resolve the nature and extent of domestic violence and abuse in the relationship, it sought to identify broader learning informed by what was known about experiences of both Asen and Katya and how agencies might respond to a similar scenario.
- 3.1.14 The Review Panel considered the issues relating to equality and diversity, with a focus on the sex of the victim (reflecting both on men as victims of domestic violence and abuse, as well as the experience of women who experience domestic violence abuse, particularly those who do not speak English or who are from a minority ethnic community). These issues are addressed in 3.5 below.
- 3.1.15 A further feature of this case are the differing accounts of Asen's potential return to their country of origin. For example, Asen's wife (Lejla) stated that Asen wanted to return but Katya destroyed his passport to prevent this; similarly, Asen is reported to have told a cousin he would be returning. In contrast Katya's mother (Aisha) said that while Katya did not want to return, she was not preventing Asen from doing so and was indeed actively encouraging him to go, but that he did not want to leave her because he thought she would get another boyfriend in his absence. Katya herself, in her interview as part of the review, was clear that she did not want to return, stating "going back would be me walking into trouble with two families" and "going back would mean losing everything that was going well for me" (see 2.9.14).
- 3.1.16 The Review Panel did not feel able to make comment on the destruction of Asen's passport, or indeed as to Asen or Katya's intentions in relation to remaining in the

UK or returning to their country of origin. However, the Review Panel did note that just prior to the murder of Asen, the couple had been given notice of eviction.

- 3.1.17 Taken together this information suggests that this was a period of considerable relationship stress, and may have also been the start of a potential separation or at least uncertainty as to the future of the relationship.
- 3.1.18 There is a well-established evidence base as to the risk that is posed around and following the point of separation. For example, the Femicide Census supports the view that women are at significant risk at the point of separation from an abusive partner: 152 (76%) of women killed by their ex-partner or ex-spouse were killed within the first year that followed their separation.⁹ In the recent DHR analysis by STADV and the London Metropolitan University,¹⁰ ten of the victims (10/24) were separated from the perpetrator at the time of the murder and a further two of the victims (2/24) had not separated at the time that the murder took place. However most of this data is exclusively or mostly related to women killed by men.
- 3.1.19 The panel reflected on the potential issues for both Asen and Katya:
- For Asen, if he was the victim of domestic violence and abuse, his subsequent death would certainly fit with this evidence base as to the risk that is posed around and following the point of separation, although it is of note that most of this evidence relates to female victims and there is a far less developed evidence base in relation to male victims.
 - For Katya, if she was the victim of domestic violence and abuse, the Review Panel noted that separation might have increased her vulnerability. For example, her mother (Aisha) talked about why she would not have felt able to return to her country of origin for reasons of shame. The issue of shame, as well as potential consequences from family, was also referred

⁹ Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

¹⁰ Brennan, D. (2016) *Femicide Census: Profiles of Women Killed by Men*, London: Women's Aid and Nia

to by Katya when she was interviewed by the chair. This is considered further in the section on equality (3.5) below).

- 3.1.20 The Review Panel did not make any specific recommendations in relation to separation, but felt that the review provided a further salutatory reminder of the importance of professionals recognising the risks posed around and after the point of separation. The panel also noted that while separation may be an key marker of risk, there may be other ways that this may present. For example, it is important to reflect on Katya's description of wanting "help" for Asen (see 2.9.11). Regardless of the nature of the relationship, it is important to recognise that people may often seek help and support for their partner in the first instance.
- 3.1.21 A further feature of this case is the range of different members of the public, including neighbours, as well as people working in the service industry (shop keepers, the salon owner), who were aware of difficulties, conflict or domestic violence in the relationship. There is no indication that members of the public had critical information that could have made a difference in the outcome of this case and the death of Asen, not least because different people had different information. There was only one direct disclosure of domestic violence and this was by Katya (and when this disclosure was made, the salon owner encouraged Katya to seek help), with a further occasion when a member of the public called the MPS in response to what they had seen. Nonetheless these points of contact serve as an important reminder of the role of the public. Despite significant changes, including the recent focus on coercive control, the understanding of domestic violence among the public, as well as people's knowledge of sources of help and support that are available, is variable. Additionally, individual members of the public are often unsure of their role as 'bystanders'.
- 3.1.22 A key element of the Strategic Objective within the 2016-2026 VAWG Strategy is developing a coordinated community response. This is positive and reflects an increased focus on community responses, an example of which is Women's Aid's

'Ask Me Scheme'.¹¹ As part of that the local strategy, Haringey will develop phased communications campaigns to raise awareness and will have a bystander intervention element which will seek to ensure that everyone across Haringey knows how to respond safely to domestic violence.

Recommendation 2: The VAWG Strategic Group ensures that the findings from this review inform the development of a bystander intervention campaign locally.

3.2 Medical Centre (General Practice)

- 3.2.1 Katya was a registered patient with the Medical Centre although the Medical Centre did not have a great deal of contact with her. Her contacts with the surgery included a routine new patient health check and a GP appointment in relation to her pregnancy.
- 3.2.2 The Medical Centre submitted an IMR, which made no recommendations. The IMR prepared by the Medical Centre was limited, and required further questions to be asked of the Medical Centre. The summary provided below includes the information provided in the IMR and subsequently, and broader learning is considered in relation to both contact by the Medical Centre and the completion of IMRs.
- 3.2.3 The Review Panel accepted that because Katya had limited contact with the Medical Practice, the opportunity to establish a relationship, or make enquiries, which may have resulted in a disclosure of domestic violence were limited. It also noted that, in contact with Katya, the Medical Centre made appropriate use of translators. This is commented upon more broadly as in the section on equality and diversity below (see 3.5)

¹¹ Further information is available on this scheme at <https://www.womensaid.org.uk/our-approach-change-that-lasts/> (last accessed 12.02.18)

3.2.4 However, given the absence of any recommendations, the Review Panel sought additional information from the Medical Centre in relation to training and practice around domestic violence because it is well established that even limited contact with health professionals may provide a unique opportunity for disclosure or enquiry.¹²

3.2.5 The Medical Centre provided the following additional information upon request in relation to training and practice:

- Safeguarding policies are in place which encompass domestic violence; these policies are in line with local Haringey safeguarding policies and procedures as well as national NHS guidelines.
- Training is undertaken internally through practice meetings as well as online training modules for administrative staff and face to face training for clinical staff (GPs and nurses).
- The Medical Centre does not routinely screen for domestic violence but if any member of staff has any suspicions of possible domestic violence they have been instructed to raise it with the Safeguarding Lead. If warranted this will be escalated to Haringey Council's safeguarding team. The Medical Centre also takes part in the local MARAC's process.
- If domestic violence is suspected or confirmed the Medical Centre will record this information in the victim's and the perpetrator's medical record in a way that will not put the victim at risk of any further violence. This is done by adding alerts to the patient's records and using 'coding' where appropriate and safe to do so, which will be visible to staff accessing the victim's or perpetrator's medical record.

3.2.6 In considering the information provided by the Medical Centre, the Review Panel reflected on the IMR author's focus on specific indicators of domestic violence

¹² Eighty percent of women in a violent relationship seek help from health services, usually general practice, at least once, and this may be their first or only contact with professionals. Department of Health: DV: A health response, 2000

(“mental health/relationship problems”, which are also referred to as “mental distress or disharmony in the relationship”) and framing of any disclosure as being received by staff (“No indications from patient about what would later occur” and “no mention of mental health/relationship problems”).

