Newham Domestic Homicide Reviews

Summary of Lessons Learned and Findings

September 2016

What is a Domestic Homicide Review?

Domestic Violence and Abuse (DVA hereafter) may preventable. Early intervention can help to increase the safety of victims, and stop abuse and violence from escalating. We know from looking at the history of domestic homicide review cases (DHR hereafter), that rarely the homicide is the first ever attack and a history of DVA is likely, and that there would have been patterns of violent and controlling behaviour. Services may know about previous incidents, they may not. It is likely that friends, family, neighbours and colleagues are aware of previous incidents between the parties.

In order to help prevent DVA and for early intervention to be effective, agencies should have in place adequate policies, procedures and training in place for staff on how to respond to DVA.

The Multi Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews (revised March 2013)[1], set out the provisions for when a DHR should be conducted. DHRs were implemented under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and came into force on 13th April 2011. The Act states that that:

"A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- *A person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death."*

The DHR is a statutory requirement, meaning that the Secretary of State may in a particular case direct a specified person or body to establish, or to participate in, a DHR.

The DHR process is not about apportioning blame or culpability to individuals or agencies for the homicide, but is a collaborative and consultative process which identifies and establishes lessons to be learned and establishes how agencies can better safeguard victims by working to improve the response to DVA.

Definitions

It should be noted that for the purposes of the DHR, an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

DVA is defined as:

"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

[1] *The revised DHR guidance can be accessed from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf*

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*
- *Emotional.*

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

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

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

A member of the same household is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as:

> *"A person is to be regarded as a member of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;*
>
> *Or*
>
> *Where a victim lived in different households at different times, "the same household as victim" refers to the household in which the victim was living at the time of the act that caused the victim's death."*

Domestic Violence and Abuse in Newham

- The costs of DVA to Newham has been estimated to be £28.2 million a year (this does not include the human or emotional costs) – nationally the figure is £5.4 billion[2]. These costs are likely to be a significant underestimate since they do not include DVA by family members who are not intimate partners

- In terms of recorded DVA incidents throughout 2015/16, Newham had the second highest volume in London[3]

- In relation to the rate of DVA and population size, Newham has the 7th highest rate of domestic incidents per 1,000 of the population in London[4]

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[2] The costings use the estimates for the costs of Domestic Violence (Professor Sylvia Walby 2009) to calculate an estimated cost for each local authority area, based on the size of the 16-59 year old population. This is the age range that is targeted by the British Crime Survey, from which national estimates of domestic violence prevalence are obtained. It uses the Office for National Statistics 2009 mid-year population estimates.
[3] Domestic Abuse in London 2015/16, May 2016 MOPAC
[4] Ibid

- In 2015/2016, there were 3,424 DVA offences recorded by the police in Newham (6,677 DVA incidents in total)[5]

- In the last 12 months (up to May 2016) the Specialist DV Court has a conviction rate of 64.4%[6] (out of 32 London boroughs, Newham is ranked 8th from bottom)

- Between January 2015 – December 2015, 402 high risk cases of DVA were discussed at the Multi Agency Risk Assessment Conference[7] (a 29% increase in cases that year) – against SafeLives recommended volume of 450 cases

- It is estimated that nationally only 10% of all DVA incidents committed are reported to the police

- In 2015/16, 75% of LBN Children's Social Care child protection plans had DSV as a known factor (271/363 cases)

- Around a quarter of all victims who report DVA to the police are repeat victims Newham's repeat rate is currently 26%.

Common themes and learning identified from the 5 Newham DHRs

In 2015/16 across London there were 26 domestic homicides recorded - an increase of 8 domestic homicides compared to the previous year. 4 DHRs were convened by Newham Community Safety Partnership in 2013, and one in 2015 (all of which were concluded and published in 2016).[8] Some common themes are evident in these 5 DHRs such as:

1. All victims were of black, minority ethnic origin[9]

2. All of the perpetrators were male and 4 out of the 5 victims were female

3. 3 out of the 5 perpetrators had history of domestic violence towards their previous partners

4. Victims and their families prior to or at the time of the homicide did or appeared to have experienced feelings of isolation and shame

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[5] MOPAC Domestic and Sexual Violence Dashboard
[6] CPS court data spread sheet
[7] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.
After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.
[8] In 2011 the DHR into the death of Amolita (Amolita is an pseudonym) was published, (this was the first DHR Newham conducted). The DHR report in to the death of Amolita (2011) can be viewed at: https://www.newham.gov.uk/Pages/ServiceChild/Domestic-homicide-reviews.aspx

[9] Most people in the Borough are either Asian (43 per cent) or Black (19 per cent), 29 per cent of Newham residents are White - Census 2011

5. Generally there was no significant history of DVA reported to agencies, or contact with specialist DSV services prior to the homicide

6. None of the victims were known to the Multi Agency Risk Assessment Conference

7. The dynamic of DVA was largely invisible to professionals in contact with both the victims and perpetrators. The DHRs showed that there is a widespread lack of professional curiosity to enquire further about family life, nature of relationships, exploration of safeguarding issues and support networks (particularly by health services who had contact with the victims, perpetrators and children). All of the DHRs identified missed opportunities for professional to find out more about the lives and circumstances of those individuals subject to the reviews.

