

**Restricted until publication**

# **Safer Kingston Partnership**

## **DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY**

---

### **Report into the death of Agapito**

Published 14<sup>th</sup> November 2014

## Contents

SUMMARY OF THE CASE .....	3
THE REVIEW PROCESS.....	4
PARALLEL INVESTIGATIONS .....	5
CONTRIBUTORS TO THE REVIEW .....	5
SUMMARY OF AGENCY CONTACTS.....	6
SUMMARY OF FINDINGS.....	10
CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW .....	12
ADDITIONAL LESSONS LEARNED .....	13
WAS THIS HOMICIDE PREVENTABLE? .....	13
Appendix 1: Glossary of Acronyms .....	14

## REPORT INTO THE DEATH OF AGAPITO<sup>1</sup>

Name	Age at time of the incident	Relationship
Agapito	37	Victim
Sarim <sup>2</sup>	29 (28 on some Agency Records)	Perpetrator and partner of victim
Grace <sup>3</sup>	2 years, 3 months	Daughter of victim and perpetrator

Address 1 is the home in Kingston where Agapito lived with her partner and child from around September 2010. Their address prior to this is address 2.

### SUMMARY OF THE CASE

Sarim entered the United Kingdom, from Pakistan, on 17 September 2003 on a student visa.

Agapito was originally from the Philippines. She entered the United Kingdom in 2007 on a visa entitling her to visit her brother and was subsequently issued with a student visa.

Agapito and Sarim had originally met via the internet and began a relationship. In 2009 they had a daughter, Grace. At this time, the couple were living at address 2 in the London Borough of Merton but by September 2010 had moved to address 1 in the Royal Borough of Kingston (RBK), a single bedroom first floor flat in a house of multiple-occupancy.

Agapito herself, and the trial, would later reveal that the relationship was unhappy by the summer of 2011. Agapito confided – via Facebook and SMS – in a friend who had once been her boyfriend many years before. From 1 September onwards, the couple's relationship deteriorated rapidly with both Sarim and Agapito making contact with several agencies which also generated subsequent referrals. The agencies were the Metropolitan Police, the NSPCC, RBK Children's Social Care, Kingston Hospital Trust and South West (SW) London and St George's Mental Health Trust for adult mental health services.

On 26 September 2011 Agapito made her final agency contact when she went to the One Stop Shop (OSS) in Kingston, a multi-agency domestic violence drop in service.

Later that evening, police were called to address 1 by a neighbour.

Officers found Agapito in her flat lying face down with injuries to the back of her head. Beside her body was a blood stained hammer. Sarim was found sitting in the room, holding his daughter Grace.

Agapito was pronounced dead at the scene and Sarim was arrested. In December 2012, Sarim was convicted of murder with a recommended minimum tariff of 12 years.

---

<sup>1</sup> Not her real name

<sup>2</sup> Not his real name

<sup>3</sup> Not her real name

## THE REVIEW PROCESS

The Kingston Domestic Homicide Review Panel was initially convened on 26 October 2011 with all agencies that potentially had contact with the victim, perpetrator and their child prior to the murder.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance.

Each agency's IMR covered the following:

- A chronology of interaction with the victim and/or their family;
- What was done or agreed
- The quality and efficacy of information sharing and communication between agencies
- The quality of risk assessment and risk management
- Whether internal procedures and policies were followed, including thresholds for intervention
- Consideration of equality and diversity issues and how these may have impacted on responses
- Whether staff had received sufficient training to enact their roles
- Whether organisational changes affected responses
- Lessons learned
- Recommendations

The full terms of reference which guided IMR authors can be found in the main report on page 6.

Enquiries were made with a number of agencies and those that had contact with Agapito, Sarim or Grace were asked to complete an IMR. These agencies were:

- Metropolitan Police<sup>4</sup>
- NHS Kingston - Designated Nurse for Child Protection<sup>5</sup>
- NSPCC
- Royal Borough of Kingston upon Thames Children's Social Care
- South West London & St George's Mental Health Trust
- UK Borders Agency - Hounslow Richmond & Kingston Local Immigration Team
- Victim Support

The DHR was then suspended, awaiting the outcome of the criminal trial.

Each IMR was scrutinised at a Panel meeting and in some instances, additional recommendations were made which have been included in the action plan.

---

<sup>4</sup> The Metropolitan Police are the formal employers of the Manager of the One Stop Shop. To ensure her particular perspective was heard, the Chair interviewed her separately.