3.2.7 The Review Panel was concerned that, in the completed IMR, this could be illustrative of a narrow focus on a small number of indicators of domestic violence, or an assumption of disclosure by the victim. This is despite the established evidence base in relation to health care that identifies the wide range of presenting problems or conditions that are associated with domestic violence. A summary produced by NICE¹³ identified the following indicators including:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance use
- unexplained chronic gastrointestinal symptoms
- unexplained reproductive symptoms, including pelvic pain and sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care, miscarriage, premature labour and stillbirth
- unexplained genitourinary symptoms, including frequent bladder or kidney infections
- vaginal bleeding or sexually transmitted infections
- chronic pain (unexplained)

¹³ NICE (2014) *Domestic violence and abuse: multi- agency working (PH50)*, London: National Institute of Clinical Excellence. <https://www.nice.org.uk/guidance/ph50> (last access 12.02.18)

- traumatic injury, particularly if repeated and with vague or implausible explanations
- problems with the central nervous system – headaches, cognitive problems, hearing loss
- repeated health consultations with no clear diagnosis
- Intrusive 'other person' in consultations including partner or husband, parent, grandparent or an adult child (for elder abuse).

3.2.8 Additionally, the Review Panel noted that the training provided to both administrative and clinical staff in relation to domestic violence is limited, being embedded in wider safeguarding training. Referring again to the NICE guidance, this describes the importance of specific training for health and social care professionals in how to respond to domestic violence, including as a minimum a response to a disclosure but also more targeted training to ask about domestic violence in a way that makes it easier for people to disclose.

3.2.9 As part of the discussion on training, the Haringey Clinical Commissioning Group (CCG) provided an overview of safeguarding training locally: GPs in Haringey have access to Skills for Health E-Learning for safeguarding adults and children (level 1 and 2), as well face to face training for children (level 3). These different levels have different competency levels, to suit the wide range of professionals targeted, but are mapped to the required competency levels set out in the relevant NHS England intercollegiate guidance. These training packages include information on domestic violence. In addition, the CCG named GP for child protection and designated nurse for child protection deliver level 3 safeguarding children face to face training throughout the year. During 2015-2016 training was delivered to GPs in Haringey which covered in depth domestic abuse and violence. This training will be rolled out again during 2018-2019.

3.2.10 While the availability of training locally is positive, Review Panel also made the following recommendation for the Haringey CCG and NHS England.

Recommendation 3: NHS England & Haringey CCG, as co-commissioners of primary care, should ensure that the practice has undertaken training in line with recommendation 16 from the NICE guidance - “GP practices and other agencies should include training on, and a referral pathway for, domestic violence”.

- 3.2.11 In making these observations on both identification and training, it is of note that the IRIS (Identification and Referral to Improve Safety) project is being rolled out in Haringey. This is a General Practice-based domestic violence and abuse training support and referral programme. IRIS has recently been commissioned in Haringey. This work is delivered by the Nia Project and is funded by the CCG, with this funding transferred to Haringey Council and managed as part of a wider contract with the Nia Project for domestic violence services in the borough. There is a multi-agency steering group which is chaired by the CCG.
- 3.2.12 General Practices were invited to submit an expression of interest based on their level of referrals to the local Multi-Agency Risk Assessment process.
- 3.2.13 In 2015, the Medical Centre was invited to participate but they did not do so. This was a missed opportunity because those General Practices that adopt IRIS are supported to promote safe opportunities for disclosure, as well as selective enquiry. If a similar set of circumstances as experienced by Katya occurred in the future, a victim of domestic violence may find that this makes the difference in making a disclosure or seeking help.
- 3.2.14 Since the review commenced, the IRIS Project Advocate Educator has met with the Medical Centre (in December 2016). This is welcome.
- 3.2.15 The Review Panel therefore identified recommendations for the Medical Centre in relation to improvements that could be made within this practice, including participation in the IRIS project.

Recommendation 4: The Medical Centre institutes a domestic violence policy based on good practice and the NICE guidance, supported by its planned participation in the roll out of the IRIS project locally.

3.2.16 Reflecting on the issues identified during the General Practice's participation in the DHR, the Review Panel also identified a recommendation for the Haringey CCG to better support General Practices locally in their participation in reviews. However, in recognition that this is likely to be a recommendation with wider national significance, the Review Panel also identified a recommendation for the Department of Health and NHS England in relation to underlining the expectations around General Practice involvement in the Domestic Homicide Reviews.

Recommendation 5: The Haringey CCG should identify how it could provide support to General Practices to enable their participation in the Domestic Homicide Review process.

Recommendation 6: The Department of Health and NHS England consider how to ensure that there is a clear guidance for the engagement and representation of General Practices in Domestic Homicide Reviews and ensure that such guidance is embedded in contractual arrangements.

3.3 North Middlesex University Hospital Trust

3.3.1 NMUHT had the most extensive contact with Asen and Katya of any agency involved in this review, although this contact was limited.

3.3.2 The IMR prepared by NMUHT was of a high quality and, relating to contact, identified several issues, which are noted and then considered in turn.

3.3.3 In relation to Asen there was one contact, when he presented on the 29th of June 2015 to the Accident and Emergency Department with right hand injury pain, was triaged and left before being seen. In its IMR, NMUHT did not identify any missed opportunities in relation to this contact, an assessment which was accepted by the Review Panel, which agreed that this was not a key practice episode. However, NMUHT did reflect on the barriers to men reporting domestic violence

and this is considered more broadly in the equality and diversity section below (see 3.5).

- 3.3.4 NMUHT also noted the absence of a Health IDVA in the Accident and Emergency Department. However, given Asen made no disclosure to staff at Accident and Emergency, and this point of contact has not been identified as a key practice episode, the Review Panel has not made recommendation in relation to Health IDVAs. While the Review Panel felt that it was beyond the scope of this review to make a recommendation, it did note that there is a range of evidence on the value of domestic violence services in hospitals, including the opportunity to enable earlier identification of victims of domestic violence. Most recently this has been summarised in a SafeLives report.¹⁴ The Review Panel commended the willingness of NMUHT to consider wider learning from the review in that regard.
- 3.3.5 In relation to Katya, NMUHT had contact with her in relation to her pregnancy.
- 3.3.6 NMUHT has a policy in place regarding domestic violence and there is maternity specific guidance to supplement this. The policy informs staff of the process and action to take for domestic abuse, this includes selective and routine questioning, pathway when disclosures are made, mechanisms for referrals and support from specialist domestic abuse service including those for male victims, MARAC referrals, screening tools and pathways for perpetrators.
- 3.3.7 Staff receive mandatory training on domestic abuse, this is delivered through adult and child safeguarding training. There are levels of the training that are dependent on the member of staff job role. Clinical staff that are providing care to patients in the Maternity Service and Ultrasound Department and Senior Staff (Band Six and above) and the medical staffing in Accident and Emergency Department, receive level three safeguarding children training and level two safeguarding adults training.