8. Involvement and/or influence of religion and cultural expectations/pressures in resolving family and relationship difficulties

9. Sharia Law issues were evident in 3 out of the 5 DHRs

10. Lack of awareness, on the part of both professionals and friends/family members of the victims, of Domestic and Sexual Violence (DSV hereafter), referral pathways and the local support services available. Family, friends, colleagues were often aware of issues but did not have information available or as to what to do or say or where to go for further help.

11. Professional's responses to DVA would be improved by providing training DVA enquiry, risk assessment, safety planning and referral practices.

Common recommendations from the 5 Newham DHRs

A combined themed action plan that includes all of the recommendations from the 5 DHRs has been created for the Newham Community Safety Partnership to ensure the timely completion of the actions as identified by the reviews. The recommendations have been translated into SMART objectives for the action plan. The action plan will be delivered by a DHR Task and Finish Group and progress will be reported to the DSV Partnership Board and CSP every quarter. Common themed broad recommendations for the 5 DHRs are:

1. Share the learning identified and lessons learned widely across the partnership

2. Public awareness of DSV needs to be improved, and a publicity campaign is needed focusing on:
    - Friends and family members
    - Highlighting how to access support
    - Faith communities/places of worship
    - Messages to explain isolation and coercive control
    - Highlights women's rights in the UK
    - Through training and publicity campaigns creation of a culture within health services where DVA is named, visible and spoken about.

3. Training is needed on DVA enquiry, awareness, risk assessment and referral pathways – particularly noted for all health services including GPs[10]

4. Implementation of the NICE PH50 Domestic Abuse Multi Agency Guidelines by health services[11]

5. Understanding of the connection and dynamic between caring responsibilities, adult safeguarding, carer abuse and DVA requires improvement

6. Procedures and training needed for staff across the partnership to ensure appropriate provision of professional interpreters rather than relying on friends, family, children or partner (perpetrator)

The tables below list the 5 Newham DHRs summarising their key points, to provide a background to the homicide, what learning the review identified and summary of the recommendations made. The full overview report and executive summaries can be accessed at: https://www.newham.gov.uk/Pages/ServiceChild/Domestic-homicide-reviews.aspx

Case name	**Nadira**[12]
Case dynamics, characteristics and nature of relationship between victim and (perpetrator)	The victim was stabbed at home address, the perpetrator organised her homicide. Her son arrived home early and heard his mother crying for help. When a neighbour got into the property Nadira was found dead. The review established that the perpetrator's first wife had accessed support for DVA previously although she is now deceased (poisoned in India). Victim had previously been married to perpetrator's son.
Themes identified	1. Mental health 2. Lack of DVA enquiry and assessment 3. Cultural issues, feelings of shame, victim isolated 4. Victim had limited English language skills 5. Services not using official interpreters.
Lessons learned	Family members were aware of two previous incidents of physical assault and verbal arguments between the couple, but none of her close friends were aware of any DVA. The panel were of the view that it was likely that honour and shame silenced the victim, and meant she was unable to seek help for what was happening to her. Creative publicity messages and strategies on DVA are needed as this would help to increase the opportunities to reach isolated victims (including those newly arrived in the country and may

[10] *Whilst not a specific recommendation the Newham DHR Task and Finish Group wish DSV training to be held on an inter agency basis and have mandatory status.*
[11] *https://www.nice.org.uk/guidance/ph50*
[12] *All DHR case names in this document are pseudonyms*