<sup>5</sup> This comprised seven separate IMRs from the following: Kingston Hospital Trust; St George's Hospital Trust; St George's Hospital Trust - Midwifery; Kingston GP; Hospital GP; Your HealthCare (Kingston); Merton & Sutton NHS

## **PARALLEL INVESTIGATIONS**

The Local Safeguarding Children Board (LSCB) decided not to hold a Serious Case Review. As such, issues relating to the child were fully considered throughout the DHR process. During this time period, there were two Ofsted inspections.

There was also a criminal trial and an inquest.

## **CONTRIBUTORS TO THE REVIEW**

DHR panel members were as follows:

- Assistant Chief Officer - Kingston & Richmond Local Delivery Unit, Kingston Probation
- Designated Nurse for Safeguarding and Looked after Children, Kingston Clinical Commissioning Group
- Detective Inspector, Specialist Crime Review Group, Metropolitan Police Service
- Detective Sergeant - Kingston Community Safety Unit, Metropolitan Police Service
- Divisional Manager – South West London Victim Support
- Divisional Manager, Royal Borough of Kingston Housing
- Domestic Violence Coordinator, Safer Kingston Partnership
- Head of Children’s Social Care Royal Borough of Kingston
- Immigration Enforcement Team Leader UKBA (now the Home Office)
- Director of Public Health, Royal Borough of Kingston
- LSCB Chair, Kingston LSCB
- NSPCC
- Relationship Manager, Safer Kingston Partnership
- Service Manager Hestia Housing and Support
- Service Manager, Adult Safeguarding, Royal Borough of Kingston

All of the above agencies were represented by senior staff and were all independent of the case. IMR authors attended those Panel meetings where their IMR was discussed.

Several individuals also approached the Review to provide information. To protect their privacy, only job titles have been used. These were:

- BBC journalist
- Surrey Comet journalist
- Chief Executive of RB Kingston local authority
- Former Acting Head at RB Kingston Children’s Social Care
- Former Social Work manager at RB Kingston Children’s Social Care

Two further individuals were approached by the Chair to seek clarification on specific issues:

- CPS Prosecutor in the trial of Sarim
- Manager of the One Stop Shop

## SUMMARY OF AGENCY CONTACTS

Whilst there were agency contacts prior to September 2011, these concerned immigration issues and routine medical appointments before and after the birth of Grace in 2009. Contacts pertinent to the homicide are summarised below.

### **01/09/2011: Kingston Hospital Trust**

Sarim attended the A&E Department at Kingston Hospital after taking an overdose of paracetamol although blood tests showed an insufficient amount had been consumed to require treatment. Sarim told staff that he had taken the overdose on discovering that Agapito was cheating on him.

He had discovered this by accessing her emails and messaging service. He talked about accessing her emails, translating messages on Yahoo, finding out that his girlfriend and her ex-boyfriend were meeting. He mentioned how they had talked about the situation but still she went to meet her ex-boyfriend, switching her phone off. He then felt '*he couldn't cope*'.

Staff assessed it as an impulsive overdose and discharged him with a referral to the Crisis Home Treatment Team (CHTT) to contact him the following day. CHTT phoned Sarim and arranged to meet on 04/09/2011.

It should be noted that the subsequent investigation and trial did not discover any evidence that Agapito was having an affair. Prior to her death, Agapito had made contact with a former Filipino boyfriend via Facebook. He had been her boyfriend many years before. At the time of contact being renewed, he was himself married with a family and lived in Wales. Contact was solely by email except for one visit when the former boyfriend travelled from Wales to London and back in the same day. At trial, the defence produced an email sent around noon on the day of the murder. This seemed to indicate that there was an affair but later investigation found that the email had been sent by Sarim.

### **04/09/2011: NSPCC and South West London and St Georges Mental Health Trust**

At 07.20 am, Agapito contacts the NSPCC help-line via email. She expresses concerns that her partner may try to abduct their 26 month old daughter. She also wrote about '*fighting*' with her partner in front of Grace. She was seeking information about protecting her daughter so that her partner could not take her away. A reply is emailed to Agapito at 11.13 am informing her that a referral was being made to RBK Children's Social Care recommending an initial assessment be carried out. This would be to determine the level of risk to her daughter and identify possible areas of support.

