Domestic Homicide Review Overview Report

Subject of the report: "Hanita"
Month of death: January 2017

INDEPENDENT CHAIR:
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Safer Leicester Partnership
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1. INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004.

1.2 The purposes of a DHR are 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 these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

1.3 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process.

1.4 Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review also assesses whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

1.5 This report of a domestic homicide examines agency responses and support given to Hanita, a 46-year-old woman of South Asian heritage. The Review Chair, Review Author and domestic homicide review panel send their condolences to Hanita's family.

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

1.7 To ensure confidentiality, the victim in this case will be referred to as Hanita, the perpetrator as Sanjiv and children as Aadinath and Pandita respectively.

1.8 Hanita was reported missing and found deceased the following day, having been murdered. The convicted perpetrator is her former husband, Sanjiv, 51 years. Although the couple divorced in 2014, they remained residing in the family home. In 2018, Sanjiv was found guilty of murdering Hanita by strangulation, and sentenced to life imprisonment; to serve a minimum of 18 years before release.

1.9 Hanita, through an arranged marriage in India, married Sanjiv in 1988. They had two children, Aadinath born in 1992 and Pandita, born in 1999. The marriage subsequently broke down and they formally separated in 2012 and divorced in 2014. However, the family home was jointly owned and Sanjiv remained living in the home, separately, in a downstairs room.

1.10 There are two historical police reports of domestic abuse within this family. The first was in January 2011 and the second after their divorce in August 2015. Hanita reported both of the incidents.

1.11 This review is seeking to examine the role of agencies, and others, who may have come into contact with Hanita and her children, or who came into contact with Sanjiv. A specific focus is to establish if there are any lessons to be learned in relation to missed opportunities for agencies to engage with the family. Also, to seek to understand the family's ability to be aware of, and access, services they may have needed.

1.12 There are a number of domestic abuse services available to victims and perpetrators in Leicester City throughout the scoping period and currently[1]. Services are delivered through one provider: United Against Violence and Abuse (UAVA), which is a co-operative consortium of three specialist Domestic and Sexual Violence Abuse organisations:

- Living Without Abuse,
- Women's Aid Leicestershire Limited,
- FreeVA

1.13 Counselling provision is sub-contracted to other specialist local organisations with the aim of providing an integrated, seamless service:

- Leicester Rape Crisis;
- First Step;
- Trade;
- New Dawn New Day;
- Quetzal

1.14 Helpfully, Leicester, Leicestershire and Rutland completed a Sexual and Domestic Violence and Abuse Needs Assessment[2] in October 2017, the findings of which are referenced in this report where appropriate.

1.15 This review commenced on the 24th April 2017 and concluded on the 11th September 2018. There has been a delay in completing this review due to Sanjiv's criminal trial not being heard until early 2018 and the impact this has had on the ability of the review to seek to engage with family members. However, single agency learning identified from this review has been progressed in advance of completion.

[1] See Appendix 3 for full outline

[2] Sexual and Domestic Violence and Abuse Needs Assessment for Leicester, Leicestershire & Rutland. Published October 2017 provides evidence of unstable housing as being the most common factor across DHR's; and identifies that people with some protected characteristics appear to be less likely to access local services than others, including South Asian women.

2. TERMS OF REFERENCE

2.1 The detailed terms of reference and Project Plan appear at Appendix 1. The terms of reference detail the purpose, framework, agency reports to be commissioned and the particular areas for consideration of the review.

2.2 For effective learning, it was agreed that the scoping period for this review will be from the 1st August 2014 until the 17th January 2017 due to key practice episodes falling within this time frame. There are, however, incidents that occurred in the past, prior to the review period, that have significance, and these will also be included where they provide learning.

3. METHODOLOGY

3.1 The Review sub-group of the Leicester Safeguarding Adults Board recommended the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and this was approved by the Safer Leicester Partnership. The Serious Incident Learning Process (SILP) model of review was commissioned to be used within the domestic homicide review process.