	have limited English language skills). It was recognised that focusing on friends and family to explain DVA and outline what help and support is available would also help reach victims. GP notes record the victim had poor English language skills but official interpreters were not used. The perpetrator was regularly used at appointments for this purpose. This was an effective tactic employed by the perpetrator to further control and isolate the victim. The Mental Health Serious Incident Review[13] pointed out that "despite the known high prevalence rates of DVA both within the borough and in women presenting with mental health problems" the care pathways followed by East London Foundation Mental Health Trust Psychiatric Acute Community Team do not lend themselves to exploring DVA with patients. Health services and clinicians need to be better skilled at identifying and responding to concerns, indicators and disclosures of DVA. Weaknesses were identified in the system for sending discharge summaries to GPs from the Community Mental Health Team. Steps have already been taken to remedy this via the Mental Health Serious Incident Review.
Recommendation summary	1. DVA awareness communications campaign needed 2. Health services to use official interpreters – not family members 3. Health services require training so able to ask patients about DVA, undertake risk assessments and understand referral processes including to the MARAC 4. Sensitive and appropriate allocation of case workers to clients/patients depending on clients background and concerns 5. Introduce and implement a DVA pathway for GPs 6. Ensure that health services implement the NICE 2014 PH50 Domestic Violence and Abuse multi agency guidelines.
Criminal case outcome	Perpetrator was found guilty and sentenced to life in prison (to serve a minimum of 30 years) and the victim's husband was found guilty and sentenced to 24 years (to serve a minimum of 23 years) - Husband appealed however his sentence was upheld.

Case name	**Avani**
Case dynamics, characteristics and nature of relationship	The victim had been with the perpetrator since 2005 after moving to UK from India and had no family in UK. The couple were married and had 2 children. The victim was employed. The perpetrator believed she was having an affair. The perpetrator was still married to his first

[13] *Convened by NHS England as the perpetrator was receiving mental health services and had committed a homicide.*

between victim and (perpetrator)	wife (whom he had 5 children with, although they had separated). The perpetrators first wife had reported having experienced DVA from the perpetrator in the past. Prior to, or at the time of, her marriage the victim converted from Sikhism to Islam.
Themes identified	1. The family's contact with health services did not raise any safeguarding concerns. She was asked about DVA during her second pregnancy and she said it was not an issue for her. It is unclear from records whether she was asked later on by Health Visiting Services (and an enquiry at this late stage may have been a missed opportunity) . 2. ELFT did not follow its procedures in relation to the 'transfer-in' of Avani's younger child when they were transferred from GSTT to ELFT 3. Interpreters were not used by health services (the victim and perpetrator once interpreted for the oldest child) 4. Lack of professional curiosity to find out more on several occasions e.g., when the couple were deemed to be 'evasive' about their living arrangements, provision of different addresses and on occasion when one of the children was seen by Barts Health. 5. The victim converted to Islam at the time of, or prior to, marrying the perpetrator and had moved from India. This may have potentially resulted in her being cut off from her family, increasing her isolation.
Lessons learned	There were a number of opportunities for agencies to explore with Avani her relationship with the perpetrator – notably health services: • Following the birth of her first child, when she stated on one occasion that she and the perpetrator were now separated. This disclosure of her change of circumstances would have provided an ideal opportunity to ask about family life and any issues occurring, so that support needs could be identified. • When frequently seeking contraception from her GP • Health Visiting service when stated that she and the perpetrator had separated and on occasions when they did not appear to be living together. Professionals need to have a degree of curiosity to understand what is happening in their clients lives in order to help safeguard individuals at risk of harm Isolation is a significant barrier for victims to overcome in order to seek help. Avani's transience appears to have been perceived by agencies at times as 'normal' for someone of her background or culture, and it may be that this prevented further probing and questioning of her living situation.
Recommendation summary	1. DVA training for GPs so they can ask patients and respond appropriately

	2. GPs and pharmacies to enquire about DVA and relationships as part of contraception advice and prescribing emergency contraception 3. GSTT and ELFT to audit their transfer in and out processes, as they did not follow 'transfer' procedures in relation to records being transferred from GSTT to ELFT, and then for ELFT in relation to appropriate appointments being made for the family (note: while this would not have had a bearing on this case, as there were no concerns identified to be shared, the Panel discussed the issue and felt that there is a need to address the procedures in relation to transfers, and a recommendation was made. A recommendation is also made regarding responses to transient families, (recommendation that that the response to transient families moving across borough boundaries to be more robust 4. Awareness raising of DVA with the community through local mosques.
Criminal case outcome	Perpetrator found guilty and is serving life in prison.