At 11.09 am, Sarim contacts the NSPCC help-line by email. The trial established that Sarim was at some point accessing Agapito's emails. The exact date is not known but it is probable that Sarim contacting the NSPCC a few hours after Agapito was no coincidence, particularly since he had told mental health staff three days earlier that he had accessed Agapito's on-line accounts. The NSPCC were not aware of this. In Sarim's email, he writes about how he met Agapito, about their relationship, and birth of their daughter. He is seeking advice because he thinks Agapito is now seeing her ex-partner and is concerned that she will take their daughter away. He also discloses his recent overdose.

Later that afternoon, the CHTT call Sarim as he had not attended his appointment. Sarim said that he had been expecting directions to be sent to him and was now unable to attend. He declined an

appointment for the following day as he was hoping to meet with his lawyer but said that he would contact CHTT to re-arrange.

**05/09/2011: NSPCC**

NSPCC referred Agapito and Grace to RBK Children's Social Care recommending that an initial assessment be completed due to Agapito reporting relationship conflicts and fear for her daughter being abducted. Referral is made by both phone and fax.

NSPCC responds to Sarim's email encouraging him to prioritise his daughter's needs, and to see his GP in relation to the overdose and how he is feeling. Contact details were provided for Families Need Fathers and community legal advice.

**05/09/2011: South West London and St Georges Mental Health Trust**

Sarim calls the CHTT to rearrange his missed appointment and agrees to meet outside McDonalds on 07/09/2011

**05/09/2011: RBK Children's Social Care**

Following the referral from NSPCC, checks were made of internal records to establish whether the family were known. They were not. A decision was made to respond with information and advice. This decision is not implemented for three days and is not recorded on ICS (the case management system) until 12/09 2011.

**07/09/2011: South West London and St Georges Mental Health Trust**

Sarim met with CHTT. He spoke about his relationship, his belief that Agapito was having an affair and that she will leave and get married when the boyfriend has got divorced. He said he was embarrassed about his overdose but he wants to save the relationship. However, he also said that he would move to Ireland soon with his daughter and help with his uncle's business. He said he was planning to see his lawyer today and to discuss options of sole custody. He did not feel that he required further input and agreed to be discharged from the service effective immediately. He was assessed as of no current risk to himself or others although issues of parental responsibility and sole custody were not raised or discussed and the threat of abducting a child was not specifically followed up. Advice was given regarding Relate or counselling through his GP and information about Crisis Line.

**08/09/2011: Children's Social Care**

An email is sent to Agapito by RBK Children Social Care Safeguarding duty social worker (Team 2). Information is provided about three possible local domestic violence contact points and a list of solicitors to approach for legal advice regarding Grace being abducted. An email reply from Agapito is received the following day expressing thanks for the information provided and stating that the matter had been sorted out. Both of these emails are sent from individual accounts and are not recorded centrally making them inaccessible to other staff.

**23/09/2011: RBK Children's Social Care**

Agapito e-mailed the individual email account of the duty social worker (Team 2). The Duty Social Worker telephoned her, offering information and advice as requested. Agapito disclosed that an argument had taken place the previous evening (22/09/11) as she had confided in an ex-boyfriend and Sarim had found out. Sarim had shown a pornographic video to Grace and kept saying *'this is*

*what your mummy's doing, she is a prostitute, whore, dirty woman'*. He let Grace play with cigarettes and told her that in a future she will learn how to smoke. She also disclosed Sarim's recent attempted overdose. Agapito was worried because she works while Sarim stays home with Grace. Advice was given to contact the Victim Support Domestic Violence Coordinator<sup>6</sup>. Permission was obtained to contact the GP and Agapito was encouraged to make contact again if needed.

### **23/09/2011: Victim Support**

On the advice of the Social Worker, Agapito made contact with Victim Support by phone. Practice is that a full risk assessment is done face to face so a meeting was arranged for 29/09/2011 in Victim Support's office. A brief but incomplete risk assessment was done on the phone using the SPECCS<sup>7</sup> checklist. As Agapito had said that she had been referred by RBK Children's Social Care, a referral was not made to them. A text was sent to Agapito confirming the appointment.

### **23/09/2011: NSPCC**

A second email is received by the NSPCC help-line. In it, Sarim describes difficulties in his relationship with Agapito . writing that she was *'always trying her level best to get me angry...Last night I got angry cause wherever she goes now she takes my daughter...'*. He described a recent argument when he took his daughter to see his brother which Agapito did not like. He was seeking advice about controlling his emotions.