3.2 SILP is a learning model, tried and tested in safeguarding reviews for both children's and adult's cases and takes account of principles enshrined in government guidance. The process engages front line staff and their managers in reviewing cases; focussing on why those involved acted in a certain way, at the time.

3.3 The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners
- Engaging with families
- Systems methodology

3.4 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again for a recall event to study and debate the first draft of the Overview Report.

3.5 This review has been undertaken in a way that reflects the principles of a systems methodology; wherever possible seeking to review organisational factors and not apportioning individual blame. It also seeks to include family members at every opportunity.

3.6 The review panel included representatives from the following agencies:

Name	Representing	Contribution
Leicestershire Police	Jez Pollard and Siobhan Barber	Individual Management Review (IMR), provided by an Independent Review Officer. Attended Learning and Recall Event
Leicester City Council Children's Services	Lesley Booth - Service Manager	IMR provided from an Independent Safeguarding Lead. Attended Learning and Recall Event
College 1	Not disclosed as this would identify the College concerned	IMR provided from the College's Designated Safeguarding Lead. Attended Learning and Recall Event
College 2	Not disclosed as this would identify the College concerned	IMR provided from the College's Designated Safeguarding Lead. Attended Learning and Recall Event
College 3	Not disclosed as this would identify the College concerned	IMR provided from the College's Designated Safeguarding Lead. Attended Learning and Recall Event
General Practitioner	Dr Ahmed Girach	IMR provided by GP.
Leicestershire Partnership Trust	Vicky Spencer and Jean Wilson	Summary report provided. Attended Learning and Recall Event
Leicester City Council	Stephanie McBurney	Domestic Abuse Specialist: Team Manager, Domestic and Sexual Violence Team. Attended Learning and Recall Event
Leicester Safeguarding Adults Board	Caroline Green– CrASBU Officer Lindsey Bampton– Board Manager	Administered process. Provided advice and guidance
Safehouse – an independent charity	Sandra Manak – Director, Panaghar	Domestic Abuse and Black & Minority ethnic Specialist: Attended Learning Event

supporting victims of Domestic Violence		
Clinical Commissioning Group	Mina Bhavsar– Head of Adult Safeguarding for CCG	Attended Learning and Recall Event

3.7 Whilst applying the principles of the SILP methodology, the independent chair and author have followed the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016. Importantly, the model has incorporated 4 meetings of the review panel. This has been a sufficient number of meetings in this case for the panel to effectively support the review and to discharge their duties.

3.8 An initial scoping meeting and first panel meeting was held on the 24th April 2017 where agency representation, terms of reference, the scoping period and the project plan were agreed.

3.9 A meeting for Authors of individual agency reports was held on the 17th July 2017, where the SILP process and expectations of the agency reports was discussed. A full day learning event, which incorporated issues pertinent to the DHR panel meeting, followed on the 7th February 2018, with the agency reports having been circulated in advance. Agencies involved were represented by their report author and managers, and where available, staff who had been involved during the scope period.

3.10 At a Recall Event and panel meeting on the 14th March 2018, participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the contents and clarify their role and perspectives. The report was endorsed by a meeting of the Safer Leicester Partnership's Review sub-group on the 11th September 2018.

3.11 The review has been chaired by Donna Ohdedar, an independent safeguarding consultant with no links to the Safer Leicester Partnership or any of its partner agencies. Donna has 16 years' public-sector experience, including her last role as Head of Law for a leading metropolitan authority. Now a safeguarding adviser and trainer, Donna is involved in serious case reviews in both children's and adults' safeguarding, domestic homicide reviews and SILP.

3.12 The report has been authored by Carolyn Carson, an independent safeguarding reviewer, who has been independent of agencies in Leicester for 8 years. Carolyn is a retired Police Superintendent who specialised in Safeguarding and who has conducted adults safeguarding reviews, domestic homicide reviews and SILP, independently, over the last six years.

3.13 The process has been efficiently administered and supported by officers within the Leicester Safeguarding Adults Board and the Domestic and Sexual Violence Team.