Case name	**AB**
Case dynamics, characteristics and nature of relationship between victim and perpetrator	Son killed his father. No previous reports, signs or indicators of DVA. The perpetrator was interviewed as part of the DHR and stated that he had reduced his anti-psychotic medication without the knowledge of healthcare professionals or his family before he killed his father. The perpetrator had sought help from his church for his mental health difficulties and had been subject to an "exorcism" to help heal him.
Themes identified	1. The perpetrator was under the care of ELFT Mental Health Service (the psychology team) at the time of the homicide 2. Caring responsibilities, and lack of support offered to families where mental health is an issue 3. Connection with faith communities for intervention with mental health issues.
Lessons learned	Agencies involved in this case generally followed policies in relation to their internal working relationships, but communication between some agencies (psychology team, carer support and with the family) could have been better. The family did not have a point of contact with team who were treating the perpetrator (the psychology team), where they could share their concerns. There was no awareness within the family of carers' support available. The case highlights the importance of ensuring that patients, carers and the health care provider are properly linked together to ensure individuals are supported. It was agreed by the panel that due to the lack of DVA history and concerns, any other person could have been the victim of an attack

	whilst the perpetrator was in a psychotic state. This case does not reveal a failure to deal with ongoing DVA within the family and demonstrates the need to maintain a dynamic view of potential safeguarding concerns and risks to all members of a family and the community, when managing a family member who is experiencing significant mental ill health.
Recommendation summary	1. Review support for carers when mental health issues are a concern 2. Address the issue of faith based abuse and its links to DVA and mental health 3. Training on DVA enquiry, awareness, referral pathway needed for health services so that relationships and support can be better explored in routine health appointments 4. Increase awareness of carers of support available – specifically on the issue of DVA 5. Improve ELFT information sharing systems with carers of persons with mental health issues.
Criminal case outcome	Perpetrator found guilty and detained under the Mental Health Act.

Case name	**Adult ZA**
Case dynamics, characteristics and nature of relationship between victim and perpetrator	Victim and perpetrator had been in a relationship for 2 years. The victim was 3 months pregnant when she died. The victim had three other children. They went to local schools and she worked as an administrator. She was considered by her children's school and her work colleagues as a lone parent. It is known that ZA had been in a relationship with WX since November 2012 and within six months they had undertaken an Islamic Sharia marriage. The victim obtained a non-molestation order and occupation order for DVA against the perpetrator expressing that she was in fear of her life. ZA indicated she had difficulties in getting the perpetrator to leave the home. She later withdrew the allegations of DSV but it was confirmed in court affidavit, in the solicitor interview and captured on police body camera. She later stated that the perpetrator had forced her to withdraw the orders otherwise she would not see her children. The perpetrator disclosed to colleagues that he believed his wife was having an affair and that he planned to kill her. This was not known to anyone else and was not reported to Police. The police received an abandoned call which they traced to the victim and attended her address. The perpetrator denied that ZA was at home, but one of the children stated they heard their mother screaming earlier. The police officers went into the house and found her unconscious and could not revive her.

	The perpetrator had previously been found guilty of a DV offence of strangulation in 2011 & sentenced to 100 hrs unpaid work (this offence concerned another woman).
Themes identified	1. Victim was isolated from her family who had cut off all contact with her before the homicide took place 2. Colleagues were aware of changes in her manner and appearance, leading up to death. She started wearing a hijab to work and the perpetrator started to pick her up from work. Colleagues stated that she stopped wearing makeup and was described as looking sad in her hijab and it felt like 'her personality was being squashed'. 3. Police polices and procedures were not robustly monitored to ensure staff were trained to follow them according to their roles and responsibilities 4. The victim made multiple attempts to seek help and support from services but was left unprotected. 5. A number of opportunities to ask the victim and the children about family life and DVA were missed.
Lessons learned	It was the opinion of the panel that adherence to procedures and communication between agencies, in particular the police services, may well have prevented the death. This case has highlighted occasions when the victim, and her children, came into contact with statutory health services and the possibility of DVA could have been raised. One of the children was experiencing bullying, it was not disclosed where that bullying was taking place. It is more likely that the view was taken that the bullying was a school problem and not related to issues at home. Concerns were communicated to the school nurse but these do not appear to have been passed to the Attendance Officer. In addition, exploration of the child's presenting issues may have revealed the role of the perpetrator within the family (he was providing consent for health procedures and school absences without any legal authority and this was unchecked). The police failed to correctly deal with the processing and administration in relation to the service of court orders and reports of DSV. Organisations must establish processes to audit and monitor supervision and compliance with their policies. Despite all the contacts with the police, no action was taken to protect the victim, her children or bring the perpetrator before the courts. The police service has dedicated resources to dealing with DVA and serious sexual offences. The Community Safety Unit sits within the Borough structure with established links to specialist DVA services and the local authority. The Sapphire Teams who deal with sexual offences sit outside that structure. It appears that some of the most serious sexual abuse investigations are not structurally linked to the essential borough based services. There needs to be established joint working practice on all serious sexual offences between intimate