A reply the same day urges again for Sarim to prioritise his daughter and to seek help from provided agency details.

### **24/09/2011: NSPCC**

A third email is received from Sarim at 11.37 on Saturday morning. He wrote that the situation with Agapito had *'gotten worse'*. He stated that they had argued and he became angry and broke her mobile phone. Agapito had left the house with their daughter and a man who lived downstairs. He does not know where they have gone. He further claimed (inaccurately) that Agapito did not let him have any contact with their daughter. He mentioned in the email that he was aware that Agapito had previously contacted the NSPCC. This triggered a search of the records which located the referral to RBK Children's Social Care and the original email from Agapito. However, this was not made clear in the second referral to RBK Children's Social Care which was prepared to be sent on Monday morning.

A reply to the email informs Sarim that the NSPCC will be making a referral to RBK Children's Social Care recommending that an initial assessment be carried out to determine level of risk to his daughter and discuss support for him and his partner. It also suggests that if his partner and daughter do not return, he could contact the police to report them missing.

At 16.02 a fourth email is received from Sarim saying that his partner and daughter still had not returned and seeking advice as to whether he should contact the police now or should he wait. The NSPCC respond at 17.21 acknowledging his distress and informing him that he did not have to wait 24 hours before reporting a missing child. The reply concluded by saying that they would include this additional information in the referral they were making to RBK Children's Social Care.

---

<sup>6</sup> Now called the Independent Domestic Violence Adviser

<sup>7</sup> An earlier risk assessment model used by the Metropolitan police, subsequently replaced with DASH.



### **24/09/2011: Metropolitan Police Service**

Agapito attended Kingston police station to report the incident that occurred two days earlier which had resulted in criminal damage to her mobile phone. A SPECCS risk assessment is completed. Sarim is arrested the same day for criminal damage and the police make a referral to Children's Social Care as follows:

*'On 24/09/11 and 25/09/11 Agapito attended the police station and outlined that on Thursday 22/09/11 at around 19.30 p.m. Sarim returned home displaying strange behaviour. He could have been on drugs or under the influence of alcohol acting in an aggressive manner, shouting and swearing at her. He put the computer on, played a sex video and picked up a few rings and threw them at her. These hit her in the chest but there were no injuries. He allowed Grace to play with the cigarette packet indicating that she will be smoking. She let him calm down and went to bed. He stayed in the room. On Saturday 24/09/11, while getting Grace ready, she left the phone charging and when she picked it up it had been smashed. Sarim admitted that he smashed it. She was shocked, picked up the phone and left the house. Sarim was interviewed by the Police. He stated that on 27/08/11 he managed to get into Agapito 's emails and found out she had been communicating with her ex-partner. He claimed that the pair had apparently fallen in love again. Agapito was supposed to have gone to Legoland but lied and had taken the week off. She was openly talking and texting the ex-partner, playing with his emotions. He denied showing Grace pornography but admitted calling Agapito names. He admitted damaging the phone. The police contacted Agapito , discussed bail conditions and concluded that it was difficult as Sarim looked after Grace while she works. In consultation with Agapito, bail conditions were not imposed.<sup>8</sup> Sarim was told that any further incidents would be construed as witness intimidation.'*

Sarim is bailed in order to assess disposal decision.

### **26/09/2011: Your Healthcare (Kingston)**

Police notification (Merlin) received by the Safeguarding Team detailing domestic abuse between 22 September and 24 September. The information is shared with the Health Visiting team at Churchill Medical Centre.

### **26/09/2011: Metropolitan Police Service**

Agapito attends the One Stop Shop (OSS). She speaks with a casework adviser.

Agapito disclosed that Sarim had made threats to kill her within the last few weeks and his attempted suicide. Agapito was offered access to the other services that the OSS provided. She declined housing assistance but spoke to both the police officer and a solicitor. The solicitor advised her that there was insufficient evidence to apply for a Non Molestation Order due to the bail conditions currently in place.

---

<sup>8</sup> This is not entirely accurate as Sarim was told he would have to live at his brothers but could still visit Agapito daily to provide childcare for Grace. This was at Agapito's request.

### **Morning of 26/09/2011: RBK Children's Social Care**

RBK Children's Social Care receives a further referral from the NSPCC concerning the emails received from Sarim over the weekend. CSC do not deal with this until after the murder.

### **26/09/2011: Metropolitan Police Service**

Later that evening police were called to address 1. The call had been made by another occupant of the building, who had heard a disturbance emanating from Agapito and Sarim's flat.