¹⁴ SafeLives (2016) *A Cry For Health: Why we must invest in domestic abuse services in hospitals*, Bristol: SafeLives <http://www.safelives.org.uk/node/935> (Last accessed 12.02.18)

- 3.3.8 The maternity service assessment of Katya included examples of good practice as an interpreter was used for the booking appointment (this is commented upon more broadly in the equality and diversity section, see 3.5 below) and Katya was asked on her own regarding domestic violence. However, as noted earlier, Katya herself indicated that at this point of contact she would not have felt she needed to mention anything.
- 3.3.9 Also of note was the identification of Katya's previous history of terminations, with Katya disclosing on the 7th January 2016 a total of seven past pregnancies, two of which had resulted in live birth, and the others having been terminated.
- 3.3.10 The IMR author notes that "It is unfortunate that Asen's death occurred from the actions of Katya before she was able to establish a good relationship with her midwife as this may have enabled her to disclose further details regarding her relationship with Asen and home situation". This observation is particularly relevant in relation to the number of terminations, which would have been noted at this first contact but would have been explored further if additional contact had been had with Katya.
- 3.3.11 The Review Panel also felt this was important, given the other – albeit limited – information about terminations, when the wife of Asen (Lejla) referred to an argument between Katya and Asen about a termination (see 2.6.5). This is discussed further in 3.5.17 – 3.5.18 below.
- 3.3.12 Following the booking assessment Katya had a letter generated to advise the GP of the pregnancy and risk factors that had been identified. This is an example of good communication and liaison between the GP and the maternity services.
- 3.3.13 The contact that Katya had with the ultrasound department was the most frequent of any contact, however this was limited because these interactions were for specific clinical procedures. There were no concerns raised by professionals. NMUHT has confirmed that if there were specific concerns raised or observed for

Katya regarding domestic violence at these contacts, staff would contact or refer to the safeguarding team and ensure a maternity LINK form was completed.¹⁵

3.3.14 NMUHT submitted an IMR, which made three recommendations (in addition to a recommendation related to Health IDVAs, which is noted above, see 3.3.4). These were:

- NMUHT should continue ongoing training for staff for domestic abuse and ensure that compliance is maintained at 90% to ensure that learning for staff is embedded.
- The maternity service and accident and emergency department at NMUHT should continue with planned area specific training events on domestic abuse to increase staff awareness and understanding as these are common areas where patients may present or disclose domestic abuse.
- The good practice and learning from the review to be shared across the organisation through training and communication bulletins to staff.

3.3.15 The Review Panel accepts that these are appropriate single agency recommendations, which would help ensure that existing good practice is sustained as part of a wider coordinated community response.

3.4 Metropolitan Police Service (MPS)

3.4.1 Prior to the death of Asen, the contact by the MPS was related to a single incident.

3.4.2 The IMR prepared by the MPS was of a high quality and, relating to 15th October 2015 incident, identified several issues, which are noted and then considered in turn.

3.4.3 Firstly, following Asen's murder, attempts were made to locate the Form 124D and independent witness statement from the prior incident; neither could be

¹⁵ The LINK form is a maternity tool to ensure that there is appropriate communication and plan in place for women with social, medical and psychological concerns.

located. At the time 124Ds would either be given to the Investigating Officer (IO) or scanned onto the borough's electronic shared drive however, the system for retention / tracking was not, in the view of the IO, well managed.

- 3.4.4 In the IMR, the Review Panel received assurances that, in July 2016, a new process for recording receipt of Form 124Ds¹⁶ was implemented in the Enfield borough. All completed Form 124Ds must be signed for and cross referenced against the relevant CRIS report. They are stored locally in the Criminal Investigation Department (CID) office for a period of two years before being 'Filed on Division' (FOD). Considering this action, the Review Panel accepts the MPS decision to make no recommendation on this issue given action has been taken to address the root cause, specifically practice at Enfield is now in line with the rest of the MPS.
- 3.4.5 Secondly, the relevant section of the crime report regarding supervision of the Form 124D was not completed, and the initial risk assessment was not shown as supervised on CRIS. The CSU Detective Sergeant (DS) who closed the crime report after Asen's release said this supervisory check was the role of a Uniform Team Supervisor. This investigation was promptly referred to the CSU which may explain why the initial supervision tab on the crime report was not completed by a uniform supervisor.
- 3.4.6 In the IMR the MPS addressed the absence of supervisory checks and a lack of clarity in the recording of information on CRIS with the one recommendation made. Specifically, this was that the MPS Senior Leadership Team in Enfield Borough debrief officers involved in this incident to disseminate the lessons learnt regarding completion and supervision of risk assessments in line with MPS domestic abuse toolkits.

¹⁶ The Metropolitan Police Service Domestic Violence Working Group developed the 124D form to help operational officers handle domestic violence incidents more effectively, including capture the necessary evidence to support a victimless prosecution. The 124D is an 'aide memoire' for frontline officers to complete when assessing the risk of domestic abuse. Book 124d follows the risk identification/assessment model and requires initial investigating officers to ask a specific set of questions, the answers to which will formulate the risk as standard, medium or high.

3.4.7 The Review Panel accepts this recommendation is appropriate, identifying as it does lessons learnt from how professionals worked individually and together. However, given one of the purposes of the review is to apply these lessons to service response more broadly, the Review Panel identified a further recommendation. Specifically, the Review Panel felt that the MPS Senior Leadership Team in Enfield Borough Service should ensure that, in addition to disseminating learning, that similar circumstances could not arise in the future and that practice is in line with MPS domestic abuse toolkits.

Recommendation 7: The MPS Senior Leadership Team in Enfield Borough should take steps to ensure that the issues identified in this specific case are not an issue more broadly and that there are robust process in place to provide ongoing assurance as to the quality of recording and supervision.

3.4.8 The Review Panel also felt that the MPS more broadly should ensure that the lessons learnt are disseminated across the force.

Recommendation 8: The MPS should share the learning from this review across the service regarding the importance of ongoing assurance as to the quality of recording and supervision.

3.4.9 Thirdly, question four of the Domestic Violence Checklist states “Victim informed of outcome of investigation and rationale for action”, the response to this question was recorded as “yes completed”. However, Katya could not provide police with any contact details and the Victims Code of Practice (VCOP) actions note that Katya was uncontactable. The DS completing the closing checklist is unable to recall the specifics of this case or how Katya was notified. The DS was clear that she would not have noted this action as complete unless she had been informed by the IO that it had been done. The IO could not recall how Katya was notified of the decision to release Asen without charge.

3.4.10 In the IMR the Review Panel received, the author noted:

“In view of the absence of contact details for Katya, the method of contact with her should have been recorded. Question 8 refers to the Form 124D, its receipt

by the CSU and reference number. The response to this question is ‘complete’ without acknowledgement of receipt or a reference. The difference in addresses for Asen [on the custody record] does not appear to have been noted or clarity obtained”.

