DOMESTIC HOMICIDE REVIEW

London Borough of Newham

Case of Adult ZA

Executive Summary

Author Mark Yexley

September 2016

Executive Summary

1.1 Outline of Incident

1.1.1 In July 2013 a 999 emergency call was made to the police from an address in Newham. On arrival at the house the door was answered by the children of ZA and they were joined by WX, her husband. The children said that they had heard their mother screaming earlier, her husband stated that she was not home. The police officers went into the house and found ZA unconscious, she had been strangled. Her husband was arrested. ZA was taken to hospital where she was pronounced dead. A homicide investigation commenced.

1.1.2 WX was arrested and admitted killing ZA. He refused to be interviewed. WX was charged with murder and remanded in custody.

1.1.3 WX appeared at the Central Criminal Court on 6 May 2014 and pleaded guilty to murdering his wife. On 27 May 2014 he was sentenced to life imprisonment with a minimum term of seventeen years to be served.

1.1.4 The review panel extends its sympathy to the family of ZA at this difficult time.

1.2 The review process

1.2.1 These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the London Borough of Newham Community Safety Partnership (CSP). The initial meeting was held on 2 August 2013 to consider the circumstances leading up to this death.

1.2.2 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2.3 The purpose of these reviews is to

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic homicide review victims and their children through improved intra and inter-agency working.

1.2.4 The review process does not take the place of the criminal or Coroners Courts nor does it take the form of a disciplinary process

1.3 Terms of Reference

1.3.1 The full terms of reference are included in **Appendix 1 of the Overview Report.** The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 Agencies were asked to review all contact between January 2011 and July 2013 and to summarise contact before that date. This time period was set in order to gather and analyse contact between agencies and the subjects of this review that may have had an effect on the family. Those agencies who had contact were required to complete Individual Management Reviews (IMRs) for submission to the panel.

1.4 Methodology

1.4.1 The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with WX or ZA, and her children. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

1.4.2 Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. The final report is a product of that process.

1.5 Independent chair

1.5.1 The independent Chair of the DHR is Mark Yexley, an ex-Detective Chief Inspector in the Metropolitan Police Service with 32 years' experience of dealing with sexual violence and domestic abuse. Mark was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. He was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Mark was a member of the Department of Health National Support Team and London lead on National ACPO and HMIC Reference Groups. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey and Sussex.

1.5.2 Mark has no connection with the London Borough of Newham. Mark retired from the MPS in January 2011. Although he worked in the department investigating sexual violence, his role was in a Pan London Unit dealing with Cold Case

Investigation and Sexual Assault Referral Centres. There have been structural changes to the MPS since he left the service and Mark has no connection with the teams involved in this case. He has no personal or professional connections with the police officers involved in the case and has never held any line management responsibilities for the police teams. Mark's experience was discussed with the CSP commissioner at Newham before the review commenced and it was decided that is knowledge would be valuable in this review process.

1.6 Parallel and related processes

1.6.1 The progress of this case has been severely affected by a parallel disciplinary process. On initial examination of the circumstances of the case the Metropolitan Police Service (MPS) decided to refer the matter to the Independent Police Complaints Commission (IPCC). A total of nine misconduct notices were served on officers from MPS and Hertfordshire Constabulary in October 2013. It was apparent that the MPS IMR would require officers involved abuse to be interviewed as part of the DHR process. The IPCC made representations to the panel that any interview by IMR authors could compromise the disciplinary investigation. It was agreed by the panel that the IPCC would take primacy with interviews and that this DHR could use the content of the IPCC report to inform the DHR. The report was eventually released to the panel in the summer of 2015. A recommendation around unsatisfactory performance and learning lessons was made for select officers. At the time of writing, the final IPCC report had still not been published. The East London Foundation Trust (ELFT) conducted a serious incident review into this case before submission of their IMR.

1.7 Contact with family and friends

1.7.1 The family of ZA reside in the UK but had disowned her and cut all contact with her before the homicide took place. It is believed the severing of contact was due to opposition to her marriage to a Muslim man. ZA's family were invited to take part in this review and were made aware of the process. They have chosen not to participate in the police investigation and do not wish to assist any other enquiries.

1.7.2 The panel gave consideration as to whether ZA's children should be involved in the review. The chair discussed the review with the family social worker and she

spoke with ZA's eldest child about the process. She did not want to take part in the review as she considered it to be too painful.