Officers arrived at 9.21pm and were met outside the building by the owner of the property. The officers found Agapito in her flat lying face down with injuries to the back of her head. Beside her body was a blood stained hammer. Sarim was found sitting in the room, holding his daughter Grace.

Agapito was pronounced dead at the scene, and Sarim was arrested for her murder. When arrested he said '*she cheated on me so she deserved it.*' He was subsequently charged with her murder. Grace was taken into police protection.

### **26/09/2011: UK Border Agency**

Police call command at control at UK Border Agency to report the death. An Immigration Officer is deployed to the police station.

**27/09/2011:** RB Kingston CSC record the NSPCC referrals on their case management system.

The main report details each agency's response in more detail.

## **SUMMARY OF FINDINGS**

It should be noted when reading the findings below that they each relate to circumstances in place at the time of the murder. Much change has occurred in the interim to address these issues.

### **Communication and information sharing**

Kingston services are to be commended with regard to communication between agencies. There was good evidence of clarity between agencies concerning their roles and responsibilities. For example, except where discussed in this report, evidence was provided of appropriate referrals, information sharing and matching records. However, in the following situations, information sharing was below standard:

- The quality and detail of the discharge letter from the Crisis and Home Treatment Team (CHTT) to the GP which was missing several important factors
- Communication by the police to RB Kingston Children's Social Care SC regarding Sarim's bail conditions was unclear
- Agapito's visit to the OSS did not result in a referral back to MARAC or indeed anyone else
- Information sharing by South West London & St George's Mental Health Trust in relation to the potential risks posed by Sarim to Grace
- The different contacts with the NSPCC not always being linked together
- Victim Support not completing a safeguarding referral to RBK Children's Social Care

- The failure of RBK Children's Social Care to respond appropriately to repeated referrals
- The failure of CSC to directly refer to Victim Support with supporting information

### **Professional standards and compliance with internal domestic violence policy, procedures and protocols**

- Staff at RBK Children's Social Care did not correctly follow the local Domestic Abuse Guidance framework or the Pan-London Child Protection Procedures

Risk was not properly assessed by the Metropolitan Police, including at the OSS, in respect of Grace

### **The response of the relevant agencies to any referrals including their assessment of risk**

- As part of the risk assessment, South West London & St George's Mental Health Trust should have discussed with Sarim whether there was any violence, abuse, aggression or extreme anger in his relationship and if so what impact this had on Grace.
- The NSPCC Helpline's involvement in this case did identify risk factors to Grace but did not consider the risk to Agapito, as a result of her leaving the house with her daughter after an argument with her partner.
- The Metropolitan Police should have been using the DASH risk assessment and not the outdated SPECCS. The risk standard applied was also incorrect and lacked an assessment of the risk to Grace.
- RB Kingston CSC did not carry out any form of risk assessment in response to the referrals they received. Nor did recording on the ICS (case management) system occur in a timely way on a number of occasions with the resulting impact of decisions being made without full information.

### **The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.**

The Kingston LSCB has in place a training plan which outlines a rolling programme of training on Domestic Abuse Awareness and Domestic Abuse and Sexual Violence for practitioners and managers across all agencies. There is no record of managers attending either child abuse or domestic violence training in the 18 months prior to the incident although this was available to them through the LSCB training programme. Training on domestic violence is now a mandatory requirement for social workers in RB Kingston.

### **Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.**

- In general, coercive control was not well understood by professionals when assessing the risk to Agapito. The 'verbal argument' was perceived as less serious as was Sarim's on-line stalking behaviour. The Metropolitan Police, the IDVA and RBK Children's Social Care all assumed that the absence of physical violence meant they were dealing with a standard risk case.

**Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.**

- An issue that arose in the course of scrutinising the IMRs from St George's Hospital Trust; St George's Hospital Trust – Midwifery; Kingston & Lambeth GP; Your Healthcare CIC (Kingston) and Merton & Sutton NHS was a difference in the records regarding immigration status. This led to uncertainty over Agapito's eligibility to access NHS care which, on occasion, was withdrawn due to a mistaken belief that she was not entitled. This meant that Agapito and Grace did not have the continuity of care that is expected during pregnancy and post-partum. Whilst it is highly unlikely that this impacted on the subsequent events, it should not be forgotten that health professionals are frequently the recipients of disclosures of domestic violence precisely because of an on-going and trusting relationship.
- There were no identified issues in any other agency.

**Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.**

- RBK at the time of homicide had only one operational Victim Support IDVA in the borough; an unsustainable arrangement when annual leave and sickness have to be covered.
- The process of inquiry into Children's Social Care involvement, and further subsequent enquiry to establish whether the practice found in this case is similar to other cases, revealed that the new duty teams (following restructuring in 2011 when there was a move from an assessment and referral service to all safeguarding teams taking turns on a weekly basis to deliver a duty service) had struggled to meet what they perceived to be a new requirement of receiving and recording all referrals into children services, not just the safeguarding referrals. Much change has been implemented since.

## **CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW**

The Panel began the conclusion phase of the DHR by considering what Agapito needed and how well local provision met these needs. It was agreed that gaps in what Agapito needed were:

- Reliable and affordable childcare
- Security of immigration status
- Her concerns to be taken seriously by all professionals
- A holistic intervention that took account of all her needs
- An appreciation by professionals that reports of abuse may be commonplace for them, but for Agapito this was unknown and often frightening territory

## **ADDITIONAL LESSONS LEARNED**

In addition to the lessons detailed above in relation to the terms of reference, the DHR Panel also identified the following issues:

### **Child contact**

Agapito was the sole earner and needed reliable free childcare. Effective separation from Sarim, therefore, even on a temporary basis, must have seemed impossible. This meant that Agapito was faced with a choice of staying in contact with Sarim, or foregoing her employment.

### **Immigration**

The insecure immigration status of both Sarim and Agapito was given insufficient weight by agencies, especially when Sarim was articulating plans to remove Grace from the country.

## **WAS THIS HOMICIDE PREVENTABLE?**

This Review found that there were two points where serious issues needed to be addressed: firstly the culture of complacency at RBK Children's Social Care as detailed in the main report, including the lack of urgency in responding to NSPCC referrals, the decision by TL2<sup>9</sup> that showing pornography to a two year old was insignificant, the (disputed) allegation that TL3 took a report home with her and the retrospective record keeping. These were all suggestive of levels of complacency that are unacceptable within child protection. Although much has changed since, this homicide acts as a timely reminder of the necessity of maintaining consistently high standards.

Secondly, the assessment by SWL & St George's Mental Health Trust that Sarim was not a danger to himself or others is of concern. Whilst Sarim clearly did not meet the medical definition of deluded, he was acting on a mistaken belief about Agapito having an affair and less than three weeks later had killed her in front of their young daughter. This is not to suggest that individual staff were at fault but rather that the risk assessment tools being used at this time did not give sufficient weight to child protection and domestic violence considerations.

There were also several more missed opportunities for intervention that had they been seized, may have led to a different outcome. Better joined up systems at the NSPCC help-line could have allowed for the different contacts to be linked; a more realistic staffing level for the IDVA service and a consistency in the use of risk assessment tools may all have led to an earlier response although the final outcome may still not have averted. A particular feature of this case is the rapid escalation and in considering all of the available evidence, it is difficult to see how this could have been predicted but the question remains open as to whether more robust responses may have prevented Agapito's death.

In considering all of the available evidence, it is difficult to see how the sudden escalation could have been predicted but the question remains open as to whether more robust responses may have prevented Agapito's death.

The Panel wishes to express its condolences to Grace, family members and friends of Agapito. May she rest in peace.

---

<sup>9</sup> Designations contained within this report in no way relate to the structure within Children's Social Care at the time of the homicide

## Appendix 1: Glossary of Acronyms

<b>A&amp;E</b>	Accident and Emergency
<b>CHTT</b>	Crisis Home Treatment Team
<b>CSC</b>	Children's Social Care
<b>CSU</b>	Community Safety Unit
<b>DASH</b>	Domestic Abuse, Stalking and Honour-based violence (a risk assessment tool)
<b>ICS</b>	Case management system used by RBK Children's Social Care
<b>IDVA</b>	Independent Domestic Violence Adviser
<b>ISVA</b>	Independent Sexual Violence Adviser
<b>LSCB</b>	Local Safeguarding Children Board
<b>NSPCC</b>	<b>National Society for the Protection of Cruelty to Children</b>
<b>OSS</b>	One Stop Shop
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>RB</b>	Royal Borough
<b>RBK</b>	Royal Borough of Kingston
<b>TL</b>	Team Leader
<b>SW</b>	Social Worker