- 3.4.11 The Review Panel discussed this issue. Considering the involvement of the IO and the DS, and the recording issue, the Review Panel felt it could not conclusively take a view as to what had or had not happened. However, the Review Panel noted that given Katya did not speak English, it was unclear how she could have been effectively informed of outcome of the investigation and rationale for action without the IO having engaged the services of either a Turkish speaking officer or Language Line. The Review Panel therefore notes that, while there may be other explanations that were not identified during this review, it is entirely possible that either this contact did not happen, or appropriate language services were not engaged, meaning that Katya may not have understood the update. This latter possibility is strengthened considering the comments by Katya’s mother, to whom Katya appears to have disclosed this incident, and who did not understand why Asen had only stayed in the police station one night.
- 3.4.12 The Review Panel further noted that there were several issues in this case which might have triggered further consideration, this includes Katya’s potential isolation given she did not speak English, her statement that she did not know her address or have a telephone number, as well as her demeanour and response when asked about the incident.
- 3.4.13 The Review Panel recognised that there may be several reasons why people deny or minimise domestic violence, as well as why they may not disclose their address to the police. However, the Review Panel felt it would not have been unreasonable to take further actions in this case. For example, a visit to the addresses provided by Asen could have been undertaken.
- 3.4.14 Additionally, the Review Panel considered what if any ‘safety netting’ advice is provided to victims following police contact, particularly where they do not want

any further action taken. The 124D includes a tear out section with a list of numbers that can be handed out. These are not translated into Turkish, but an interpreter was used at the scene in the contact with the police as noted above.

3.4.15 This consideration is given some additional merit by Katya's comment during her interview that "no one gave me clear information. If someone had given me clear information on where I could have gone to be protected I would have gone" (see 2.9.12 above). Regardless of the information that provided at the time by the police, this comment suggests that – from Katya's perspective – she was either not able to understand, retain or use this information.

3.4.16 The Review Panel considered this issue and recognised the challenges of ensuring that information is routinely available on a range of services across a city the size of London. One good practice example that was noted from Sussex, where website www.safespacesussex.org.uk was developed by the Office of the Police & Crime Commissioner for Sussex and provides an online directory of local specialist support services as well as information about different types of crime and what happens at each stage of the criminal justice system, helping to 'demystify' the process for people when they may be at their most vulnerable.

Recommendation 9: MOPAC to scope opportunities to develop an online directory of local specialist support services as well as information about different types of crime.

3.4.17 Finally, the Review Panel considered the MPS interaction with Asen. Prior to the incident that led to his death, Asen had not been considered by the MPS as a potential victim of domestic violence. However, the Review Panel felt that, given the limited nature of this contact (in the only prior contact with the MPS, Asen was the suspect and there were no other reports that might suggest Asen was the victim of domestic violence), it would not have been reasonable to expect police officers to take any other action in relation to Asen.

3.5 Equality and Diversity

- 3.5.1 The Review Panel identified the following protected characteristics of Asen and Katya as requiring specific consideration: ethnicity and language, pregnancy and maternity, and sex.
- 3.5.2 *Ethnicity:* Both Asen and Katya were from a Turkish speaking community in an Eastern European (EU) country, and spoke Turkish as their first language. There is no local data in Haringey as to the size of this specific community, although per the 2011 Census, 65% of the Haringey population are not White British.¹⁷
- 3.5.3 To inform the discussion of BMER victim/survivors experience of domestic violence specifically, the Review Panel benefited from being able to draw on the experience of the representative from IMECE. The organisation's 2015/16 Annual Report¹⁸ provides further data in relation to the different communities that this organisation serves in the borough.
- 3.5.4 While there is no evidence to indicate that Asen or Katya accessed help and support from a domestic violence service the Review Panel felt that, given the potential barriers to access to help and support that either might have faced because of their ethnicity, it is in scope of the review to consider the issue of provision for BMER victim/survivors.
- 3.5.5 This may have been particularly relevant in relation to Katya because her mother (Aisha) talked about some of the specific pressures on Katya, including her "shame" about what had happened. Although there is limited specific information, the interview with Katya provided some context to the pressure and conflict she had experienced both before she and Asen came to the United Kingdom, but which would also have been an issue if she returned to their country of origin.
- 3.5.6 Based on the information available to the Review Panel, Asen and Katya's relationship would have been considered inappropriate in their country of origin

¹⁷ Haringey Council Services (2016) *Figures about Haringey*, Available at: <http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment/figures-about-haringey> (Last accessed: 12.02.18).

¹⁸ IMECE (2016) *Annual Report 2015-2016*, London: IMECE.

and this therefore raises the possibility of wider risks, including so-called ‘honour’ based violence. Regardless of the circumstances of this case, it is not unreasonable to note that having access to a BME led specialist organisation may have been important to any victim in this context who might either have experienced violence and abuse, and in order to understand the wider cultural context up to and including the risk of so-called ‘honour’ based violence.

3.5.7 It is also of note that Katya’s mother said she would have “definitely” taken support from a Turkish speaking organisation if this had been offered to her.

3.5.8 A recent report by Imkaan¹⁹ defines specialist BME led organisations as “independent, specialist and dedicated services run by and for women from the communities they seek to serve”, which:

- Work in ways that are not only about individual women and girls’ safety, and/or the safety of their children, but are also about BME women’s autonomy, freedom and self-determination.
- Recognise the continuum of violence against women and girls and seek to offer support around every aspect of women’s needs, ensuring a holistic, needs led response.
- Work across the spectrum of risk and need, understanding the fluctuating nature of risk and are adept at recognising ‘hidden’ risk indicators.
- Are skilled in identifying indicators and experiences of specific forms of Violence Against Women and Girls (VAWG) that may be missed within a mainstream domestic violence organisation.
- In offering a range of services, are able to access women who may not even recognise their experiences as violence.

¹⁹ Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*, London: Imkaan <https://www.imkaan.org.uk/resources> (last accessed 12.02.18)

- Create flexible and diverse support systems, sensitive to the fact that for many BME women, refuge and support services may be unfamiliar and/or stigmatised.²⁰
- 3.5.9 It is positive therefore that there is such provision in Haringey, provided by IMECE, and that this provision is reflected in Haringey’s recently developed Violence Against Women and Girls Strategy 2016-2026, which includes a specific aim to “ensure that women have a choice to access specialist support services based on what they feel is the most appropriate and making sure that small, specialist organisations who provide support to particular groups (BME, disability, LGBT, older women etc.) are involved in the partnership”.
- 3.5.10 However, the same Imkaan report noted that BME specialist services are under considerable pressure in London with implications for the sustainability of such specialist provision. The report concludes that it “is important that this support covers all areas of VAWG and that it includes the protection of specialist BME ending VAWG organisations”.
- 3.5.11 It is beyond the scope of this review to make recommendation as to how to sustain BME specialist services, but the Review Panel identified the importance of individual areas being aware of their local population, including the level of need and the requirement for specialist BME led provision. In considering how to achieve this, it is important to recognise that some of those BME victim/survivors will be men.
- 3.5.12 However the Review Panel recognised that for individual London boroughs it is neither possible nor desirable for areas to work alone in this regard, and that there is therefore a wider regional importance to ensure that BME led specialist services are sustained in order that BME victim/survivors can access help and support in an environment where staff have the knowledge and expertise in

²⁰ *Ibid*

providing support to those affected by various forms of violence in specific individual, family and community contexts.

Recommendation 10: The VAWG Strategic Group scopes the requirement for specialist BME led provision in the borough.

Recommendation 11: The Haringey CSP works with other commissioning bodies in London, including MOPAC, to ensure that there is sufficient specialist BME led provision available.