1.7.3 The police were able to provide details of ZA's work colleagues and friends. They were able to give information to the review and this proved valuable to the process.

1.8 Summary of the case

1.8.1 The victim was born in West Bromwich in 1975. She had been previously married to a man from India. This relationship ended after her husband was convicted for unrelated matters and they were divorced in March 2013. ZA had three children during this relationship. Her daughter, FV, was born in 1998. ZA had two sons. BV born in 2000 and EV born in 2005. The children went to local schools and ZA was employed in an administrative role in an NHS GP practice in Ilford. She was considered by her children's school and her work colleagues as a lone parent.

1.8.2 The perpetrator was of Islamic faith born in Bangladesh. He was known by the police to have had three previous partners before meeting ZA.

1.8.3 His first known partner, GS, reported domestic incidents to the police in Newham and Essex. His second known partner, HT, reported incidents to police in Essex and his third partner SK reported an incident in Hackney.

1.8.4 WX had three children with GS and the family lived in Essex. As a result of his first marriage, WX was granted UK naturalised status in 2006. Very little is known about WX's second wife HT. From police reports it appears that WX commenced an Islamic marriage with his second wife in the summer of 2011. This marriage ended in July 2012. WX is known to have had a relationship with SK before he met ZA. In November 2012, WX met ZA. The couple entered into an Islamic marriage on 27 April 2013. WX worked as a Cross Rail security officer at the time of his arrest for homicide. WX was known to the police through previous incidents of domestic abuse.

1.8.5 It is not known how ZA met WX. It is known that ZA had been in a relationship with WX since November 2012 and within six months, on 27 April 2013, they had undertaken an Islamic Sharia marriage.

1.8.6 After ZA had commenced her relationship with WX her daughter, FV, developed medical problems.

1.8.7 On 15 January 2013 FV was taken to Accident and Emergency (A & E) with severe abdominal pains. She had her appendix removed, although this was found to be healthy.

1.8.8 On 22 February 2013 FV reported to her GP that she was too unwell to attend school through chest pain and constipation, she was admitted to hospital. The staff were concerned about her low body weight and recent weight loss. She

had reported abdominal pain since January 2013 and no organic cause had been found. There was thought to be a psychological element to FV's illness and she was referred to the Child and Adolescent Mental Health Service (CAMHS) by the hospital. FV's referral to CAMHS identified that her pain started when WX moved into the family home in January 2013.

1.8.9 The psychiatric assessment of FV took place. The provisional formulation was of Pain Disorder with related psychological factors. Appropriate referrals were made to psychotherapy with the school nurse being informed. There were no questions asked about the possibility of domestic abuse. A referral was made to Children's Social Care (CSC).

1.8.10 The reason for the referral to CSC was due to FV reporting pain, with no medical cause being found. FV's relationship with her mother was considered to be good. There was speculation that FV could have been subject to bullying at school. This was due to her body language when questioned about bullying. Her case was referred for CSC triage. It was decided that there was no evidence of safeguarding concerns or need for support. The school nurse was informed and school contacted regarding potential bullying. There were no other concerns reported at school. CAMHS also had discussions with the school.

1.8.11 During the period of January to March 2013, ZA had seen her GP and out-of-hours service for treatment for urinary infection and a Sexually Transmitted Infection (STI). Diagnosis and prescribing took place with the out-of-hours services. In dealing with the out-of-hours service the presenting features would only be discussed. This did not provide ZA with opportunity to discuss her domestic circumstances. She was advised to attend a Genitourinary Clinic (GU) for more complicated symptoms, which she did on 13 February 2013. The opportunity to discuss ZA's domestic circumstances was not taken by the GP or GU service.

1.8.12 On 24 May 2013 ZA was seen in the pregnancy advisory clinic. She had an unplanned pregnancy of about six weeks. She was given her first dose of medication to begin the termination. She was given the second dose on 1 June 2013. ZA was not seen by the counsellor. No time was taken to discuss the potential for domestic abuse and coercion by her partner.

1.8.13 On 3 June 2013 ZA contacted her GP stating that she had been feeling unwell since she had taken the medication and she was concerned that the pregnancy had not been terminated. She was advised to visit the Termination of Pregnancy Clinic (TOP). ZA also reported that her daughter's hair had been falling out for four days. She was advised to bring FV into the surgery but there was no discussion on potential stress and links to CAMHS.