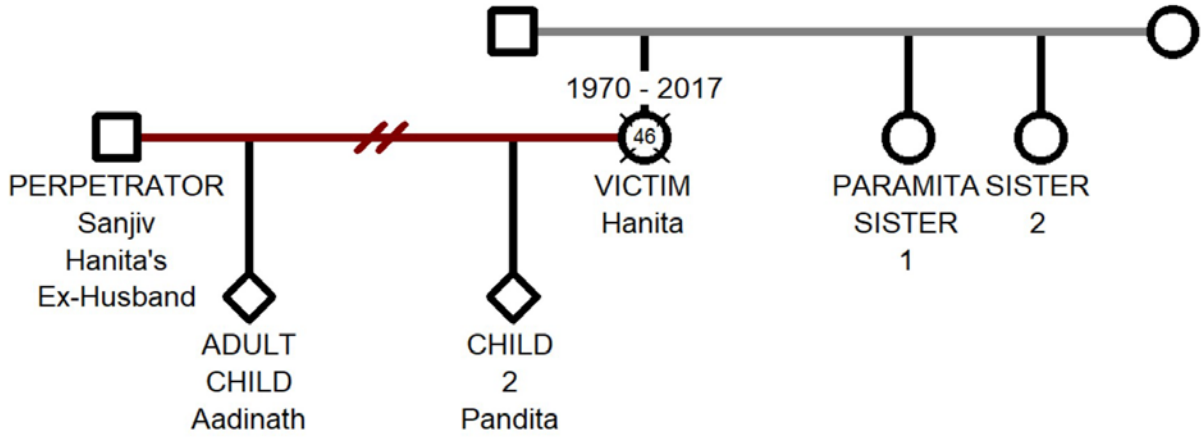
3.14 Whilst this review was on-going, there were two parallel reviews; namely the criminal investigation and the Coroner's Inquest. Both have been notified of this review. In particular, the criminal investigation Senior Investigating Officer has provided advice and guidance in relation to the timing of speaking to family members and others who were witnesses in the criminal trial. The criminal trial concluded in February 2018, after which, the review approached family members.

3.15 Hanita and family are of South Asian ethnic origin, from the Gujarat, and considerations in relation to the Equality Act 2010[3], Equality and Diversity are incorporated within the review where appropriate. Specifically, issues of Culture and Belief have been analysed within the report at section 8.6.

[3] https://www.gov.uk/guidance/equality-act-2010-guidance

4. HANITA, SANJIV, THEIR FAMILY AND THE WIDER COMMUNITY

4.1 Genogram



4.2 This review has been able to ascertain little detailed information from agencies about Hanita. However, we do know that Hanita, Sanjiv, Aadinath and Pandita came into contact with agencies through the review period; namely schools, the police, children's social care, GP, CAMHS and the Leicester Royal Infirmary. Hanita attended her GP surgery on a number of occasions for medical matters the panel are satisfied are not pertinent to this review.

4.3 Hanita was born in the UK. She was employed part time within a call centre, at a large organisation in Leicester City, near her home. Her elder child, Aadinath, attended higher education through the review period and her younger child, Pandita, attended secondary education and sixth form college.

4.4 Sanjiv was employed as a machine operator prior to being made redundant in 2013. From March 2015, it is known that he re-entered employment as a night shift manual worker. In December 1997, Sanjiv was convicted of driving with excess alcohol and was sentenced to a 12-month driving ban. The first report of domestic abuse to agencies, in January 2011, identified Sanjiv's use of alcohol and again at the second report in August 2015. On both occasions, Sanjiv was seen to be drunk. No substantive offences were disclosed to the police at either report and Sanjiv was not known to the police outside of these three incidents.

4.5 The review is aware that the marriage between Hanita and Sanjiv broke down irretrievably and divorce proceedings commenced in 2013. A Decree Nisi was granted in March 2014 and Decree Absolute in September 2014. Their home

was jointly owned and on divorce, Sanjiv continued to live at the family home, due mainly to neither being able to afford to buy the other out. At Family Court[4] proceedings 'cross-undertakings'[5] that neither should be abusive to the other whilst co-habiting, were accepted by both Hanita and Sanjiv, in lieu of pursuit of a Non-Molestation or Occupation Order as applied for by Hanita. A stated intention to pursue an application for a financial order[6] was not progressed by Hanita.