- 3.5.13 *Language:* An additional barrier can be language, where someone speaks relatively little or (as was the case with Katya) no English.
- 3.5.14 The Review Panel felt that Asen faced some additional barriers to service provision because Turkish was his first language, and while he spoke English, this was limited. At the point at which services had contact with him (following his arrest and interview by the MPS) appropriate arrangements were made to provide translators, although there is no information as to whether this barrier was identified during his presentation to NMUHT Accident and Emergency.
- 3.5.15 The Review Panel also felt that Katya was likely to have faced a potential barrier to service provision because she did not speak English. This view was reinforced by the interview with her mother (Aisha) who said that that Katya would have found it difficult to ask for help, or receive information or advice, because she did not speak to English.
- 3.5.16 All the services that had contact with Asen and Katya sought to address any language barrier by using translators - in the case of the MPS (a Turkish speaking officer, who was called upon to assist, as well as access to interpreters and Language Line) and NMUHT (Language Line or Translators). This is good practice. However, the Review Panel noted that there can be significant challenges for smaller organisations in resourcing translation services, with cost as something that should be recognised by commissioners when developing service specifications.

Recommendation 12: The VAWG Strategic Group, as part of the scoping for specialist BME led provision in the borough, should include consideration of how to ensure that translation services are made available.

- 3.5.17 *Pregnancy and maternity:* At the point of Asen's death, Katya was pregnant. She had accessed services initially from the Medical Centre where she was a registered patient, before referral to and take up of services from NMUHT.
- 3.5.18 At the Medical Practice, Katya made no disclosures of domestic violence. However, it is of note that staff at the practice were aware that Katya was pregnant. This underlines the importance of ongoing work in general practices to ensure that staff have the skills and knowledge to create safe spaces for disclosure, selectively enquire or respond to a disclosure. This has already been addressed in the discussion related to the IRIS Project and the Medical Centre.
- 3.5.19 At NMUHT, there was appropriate consideration of the additional risk of domestic violence that is associated with pregnancy, with this reflected in the wider trust policy to undertake routine enquiry in the provision of maternity services. This is good practice.
- 3.5.20 In this case, it is of note that Katya had multiple previous terminations. It is not clear whether Katya had conceived these pregnancies with Asen or her husband, or whether the father in these pregnancies was aware that Katya had been pregnant or had obtained a termination. That this information was collected by NMUHT as part of their limited contact with Katya was good practice, in keeping with trust policy and procedures when someone is first 'booked in' with maternity services. The Review Panel agreed with NMUHT's assessment that the developing relationship with her midwife may have enabled opportunities for Katya to make further disclosures. Although there was not an opportunity for further discussion, and without making a judgement as to the situation in this case, the Review Panel noted that there is evidence in relation to the links between terminations and domestic violence and therefore identification of previous terminations is an example of good practice.

- 3.5.21 The Review Panel felt that pregnancy and maternity was a significant issue for Katya, with the provision of services in relation to this area being the most substantive contact that she had with statutory services during her time in England.
- 3.5.22 **Sex:** When considering men as victims of domestic violence it is not uncommon for professionals to suggest that 'men find it harder to report than women'. While acknowledging that there are barriers to men in seeking help and support, the Review Panel noted that women also face considerable barriers to the disclosure of domestic violence and abuse. The Review Panel felt that an either / or approach is not helpful, instead recognising that it is hard for any victim of domestic violence to disclose their experiences and to seek help and support, with a victim's personal characteristics and life circumstances providing an additional multifaceted context to this process.
- 3.5.23 Considering domestic violence and services for men specifically, the Review Panel drew on the experience of Victim Support (which provides support for male victims in the borough), as well as the co-chair and Overview Report author (who has a background in work with male victims).
- 3.5.24 There is no stand-alone service for men who are victims of domestic violence in Haringey. However, between April 2014 and September 2015 there was a male case worker employed in another local service (Hearthstone) to work with domestic violence cases. During that time, a total of 12 referrals were received (of these, 3 cases involved a victim of domestic violence; in 1 case it was not clear if the referral involved a victim or perpetrator; 4 cases involved a perpetrator; 1 case did not relate to domestic violence and 3 cases related to family breakdown but not domestic violence).
- 3.5.25 Since that pilot, MOPAC has funded an additional 0.5 Full Time Equivalent (FTE) IDVA and a 0.5 FTE Domestic Violence Caseworker. The IDVA offers support to high risk male victims of domestic abuse and familial abuse victims (both female and male) and the caseworker can work with victims assessed as standard and

medium risk. As this capacity is provided by Victim Support, which also provides the Pan London Domestic Violence Service, victims can access specialist support through this additional capacity the wider service.

3.5.26 This focus on male victims and familial abuse was agreed in discussions between Victim Support and the London Borough of Haringey when the additional funding from MOPAC was made available.

3.5.27 A Victim Support Operations Manager described the local offer:

- Victim Support staff receiving in house training on the impact of crime on victims, as well as specific domestic violence training exploring the needs of both female and male victims. Additionally, the IDVA has completed the SafeLives IDVA training.
- Referrals to the IDVA can only be made by Nia or from the MARAC (the Caseworker receives referrals directly from Nia or internally from the IDVA).
- When a referral is received the IDVA and DV Caseworker will screen male victims by using the Respect Toolkit (noted previously in 3.1.8) to establish who is the primary aggressor and to deal with any counter-allegations. They will also complete the Risk Identification Checklist (RIC) to identify the risk and address any immediate risk. A support plan is also completed to outline the actions to be taken to address any risk identified. The RIC and support plan are reviewed every six weeks or when there is a new incident. To consider any other needs of the victims Victim Support also use the Outcome Star to look at other areas of their lives where support is required. An action plan is created so that the client or the IDVA or other professionals can address those other needs.
- There have been presentations in the borough about the pan-London Domestic Violence Service, including the additional provision for men, although there has not been any targeted awareness campaign relating to heterosexual male victims. This reflects an agreement with the local

strategic lead that Victim Support would not promote these additional services, but information would be disseminated locally through professional networks.

- 3.5.28 From the 1st of January 2016 until the 31st of December 2016 a total of 31 men were supported in the borough. Further information on the breakdown of cases was not available.
- 3.5.29 The availability of an offer for men is positive and the Review Panel recognised why this male offer is not publicised more widely locally, reflecting the limited capacity available. However, given Victim Support is a larger organisation, this review notes that while the organisation's website includes information on domestic violence, the information is largely generic and does not include any specific content that might address the barriers to help and support for male victims.²¹

Recommendation 13: Victim Support should review the promotion of services for men to be assured that these take specific account of the needs of this client group.

- 3.5.30 As part of the Review Panel discussion, there was consideration as to the extent to which provision for male victims had been promoted in Haringey. The Haringey Council website²² includes information in terms of available support for male victims/survivors of domestic violence, including the Victim Support IDVA for male victims, as well as the national Men's Advice Line.²³
- 3.5.31 The Review Panel identified the importance of both service providers and the wider partnership in ensuring that the delivery and promotion of services for men

²¹ Victim Support (2016) *Domestic Abuse*, Available at: <https://www.victimsupport.org.uk/crime-info/types-crime/domestic-abuse> (Last accessed: 12.02.18).