1.8.14 On 14 June 2013 ZA went to her solicitor in Hertfordshire and reported that her husband, WX, was abusive. She made a sworn statement expressing that she was in fear of her life. On 17 June 2013 a non-molestation order, together with

an occupancy order was granted in favour of ZA. Copies were served on the Metropolitan Police Service (MPS) at Newham.

1.8.15 After papers were served ZA sent texts to her solicitor indicating that she had difficulties getting WX to leave her home in Newham. On 19 June 2013 ZA and WX appeared at the solicitor's office in Hertfordshire asking for the orders to be revoked. She then disclosed that she had been taken to the solicitor's office against her will by WX. WX had told her to revoke the orders or she would not see her son again. The solicitor reported the matter to Hertfordshire (Herts) Police.

1.8.16 Herts Police attended the solicitor's office and arrested WX. ZA later disclosed to police that she had been raped by WX the previous night. This statement was captured on police body worn video camera. A copy of ZA's statement to the County Court was handed to the police. This statement also outlined rape perpetrated by WX. WX was also arrested for rape. It transpired that the initial kidnap and sexual offences took place in London. Herts Police reported the matter to the Metropolitan Police Service (MPS). The MPS Sapphire (sexual offences) Team took responsibility for the investigation. The Detective Inspector in charge of the unit sent a Sexual Offences Investigative Techniques (SOIT or Specially Trained) officers to see ZA. During a four hour wait for the MPS there was no offer of medical help or Sexual Assault Referral Centre (SARC) services. The MPS SOIT officer spoke to ZA and she retracted her allegations. The MPS did not send an investigating officer to Hertfordshire. WX was not interviewed and was released without charge. The matter was recorded by the MPS as a Crime Related Incident (CRI).

1.8.17 On 27 June 2013 ZA called police to her home in Newham. She reported that WX was outside her house and there was an injunction in existence. Before police arrival, ZA phoned the police back stating her husband had left the area. MPS officers decided to continue to respond to the call and went to ZA's home, finding WX there. He was not arrested. The police officers made a record of the attendance as a domestic incident and completed a risk assessment, they assessed the risk as 'standard' and recorded that an injunction was not in existence.

1.8.18 On 3 July 2013 the GP contacted ZA by the phone. ZA confirmed that she had done two pregnancy tests and they were both positive. If the previous termination was unsuccessful then ZA would have been twelve weeks pregnant at this time. ZA said that she was under a lot of stress and was going on holiday at the end of the month. An appointment was made for a scan on 5 July 2013. The scan showed a viable pregnancy and an appointment was made for a pre-surgery meeting on 10 July 2013, followed by a surgical termination on 12 July 2013.

1.8.19 In the early hours of 7 July 2013 the MPS received a call from a mobile phone. The call was cut-off by the caller. The police operator called the phone back. It was answered by ZA's eldest daughter, who said her brother had been playing

with the phone. The original call was traced by the police and found to be registered to ZA's address. Police officers were sent to ZA's home.

1.8.20 Police were met by WX together with ZA's daughter. WX said that his wife was not home. FV then told police that she had heard her mother screaming earlier. The police officers went into the house and found ZA unconscious. She was taken to hospital where she was pronounced dead.

1.8.21 WX was arrested and admitted killing ZA. He refused to be interviewed. WX was charged with murder and remanded in custody.

1.9 Key Issues arising from this review

1.9.1 Preventability

(a) In this case it should be remembered that only one person, WX, is responsible for taking the life of ZA. However, in this review it is the opinion of the panel that adherence to procedures and communication between agencies, in particular the police services, may well have prevented the death of ZA.

(b) The main concern is the failure of the police service to deal with the processing and administration in relation to the service of court orders and reports of domestic and sexual violence.

1.9.2 Police Procedures and processes

(a) In this case ZA informed the police of her domestic abuse on three occasions and she was not protected. There was a lack of adherence to policy at several points of contact with the police. The correct supervision of policies, intelligence checks and communication with statutory partners at any point of police contact could have synthesised information and led to a different outcome for ZA.

(b) Over a period of ten days the following took place: ZA's solicitor had served a copy of non-molestation order and non-occupancy orders on her local police; ZA had reported abduction, rape and breaches of the orders; and ZA reported a second breach of the orders. Despite all of these contacts with the police, no action was taken to protect ZA and her children or bring WX before the courts.