4.6 The review reached out to Hanita's family and provided opportunities to contribute to this DHR; and respected their wishes not to do so[7] until the report had been drafted and approved by the Home Office. The panel are

[4] The single Family Court was introduced in 2014 and all Judiciary now sit as part of a unified Family Court. Through this review, the Family Court was held either by a District Judge or by a Magistrates Court. As such references will be to either a District Judge or a Magistrates Court depending on where the Family Court sat at the time.

[5] Cross Undertakings https://www.legislation.gov.uk/ukpga/1996/27/section/46 **Sec 46 Family Court Act 1996 - Undertakings.**(1)In any case where the court has power to make an occupation order or non-molestation order, the court may accept an undertaking from any party to the proceedings. An undertaking is an option that allows the parties to settle their dispute without a full hearing. It is a promise made to the court to do, or not to do, certain things. It is not an admission of guilt. Undertakings can be made in cases listed in either the County or Family Proceedings Court (FPC), although the penalties for breach are not the same in the FPC. Either court should only accept an undertaking in cases where they are satisfied it is safe to do so. The respondent can give an undertaking without having to admit to the allegations made against them. An undertaking cannot, therefore, be used in subsequent criminal proceedings as evidence of a criminal charge or as proof that any violence has occurred. Nor does it provide any factual evidence that the abuse took place. The court cannot attach a Power of Arrest to an undertaking, but breaking an undertaking is still contempt of court and is as enforceable as any other order of the court. The undertaking (which is usually worded similarly to a non-molestation order) must be signed by the person who gives it. The court usually serves form N117 on both parties before they leave the hearing.

[6] https://www.gov.uk/money-property-when-relationship-ends/apply-for-a-financial-order

[7] Family engagement was attempted at the start of the DHR Process and again at the point of the reports' completion. Attempts at contact were made by telephone, by post and in person to the family address. Family members were aware of the advocacy support available having been provided with the Home Office's information leaflet for Families. The Police Family Liaison Officer was engaged in this process and passed on information directly.

very thankful for the input of both Hanita's sisters and her children, in reading the final draft and providing comments on both the report and what they think the learning should be. The panel have noted the issues the family highlighted in this meeting and the domestic and sexual violence team will feed back progress around those areas if the family would like this. Sanjiv was invited to take part but did not respond to the invitation. The panel were pleased that the family members felt the report addressed the issues they considered to be important and that the timing of the report had felt 'about right' for them.

4.7 Friends and colleagues at Hanita's place of work have been deeply affected by her death. The review has consulted Hanita's employer and respects their wishes to provide limited engagement. There has been no useful learning concerning employers and domestic abuse to include within this review.

4.8 Hanita and Sanjiv were of the Hindu faith and the review welcomes the generic cultural perspective provided by the family temple priest.

4.9 The review welcomes the contribution made by the Family Court at Leicester and, separately, from Her Majesty's Court Service (HMCTS).

5. A BRIEF BACKGROUND PRIOR TO THE SCOPING PERIOD 1997 - AUGUST 2014

5.1 In 1997, Sanjiv received a drink-drive conviction and was disqualified from driving. Aadinath, when interviewed as witnesses for the homicide investigation, revealed their earliest recollection of witnessing violent acts by their Father towards their Mother was also in 1997. Both children expressed the opinion that their father was an alcoholic and recollect regular abusive incidents spanning from 1997 to their parents' divorce in 2014; where after the violent incidents abated but on-going domestic abuse continued.

5.2 The children outlined having witnessed violent acts: to include Sanjiv smashing a mirror over Hanita whilst holding one of the children; fits of rage and smashing of plates and pictures; assaults by slapping and punching; tipping Hanita and Pandita out of bed when he was drunk; verbal assaults accompanied by restraint of Hanita's wrists.