²² Haringey Council Services (2016) *Advice and support*, Available at: <http://www.haringey.gov.uk/social-care-and-health/health/public-health/domestic-violence-and-violence-against-women-and-girls/advice-and-support> (Last accessed: 12.02.18).

²³ The Men's advice Line is run by Respect and confidential helpline for men experiencing domestic violence from a partner or ex-partner (or from other family members). More information is available at www.mensadvice.org.uk

take specific account of the needs of this client group, including consideration of the development of targeted publicity material.

- 3.5.32 Regarding provision for men, the Haringey Council website²⁴ also notes that: “The term violence against women and girls can often cause concern about the exclusion of men and boys from services and a lack of recognition that men and boys can also experience these forms of violence and abuse. The UN Declaration is based on the concept of disproportionate impact. We understand the gendered nature of these types of abuse and crimes, and also that men and boys are sometimes victims of these types of abuse and crimes. It is important that men and boys are included in all aspects of our work on all forms of violence against women and girls (particularly work on prevention and awareness raising). We are committed to ensuring that any victim will receive a sensitive and appropriate response, according to their needs.”

The Review Panel supports the national and local focus on violence against women and girls, which reflects the disproportionate impact of violence and abuse on women and girls. The Review Panel also agrees with the proposition that most actions taken under such a strategy will be applicable to men and boys because policies and procedures should provide protection and redress to all victims. This approach is based on a gendered analysis. This is important because it enables the consideration of why women and girls are disproportionately affected by domestic violence. However, it also enables a consideration of what domestic violence means for men and boys including those specific actions that could be taken, proportionally to need, to address this client group. This might include actions to address why most of those who perpetrate violence and abuse are men, but should also include actions to meet the needs of male victims (including how men’s experiences, risks and needs, as well as

²⁴ Haringey VAWG Services (2016) *Advice and support*, Available at: <http://www.haringey.gov.uk/community/community-safety-and-engagement/domestic-and-gender-based-violence/violence-against-women-and-girls> (Last accessed: 12.02.18).

help seeking, can be different and the best ways to meet these). Given the positive steps taken locally, including asking Victim Support to use additional capacity to meet the needs of male victims, it is therefore a missed opportunity that Haringey's recently published Violence Against Women and Girls Strategy 2016-2026 does not address this issue or describe how it will be addressed elsewhere.

- 3.5.33 The Review Panel therefore identified the importance of developing a robust rationale for the approach to men and boys, noting that this must be within the context of a wider violence against women and girls strategy, as well as the identification of those specific actions that will also be taken, proportionally to need, to support this client group.

Recommendation 14: The Haringey CSP more fully articulates (including publication on their webpage) its rationale for the approach to men and boys within the context of a wider violence against women and girls strategy, including those specific actions that will be taken, proportionally to need, to support this client group.

4. Conclusions and Recommendations

4.1 Conclusions

- 4.1.1 This is a tragic case, triggered by an incident which led to the death of Asen. His limited contact with services, and unfortunately the absence of additional information from Asen's family, has meant that Asen's voice is less well represented in this review than would have been hoped.
- 4.1.2 Complicating this further is the conflicting information about the relationship between Asen and Katya and, looking more broadly than the incident that led to Asen's death, whether either or both experienced domestic violence and abuse in a broader sense of an ongoing pattern of behaviour.
- 4.1.3 There is lastly the wider context of the relationship between Asen and Katya; regardless of their relationship, their experience as members of a Turkish speaking community in an Eastern European (EU) country informed their relationship and decision making. This is this most clearly explained by Katya in relation to her account of gossip and family conflict when their relationship was first discovered, through to her concerns about returning to their country of origin.
- 4.1.4 As the review is unable to resolve some of these issues, the focus has therefore been on the identification of any learning, including its application to other cases, as well as reflecting more broadly on the experience of victim who are male, are from BMER communities and/or who do not speak English or speak only limited English.

4.2 Lessons to be learnt

- 4.2.1 The review did not identify any practice issues that were a cause for concern in relation to the outcomes for Asen or Katya, although there are specific recommendations for the police relating to recording and supervision. The lack of clarity about how an update was provided to Katya following a report of domestic

violence should serve as a salutary reminder for all professionals of the importance of accurate recording keeping, as well as clarity in how updates are provided following a report.

- 4.2.2 The review highlighted areas of good practice, most notably the use of translators or other interpreting services, as well as the importance of frontline professionals having a good knowledge of domestic violence and abuse and building relationships with service users. However, it also identified the potential barriers for those affected by violence and abuse in identifying their experiences and feeling able to seek help, as well as the challenges for services in providing information in a way that can be used by someone at both a point of crisis or after the event.
- 4.2.3 Reflecting its focus on identifying any learning in this case, and then considering what this learning means more broadly for the local partnership response and how it could be put into practice, the Review Panel has made recommendations about a range of issues. Many of these recommendations build on the initiatives that are already underway in Haringey to develop local processes, systems and partnership working. These included: taking forward the review of the development and delivering training; raising awareness of domestic violence (including through bystander interventions); and ensuring that there are pathways to support for victims, including those that support people from BME communities or who are male, or through health setting in the form of the IRIS Project. Other issues also include the work that is vital to sustain an effective partnership response, including ensuring that all parts of the health sector can participate in reviews, as well as sustaining local specialist support provision, including provision designed specifically to support victims from marginalised groups.

4.3 Recommendations

4.3.1 The single agency recommendations, made by the agencies in their IMRs are described in the section 3 following the analysis of contact by each agency, and are also presented collectively in **Appendix 2**. These are as follows:

Medical Centre (General Practice)

- No recommendations were made in the Individual Management Review submitted by the Medical Centre.

North Middlesex University Hospital Trust (NMUHT)

- NMUHT should continue ongoing training for staff for domestic abuse and ensure that compliance is maintained at 90% to ensure that learning for staff is embedded.
- The maternity service and Accident and Emergency department at NMUHT should continue with planned area specific training events on domestic abuse to increase staff awareness and understanding as these are common areas where patients may present or disclose domestic abuse.
- The good practice and learning from the Domestic Violence Homicide Review to be shared across the organisation through training and communication bulletins to staff.
- Although this recommendation has no specific bearing on this case, in order to further support patients, staff and further embed learning, NMUHT to consider the sourcing of an IDVA to work within the trust.

Metropolitan Police Service (MPS)

- It is recommended that Enfield BOCU SLT debrief officers involved in this incident to disseminate the lessons learnt regarding completion and supervision of risk assessments in line with MPS domestic abuse toolkits.