(c) In her contact with the police service ZA's children were either present with their mother or mentioned by her. There were no police referrals made to the Local Authority through existing safeguarding arrangements.

(d) In dealing with serious sexual violence between intimate partners, there needs to be an understanding that victims need the highest levels of service and support. Unless police use all the available measures to secure a victim's safety then a perpetrator can use their controlling influence to deter a victim from engaging with police. This requires involvement in a full coordinated community partnership response to provide effective support. This will also allow prosecuting authorities to gather evidence from all available bodies and widen the options for criminal justice outcomes. In this case the use of civil orders, already obtained by the victim, would have provided protection and supported a full and thorough response to ZA's needs.

(e) The police service has dedicated resources to dealing with domestic abuse and serious sexual offences. The Community Safety Unit sits within the Borough structure with established links to IDVAs, local support services and local authorities. The Sapphire Teams sit outside that structure. It appears that some of the most serious sexual abuse investigations are not structurally linked to the essential community based services. In order to overcome this, 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 domestic abuse and their established local support services.

1.9.3 Communication between agencies and awareness of Domestic Abuse

(a) This case has highlighted some occasions when ZA, and her children, came into contact with statutory Health services and the possibility of domestic abuse could have been raised. At the time there were concerns about the emotional causes of FV's problems, her school absences were increasing. The school mistakenly felt that the amount of time spent at hospital justified these absences, because of the initial presentation of a surgical problem. CAMHS and CSC communicated concerns to the school nurse but these do not appear to have been passed to the Attendance Officer.

(b) There should have been a co-ordinated multi-disciplinary response to FV's care including CAMHS, Acute Paediatrics and Education. Whilst it may not have ultimately revealed the existence of domestic abuse it would have been a valuable opportunity to share information and protect the family.

This process may then have revealed the role of WX and caused questions to be asked about his identity and role within the family. It should be noted that WX was providing consent for health procedures and school absences without any legal authority and this was unchecked.

(c) Better communication between health and education (school nurse and attendance officer) may have revealed the nature of the domestic relationship. A multi-disciplinary approach when ZA was experiencing medical problems would have shown that WX had two previous abusive relationships.

(d) It should be noted that whilst there were signs available that could indicate domestic abuse, the information from police was lacking. Had the information concerning the children coming to notice of police been shared with statutory partners, then a coordinated multi-agency response could have been instigated to protect the family.

1.10 Recommendations

The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations that mirror these. It is suggested that the single agency action plans should be subject of review via the action plan hence the first recommendation.

Recommendation 1:

That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.

Recommendation 2:

The London Borough of Newham and Newham CCG should ensure that all Schools, GPs,

Sexual Health Services, gynaecology services and pregnancy advisory services are routinely enquiring about domestic violence and sexual violence and are aware of clear pathways for referral to domestic abuse support services and MARAC. This should be monitored by regular audit and reporting performance on MARAC and Domestic and Sexual Violence referrals to the Domestic and Sexual Violence Board.

Recommendation 3:

The London Borough of Newham, Newham CCG and Education provide publicity and

information leaflets for public facing health services on domestic abuse. Priority should be given to encouraging family and friends to make third party referrals and that no religion accepts domestic violence.

Recommendation 4:
The London Borough of Newham and the MPS conduct a review of the MPS Sapphire Team involvement in the MARAC process.

Recommendation 5:
MPS Sapphire Team considers processes that will actively involve Borough Community Safety Teams in the investigation of serious sexual violence between intimate partners.

Recommendation 6:
The MPS implement processes that will monitor, supervise and audit of the quality of serious sexual violence offences between intimate partners. That process should include a level of independence from the police service and a link to community based domestic abuse services.

Recommendation 7:
The MPS implement training for all staff to ensure and awareness and understanding of civil orders in domestic abuse cases and the police service role. When police become aware of a civil order a system should be developed to allow process of receipt, generation of a new specified investigation (treated like a new allegation/ incident), instigation of contact with a victim, and trigger a referral to IDVA services locally and consideration for a MARAC referral.

Recommendation 8:
That the Home Office work with the Ministry of Justice to implement a system whereby Non-Molestation Orders and Non-Occupancy Orders can be input directly to the Police National Computer.