5.3 When interviewed, Aadinath recalled, as a means of punishment, being struck with a plug at the end of an electrical lead. He also reported being threatened

to be burnt with a hot iron, witnessed by Pandita and prevented by the intervention of Hanita.

5.4 At 9.49pm on Saturday 15th January 2011, Hanita called the police to report Sanjiv drunk, throwing items around and having pushed her and scared Pandita. The police attended and found Sanjiv drunk and to have pushed over a TV and ironing board. On being spoken to separately, both parties stated that only a verbal argument had occurred. Hanita expressed her concern that Sanjiv's drinking and threats of violence had been increasing and the police provided details of local domestic abuse support agencies to Hanita. They provided information relating to anger management and alcohol awareness to Sanjiv. A risk assessment was completed[8] with a standard risk assessed. No further action was considered necessary by the police at that time. The review notes that in 2011, whilst there were nationally available perpetrator programmes, there were no specific perpetrator programmes locally in Leicester and it was not routine practice at the time for the police to signpost to a national programme. Since 2011, services to support perpetrators have been established in Leicester.

5.5 Divorce proceedings commenced in 2013. The review has had sight of associated papers filed at the Family Court on the 15th May 2014, during the process for which, Hanita provided verbal evidence that Sanjiv, whilst holding a knife, had threatened to kill her, on two occasions.

5.6 On the 24th June 2014, The District Judge heard the application for an Occupation Order from Hanita and listed it for a hearing on notice, which was finally effective after difficulties with bailiff service, on the 17th July 2014. The court heard that no incidents of violence had been perpetrated by Sanjiv since divorce proceedings commenced in March 2013, but that he had continued to be abusive to her and Pandita and they continued to be in fear of him. On that basis, the Family Court ruled that the application should continue as a Non-Molestation Order, Hanita being unlikely to be able to prove the

[8] DASH was not implemented in Leicester until 2012. This risk assessment was recorded on form CR12 centred on SPECSS

justification for an Occupation Order. Cross undertakings[9] were accepted in terms that neither party should use or threaten violence towards the other or their child, Pandita; or, make any intimidating, threatening or abusive communication of any nature to the other.

5.7 During this background period, both children attended Community College and presented noticeably differently. Aadinath was disruptive with declining attendance from 96% to 88%. They had exhibited signs of stress and requested a letter from their GP to delay exams, on two occasions. By contrast, Pandita was described as being very quiet and withdrawn but an excellent student.

6. KEY PRACTICE EPISODES

6.1 June 2012 to March 2013

6.1.1 On the 20th August 2014, Pandita attended a GP appointment in the presence of Hanita where they were diagnosed with moderate depression; Pandita presenting with symptoms of stress and self-harming. The GP referred them to the crisis team who advised assessment by CAMHS. CAMHS offered an appointment by letter sent to Pandita's parents. They have recorded also sending a copy of this letter to the school nurse at Pandita's school. Pandita did not make contact and CAMHS offered a second appointment by letter. The GP followed this up with a telephone call directly to Pandita but could not establish a specific reason why they had not engaged, other than they hadn't wanted to.

6.1.2 On the 1st September 2014, The Magistrates Court ordered, by consent, that Hanita's application for a non-molestation order be dismissed. This was based on both parties having agreed to the on-going cross-undertakings and the

[9] An undertaking is an option that allows the parties to settle their dispute without a full hearing. It is a promise made to the court to do, or not to do, certain things. Cross undertakings are where they are agreed by both parties.

Court being satisfied they both understood the terms of the undertakings, and the potential consequences for breaching them. Also, Hanita confirmed her intention to apply for a financial order promptly; but this was not progressed. As there was no conclusion to this, the cross undertakings were not rescinded and continued in place throughout the scoping period.

6.1.3 Hanita applied for a Decree Absolute which was granted on the 11th September. Sanjiv had initially opposed this due to the existence of Hanita's pension but did not subsequently fight it.