- 4.3.2 The Review Panel has made the following recommendations, which are also described in the section 3 as part of the analysis and presented collectively in **Appendix 3**. These should be acted on through the development of an action plan, with progress reported on to the Haringey CSP within six months of the review being approved by the partnership.
- 4.3.3 **Recommendation 1:** The Training & Development Task and Finish Group of the VAWG Strategic Group ensures that training around typologies of domestic abuse is included in the minimum training standards that are currently being developed.
- 4.3.4 **Recommendation 2:** The VAWG Strategic Group ensures that the findings from this review inform the development of a bystander intervention campaign locally.
- 4.3.5 **Recommendation 3:** NHS England & Haringey CCG, as co-commissioners of primary care, should ensure that the practice has undertaken training in line with recommendation 16 from the NICE guidance - “GP practices and other agencies should include training on, and a referral pathway for, domestic violence”.
- 4.3.6 **Recommendation 4:** The Medical Centre institutes a domestic violence policy based on good practice and the NICE guidance, supported by its planned participation in the roll out of the IRIS project locally.
- 4.3.7 **Recommendation 5:** The Haringey CCG should identify how it could provide support to General Practices to enable their participation in the DHR.
- 4.3.8 **Recommendation 6:** The Department of Health and NHS England consider how to ensure that there is a clear guidance for the engagement and representation of General Practices in Domestic Homicide Reviews and ensure that such guidance is embedded in contractual arrangements.
- 4.3.9 **Recommendation 7:** The MPS Senior Leadership Team in Enfield Borough should take steps to ensure that the issues identified in this specific case are not an issue more broadly and that there are robust process in place to provide ongoing assurance as to the quality of recording and supervision.

- 4.3.10 **Recommendation 8:** The MPS should share the learning from this review across the service regarding the importance of ongoing assurance as to the quality of recording and supervision.
- 4.3.11 **Recommendation 9:** MOPAC to scope opportunities to develop an online directory of local specialist support services as well as information about different types of crime.
- 4.3.12 **Recommendation 10:** The VAWG Strategic Group scopes the requirement for specialist BME led provision in the borough.
- 4.3.13 **Recommendation 11:** The Haringey CSP works with other commissioning bodies in London, including MOPAC, to ensure that there is sufficient specialist BME led provision available.
- 4.3.14 **Recommendation 12:** The VAWG Strategic Group, as part of the scoping for specialist BME led provision in the borough, should include consideration of how to ensure that translation services are made available.
- 4.3.15 **Recommendation 13:** Victim Support should review the promotion of services for men to be assured that these take specific account of the needs of this client group.
- 4.3.16 **Recommendation 14:** The Haringey CSP more fully articulates (including publication on their webpage) its rationale for the approach to men and boys within the context of a wider violence against women and girls strategy, including those specific actions that will be taken, proportionally to need, to support this client group.

Appendix 1: Domestic Homicide Review Terms of Reference

Domestic Homicide Review Terms of Reference: Case of Asen.

This Domestic Homicide Review is being completed to consider agency involvement with Asen and Katya following the death of Asen in February 2016. The Domestic Homicide Review is being conducted in accordance with Section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

- 1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
- 2) To review the involvement of each individual agency, statutory and non-statutory, with Asen and Katya during the relevant period of time 1st January 2015 to February 2016 (inclusive). To summarise agency involvement prior to this period.
- 3) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- 4) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- 5) To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
- 6) To commission a suitably experienced and independent person to:

- a) chair the Domestic Homicide Review Panel;
 - b) co-ordinate the review process;
 - c) quality assure the approach and challenge agencies where necessary; and
 - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
- 7) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
- 8) On completion present the full report to the Haringey Community Safety Partnership.

Membership

- 9) It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
- 10) The following agencies are to be on the Panel:
- a) Haringey Clinical Commissioning Group
 - b) General Practitioner for the victim (if registered)
 - c) General Practitioner for the perpetrator
 - d) North Middlesex University Hospital NHS Trust
 - e) London Borough of Haringey Community Safety / Public Health
 - f) Nia (local domestic abuse specialist service provider)
 - g) Solace Women's Aid (local domestic abuse specialist service provider)
 - h) NHS England (London)
 - i) Metropolitan Police Service (Senior Investigating Officer (for first meeting only) and Critical Incident Advisory Team)

11) The panel recognise that the particular issues in this case relate to the gender of Asen (who was male), as well as the nationality and first language of both parties Asen and Katya. To reflect this:

- a) Victim Support will be invited to sit on the panel as they deliver provision for men in the local area. As appropriate the panel will consult with the national organisation Respect as they have expertise in relation to male victims.
- b) IMECE will be invited to sit on or advise the panel as they have expertise in relation to work with the Turkish speaking Eastern European community in the local area. Other expertise will be sought as necessary.
- c) The embassy of the country Asen and Katya are from will be invited to advise the panel in relation to the experience of that country's nationals in the UK and / or facilitate contact with family members in that country.
- d) The Panel will seek a domestic abuse specialist organisation in the area Asen's and Katya's families live, and invite them to advise the panel as they have expertise in the response to domestic abuse in that country.

12) Additional support and expertise will be requested as appropriate e.g. as Asen and Katya were resident in a House in Multiple Accommodation (HMO) advice will be sought as appropriate from the relevant Local Authority officer.

13) There are no ongoing investigations or inquests into the death.

Collating evidence

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

15) Chronologies and IMRs will be completed by the following organisations known to have had contact with Asen and/or Katya during the relevant time period, and produce an Individual Management Review (IMR):

- a) General Practitioner for Katya
- b) General Practitioner for Asen (if registered)

- c) Metropolitan Police Service
- d) North Middlesex University Hospital NHS Trust

16) Further agencies may be asked to complete chronologies and IMRs if their involvement with Asen and/or Katya becomes apparent through the information received as part of the review.

17) Each IMR will:

- a) set out the facts of their involvement with Asen and/or Katya
- b) critically analyse the service they provided in line with the specific terms of reference
- c) identify any recommendations for practice or policy in relation to their agency
- d) consider issues of agency activity in other areas and review the impact in this specific case

18) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Asen and/or Katya in contact with their agency.

Analysis of findings

19) In order to critically analyse the incident and the agencies' responses to Asen and/or Katya, this review should specifically consider the following points:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Asen and/or Katya.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

- Analyse the agency's responses in the context of the specific issues identified for this case, namely: the nationality Asen and/or Katya; that their first language was not English; and the gender (male) of the victim of the homicide, Asen.

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

Development of an action plan

20) Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Haringey Community Safety Partnership on their action plans within six months of the Review being completed.

21) Haringey 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, the perpetrator and the perpetrator's family

22) Sensitively attempt to involve the family of Asen in the review. The chair will lead on family engagement with the support of the Family Liaison Officer from the Metropolitan Police and, if required, the agencies identified in paragraphs 11 (b & c & d).

23) Invite Asen and Katya's landlord to participate in the review, with the support of the Family Liaison Officer.

24) Review (publicly available) information gathered as part of the criminal investigation from associates of Asen and/or Katya.

25) Invite Katya to participate in the review, through the prison in which she is held.

Media handling

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

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

Confidentiality

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

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

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

Disclosure

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

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

Appendix 2: Single Agency Recommendations and Action Plan

Medical Centre (General Practice)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1. No recommendations were made in the Individual Management Review submitted by the Medical Centre.						