	partners. Sapphire Teams need to work with police experts on DVA and their established local support services. The children called the police to the homicide The importance of that intervention by the children cannot be overemphasised. Given the danger represented by the perpetrator, it is not unreasonable to suggest that the call to the police may have saved the lives of the three children who were the witnesses in the house. It was important that at that time they received a response from the police, that the response was appropriate, and that they were believed.
Recommendation summary	1. Roll out of DVA enquiry processes and systems in schools, G.P.s, Sexual Health Services, gynaecology and pregnancy advisory services including DVA awareness and enquiry training, supported by a DVA referral pathway 2. DVA publicity campaign with a clear focus on presences in health sites, highlighting how friends and family can make 3rd party reports 3. Sapphire Teams to have robust links to the borough MARAC and borough police community safety units for sexual violence cases involving intimate partners 4. Police system required to monitor, supervise and audit of the quality of serious sexual violence offences between intimate partners 5. Police training so staff understand civil orders in DVA and their role 6. Non-Molestation Orders and Non-Occupancy Orders should be inputted directly to the Police National Computer.
Criminal case outcome	Perpetrator found guilty and sentenced to a minimum term of 17 years in prison.

Case name	**AA**
Case dynamics, characteristics and nature of relationship between victim and perpetrator	The ambulance service called the police to a flat in Newham. In the flat they found AA seriously injured suffering from stab wounds and being tended to by members of the public. At the flat the police found AA's husband, BA. BA admitted responsibility for stabbing his wife, stating it was self-defence. The victim was from Bulgaria and came to UK in 2012. The perpetrator entered the UK in 2011 & is from Pakistan. There was an argument between couple as the victim did not wish to open a joint bank account - which she voiced to family in Bulgaria. She also told family during a telephone call at Christmas that the perpetrator was blackmailing her (details of this not known). The victim and perpetrator married under Sharia law and had a legal marriage in 2012. In 2013 during a joint police, immigration and local authority visit to a

	licenced massage parlour (in Camden) as part of a planned police operation AA was found to be working at the premises, it was not known in what capacity. AA was found with a large quantity of condoms but denied she was offering any sexual services. The police established that AA was not at the premises against her will. This was identified by the review as a missed opportunity to ask AA about DSV.
Themes identified	1. Victim was a migrant woman 2. Routine enquiry for DVA within health settings may have helped to facilitate a disclosure from the victim 3. Wider provision of publicity material on DVA may have helped AA become aware of services available and encouraged her to access support 4. The family were aware of the DVA. AA had told her family in Bulgaria that the perpetrator was jealous man and that she regretted marrying him. In a Skype call, the victim's mother saw bruising to her daughters face – the victim stated the perpetrator had caused the bruises 5. Their marriage was motivated by the perpetrator wishing to change his residency status in the UK
Lessons learned	There were no previously reported incidents of DVA between the couple and no incidents coming to the attention of statutory agencies that would indicate the presence of DVA There were opportunities when questions could have been routinely be asked concerning relationships and DVA; e.g. registration with a new GP, appointments at hospital and when the police attended the massage parlour. There was no DVA information or advice material available at the GP practice. The display of such material helps ensure DVA is visible and also sends a message to patients that the service understands and considers DVA to be important to respond to. The provision of information in the waiting area may encourage the patient to talk to their GP about DVA or to later approach specialist support services. Visits to licenced massage parlours provide an opportunity for police and local authority staff to supply information to women working in these establishments on services available to support victims of gender based violence. It has been a common perception that women working in the sex industry may have been victims of trafficking, abuse and coercion, and the more common areas of DSV should also have been considered. Whilst it cannot be expected that women would disclose fears to authority figures on the day, the provision of information could facilitate later disclosures. The review highlighted good practice in Newham, where a sex work service has been commissioned. This service is not in operation across all boroughs and there is no similar service available in the borough where AA came to the attention of police on a massage parlour licencing visit.

Recommendation summary	1. G.P.s, Sexual Health Services, gynaecology and genitourinary medicine Services should discuss DSV when registering new patients and have clear DVA pathways in place 2. Publicity and information leaflets on DVA needs to be available in health services/venues. This information should specifically target migrant women to ensure they know their legal rights and that services believe victims of DVA 3. Police to review protocols and training for visits to licenced premises where sex workers are present to ensure that all staff are appropriately trained to deliver information and support on DSV 4. The National Ugly Mugs Scheme should review how links can be made to DVA services and to encourage reporting 5. Publicise and share Open Doors best practice nationally 6. Develop local links with the Immigration Service as associate members to local safeguarding and strategic partnership boards such as the Local Safeguarding Children's Board, Adult Safeguarding Board and the Community Safety Partnership.
Criminal case outcome	Perpetrator found guilty and sentenced to a minimum term of 20 years in prison.