6.2 Issues within the relationship between 2015 - 2017

6.2.1 At 12.44am on Sunday 16th August 2015, Hanita called the police to report her ex-husband as drunk and being verbally abusive to herself and Pandita. Hanita stated that a court order existed with a power of arrest. At 3am the police saw Sanjiv to be drunk and observed him to be living downstairs. There was no sign of a disturbance and Hanita explained they were separated and that she wanted Sanjiv out of the house. The officer made the decision to arrest Sanjiv to prevent a breach of the peace, having considered the situation could escalate if left as it was. A DASH risk assessment was completed and a standard risk recorded. Pandita had been present and expressed concerns about Sanjiv. The officer made a referral to the Child Abuse Investigation Unit, who referred to Children's Social Care.

6.2.2 On the 18th August 2015, Leicester City Children's Social Care, Early Help Services, received the referral. They noted the family was not previously known to them. Police had recorded Pandita as having been moderately affected by the incident and had told the police that they felt their father's presence at the house represented a risk to their physical well-being. Hanita wanted Sanjiv removed from the home and felt his continuing presence would result in further confrontation. The contact was recorded for 'Advice Point Only', with no further action or agency checks made.

6.2.3 Sanjiv returned to the home the following morning and took no steps to leave thereafter; and did not contribute to family finances during the last two years of their co-habitation. In the summer of 2016, an arrangement was made for Hanita's sister to purchase the home and allow Hanita and Pandita to live there, whilst requiring Sanjiv to leave. This was suggested by Hanita's sister as a means of helping Hanita to start again. The process was delayed by Sanjiv's repeated failure to sign paperwork, despite having stated that he had, which prevented the transaction from going through in a reasonable timescale.

6.2.4 In September 2016, Pandita chose to move to a different sixth form college and very quickly requested support from their counselling services.

6.3 Fatal Incident

6.3.1 On a Monday in mid-January 2017, the house sale completed and Sanjiv was expected to move out, having no continuing legal right of residence. However, he had continued to take no steps to do so. In fact, he lied to his friends and police initially, stating that the sale hadn't gone through, when the sale had been recorded as completed at 11am that day.

6.3.2 Hanita was known to return home from work on Monday afternoon, having told friends and Pandita that she was intending to go to the solicitors that afternoon to hand over the house keys, so the sale was completed officially. She had arranged to meet her sister straight away afterwards to return and change the locks; but tragically, Hanita did not get to the solicitors and was not seen alive again.

6.3.3 Hanita's family reported her missing at 7.42pm the same day and the police immediately recorded her as a high-risk missing person.

6.3.4 Hanita was found deceased the following day and Sanjiv immediately arrested and charged with her murder.

6.3.5 On the same day, Pandita's college were extremely concerned, and made a referral to Leicester City Duty and Advice Service, within Children's Social Care and Early Help, outlining concerns. The police also contacted Social Care and informed them that Pandita had told them there had been on-going domestic abuse within the family home.

7. THE VOICE OF HANITA'S FAMILY AND FRIENDS

7.1 Basic background information about Hanita as an individual and mother, and the circumstances of her shared life with Sanjiv, has been obtained through examination of witness statements prepared for Sanjiv's trial.

7.2 As an Individual, Hanita was described as having a lovely personality, being outgoing and chatty. She was always laughing and smiling, seemed happy and got on with everyone. She was religious and attended all Hindu festivals. Both children clearly adored her and Hanita was very close to both her sisters

and parents; all of whom lived nearby. All have been deeply affected by her death.

7.3 A sister describes her as always happy. She was well dressed, loved fashion, and her hair and nails were always immaculate. Her character meant that if she was sad, she wouldn't show it. She was very popular, and 'famous', at work and always went out on social events.

7.4 Hanita was very close to both children; the elder, Aadinath, only staying at weekends due to work commitments elsewhere but with Pandita, she shared a very close daily bond. A week prior to her death, she and Pandita were walking together and discussing Sanjiv finally moving out. Hanita remarked 'What if he ends up killing me or something?' They were scared at the thought but laughed it off, believing that 'even though they know he is bad, they didn't think he would do that'.