North Middlesex University Hospital Trust (NMUHT)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
NMUHT should continue ongoing training for staff for domestic abuse and ensure that compliance is maintained at 90% to ensure that learning for staff is embedded.	Regional					

<p>The maternity service and accident and emergency department at NMUHT should continue with planned area specific training events on domestic abuse to increase staff awareness and understanding as these are common areas where patients may present or disclose domestic abuse.</p>	<p>Regional</p>					
<p>The good practice and learning from the Domestic Violence Homicide Review to be shared across the organisation through training and communication bulletins to staff.</p>	<p>Regional</p>					
<p>Although this recommendation has no specific bearing on this case, in order to further support patients, staff and further embed learning, NMUHT to consider the sourcing of an IDVA (Independent Domestic Violence Advisor) to work within the trust</p>	<p>Regional</p>					

Metropolitan Police Service (MPS)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
It is recommended that Enfield BOCU Senior Leadership Team (SLT) debrief officers involved in this incident to disseminate the lessons learnt regarding completion and supervision of risk assessments in line with MPS domestic abuse toolkits.	Local					

Appendix 3: DHR Recommendations and Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1: The Training & Development Task and Finish Group of the VAWG Strategic Group ensures that training around typologies of domestic abuse is included in the minimum training standards that are currently being developed.	Local	Ensure typologies of abuse are included in the training minimum standards	VAWG Training Task and Finish Group (TTFG)	TTFG standards to be developed in 2017/2018 and will include typologies of abuse.	Q3 2017/2018	Complete
Recommendation 2: The VAWG Strategic Group ensures that the findings from this review inform the development of a bystander intervention campaign locally.	Local	Develop a robust 'bystander' campaign linked to the development of the CCR model	VAWG Strategic Group	A CCR subgroup of the VAWG Strategic Group will be created in Q3 2017/2018 to drive forward the	Intervention campaign is on the Action Plan for 2017/2018	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				intervention approach.		
<p>Recommendation 3: NHS England & Haringey CCG, as co-commissioners of primary care, should ensure that the practice has undertaken training in line with recommendation 16 from the NICE guidance - “GP practices and other agencies should include training on, and a referral pathway for, domestic violence”.</p>	Local	Ensure the practice has undertaken training on domestic abuse	Haringey CCG & NHS England	Safeguarding Children and Young people: roles and competences for health care staff – Intercollegiate document (March 2014) states that General Practitioners must receive as a minimum level 3 safeguarding training for children and adults which equates to 6 hrs refresher over a 3-year period. HCCG Named GP for safeguarding children and the	Complete	Complete

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				<p>Designated Nurse for Safeguarding Children deliver face to face level 3 Safeguarding Children training. The topic for 2017-2018 will include Domestic Abuse.</p> <p>In addition, HCCG has funded and co-commissioned the IRIS project to 25 participating GP surgeries which will support GPs in the identification and referral pathway for supporting for patients that are experiencing DVA.</p> <p>There is also significant</p>		

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				strategic work underway to improve responses to Domestic Abuse across the Haringey partnership. Specific proposals include, development of a clear Multi-agency VAWG governance document and referral pathway across Haringey, and multiagency		

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				training programme rolled out by the VAWG Strategic Group TTFG and the LSCB L&D group. The Designated Nurse and Named GP are members of the LSCB group.		
Recommendation 4: The Medical Centre institutes a domestic violence policy based on good practice and the NICE guidance, supported by its planned participation in	Local					

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
the roll out of the IRIS project locally.						
Recommendation 5: The Haringey CCG should identify how it could provide support to General Practices to enable their participation in the DHR	Local		HCCG	HCCG Named GP for safeguarding children and the Designated Nurse for Safeguarding Children deliver face to face level 3 Safeguarding Children training over the year. The topic for 2017 - 2018 includes Domestic Abuse and will include responding to and recording DVA and clinical role in this process.		
Recommendation 6: The Department of Health and	National					

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
NHS England consider how to ensure that there is a clear guidance for the engagement and representation of General Practices in Domestic Homicide Reviews and ensure that such guidance is embedded in contractual arrangements.						
Recommendation 7: The MPS Senior Leadership Team in Enfield Borough should take steps to ensure that the issues identified in this specific case are not an issue more broadly and that there are robust process in place to provide ongoing assurance as to the	Local	MPS SLT to debrief officers involved in this incident to disseminate lessons learnt regarding completion and supervision of	Enfield Senior Leadership team		Complete	Completed

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
quality of recording and supervision.		risk assessments in line with MPS domestic abuse toolkit				
Recommendation 8: The MPS should share the learning from this review across the service regarding the importance of ongoing assurance as to the quality of recording and supervision.	Regional					
Recommendation 9: MOPAC to scope opportunities to develop an online directory of local specialist support services as well as information about different types of crime.	Regional					

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 10: The VAWG Strategic Group scopes the requirement for specialist BME led provision in the borough.	Local	VAWG SG to conduct a scoping exercise to establish provision for BME services	VAWG Strategic Group VAWG Commissioning Group	BME provision is a standing agenda item on VCG. It will be explored as part of the co-commissioning of the LCPF funding in Q2 2017/2018		Complete and ongoing
Recommendation 11: The Haringey CSP works with other commissioning bodies in London, including MOPAC, to ensure that there is sufficient specialist BME led provision available.	Regional	Work with commissioning bodies across London to ensure sufficient specialist services	Haringey CCG	The Strategic lead has worked with London Councils on the commissioning of their BME provision through the ASCENT project		Complete and ongoing
Recommendation 12: The VAWG Strategic Group, as part of the scoping for	Local	Ensure provision of translation and	VAWG SG	Provision of T & I services	Ongoing	Complete. Translation and Interpreting

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
specialist BME led provision in the borough, should include consideration of how to ensure that translation services are made available.		interpreting services for BME victim/survivors				services are available to all Local Authority Officers and provision of same is included within key criteria in all contracts.
Recommendation 13: Victim Support should review the promotion of services for men to be assured that these take specific account of the needs of this client group.	Local / regional	Ensure that services are promoted to men	Victim Support	Victim Support has always offered a service to male victims of domestic abuse as well as to female victims. The service offered to men and women is the same and consists in emotional and practical support		Complete

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				<p>accordingly to the victim's needs.</p> <p>Victim Support staff receive in house training on the impact of crime on victims, both male or female as well as a 4 days specific DV training exploring both male and female needs and support.</p> <p>In Haringey, the MOPAC uplift 0.5 IDVA provides support directly to male victims.</p> <p>The Victim Support 0.5 IDVA</p>		

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				<p>is also a qualified IDVA having completed successfully the Safelives IDVA training that is designed to train IDVAs to support the needs of both male and female victims.</p> <p>The Victim Support 0.5 IDVA also attends on regular basis available external trainings designed specifically to support men as well as generic for men and women.</p> <p>When a referral is received the IDVA</p>		

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				and DV Caseworker screen male victims by using the RESPECT toolkit to establish who is the primary aggressor and to deal with any counter-allegations. They also complete the Safelives RIC to identify the risk and address any immediate risk. An ISSP is also completed to outline the actions to be taken to address any risk identified. The Safelives RIC and the ISSP are reviewed with the client every six weeks or when		

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				there is a new incident. To take into account any other needs of the male victims we also use the Outcome Star to look at other areas of their lives where support is required. An action plan is created so that the client or the IDVA or other professionals can address those other needs.		
Recommendation 14: The Haringey CSP more fully articulates (including publication on their webpage) its rationale for the approach	Local	Haringey to review webpages	LB Haringey	Haringey to ensure that all information provides information on	December 2017	Complete. Web pages have been amended and a briefing on the

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
to men and boys within the context of a wider violence against women and girls strategy, including those specific actions that will be taken, proportionally to need, to support this client group.				support for male victims as well as ensuring that the rationale for having a VAWG approach is outlined		approach to VAWG developed.