7.5 Sanjiv did not have a close relationship with either child. They didn't speak to him whilst he shared the house. Sanjiv did not buy gifts or attend parents' evenings. They resented the way he treated their mother. As soon as their mother was missing, Pandita accused their father of having harmed her.

7.6 Hanita and Sanjiv are described as having long standing problems in their marriage. They separated for a year before Pandita was born but they reconciled. Sanjiv has always been known as an alcoholic and family members are aware that the marriage deteriorated badly before the divorce. Sanjiv was known to come home drunk, throw and smash things. However, Hanita did not disclose physical abuse to wider members of the family. Pandita recalls their mother calling the police but believes she didn't call them soon enough, and Hanita had no bruises to show.

7.7 Post-divorce, Hanita and her ex-husband led totally separate lives within the same house. Hanita hoped she would get the house in the divorce because Pandita was under 16; but was told she would have to buy him out or sell. Sanjiv did not want to leave unless he received money. Hanita could not afford to buy him out, and Aadinath was not able to obtain a mortgage. Sanjiv did not contribute to household bills at all and although she would have struggled financially, she did not complain to others.

7.8 This situation continued until Hanita finally decided to sell the house and her sister agreed to buy it in June/July 2016. The transaction should have taken 6 weeks but Sanjiv continually delayed the process by lying about having signed and posted documentation, right up to exchange of contracts. Hanita commented that she would not know any peace while Sanjiv remained in the house.

7.9 Although, Hanita's sister offered for Hanita to remain after the sale, Hanita did not wish to prevent her sister obtaining rent monies. Instead she had planned to move out, with Pandita, to her parents' home before renting a small property. Sanjiv had made no plans to move anywhere else.

8. ANALYSIS BY THEME

8.1 The analysis section will consider information as gained from family and friends, thematically. All analysis leads to lessons that need to be learned from this review. The themes to be addressed are:

- Single Agency Opportunities to Examine Family Dynamics[10] and Risk
- Opportunities for Multi-Agency Working
- Housing Issues
- Potential Barriers to Accessing Services, including Impact of Culture and Beliefs

8.2 Within each section of analysis, the lesson learned will be stated, along with a recommendation for the Safer Leicester Partnership, where required. These will be reiterated in the specific sections towards the end of the report, and single agency recommendations outlined at Appendix 2.

[10] The term 'family dynamics' encompasses family background, history and relationships within the family in order to identify issues of risk and abuse.

8.3 Single Agency Opportunities to Examine Family Dynamics and Risk

8.3.1 On the 20th August 2014, when Pandita visited the GP, the GP was unable to ascertain the full reasons for the anxiety but was sufficiently concerned to contact the Crisis Team; who advised a referral to CAMHS. Pandita did not subsequently respond to offers of appointments. The GP showed good risk management by making the referral and following up on the subsequent non-engagement directly with Pandita, by telephone. However, the GP was unable to ascertain why Pandita had not wanted to engage and as Pandita did not present subsequently to his GP for stress related issues, had no further opportunities to do so.

8.3.2 The only police report of domestic abuse in the scoping period was on the 16th August 2015. The police attended and asked questions in line with the DASH risk assessment which specifically asks if there had been other violent incidents. Hanita did not disclose the incidents she had reported to the Family Court nor mention the existence of the court orders as she had to the call handler. The information Hanita had already passed to the call handler concerning the existence of a court order and, what she believed to be, a power of arrest was not recorded at any point by the police officer attending or included in the risk assessment. However, it is known that the information had been passed to officers at the scene by the Call Handler. It has not been possible to ascertain why the information was not referred to, nor is it possible to know whether it was discussed with Hanita due to the officer not being able to recall their discussions. There is no record that Hanita was provided with any advice on this matter. '

8.3.3 The existence of 'undertakings' or 'cross-undertakings' are not currently notified to the police from the Family or Magistrates Court for recording onto police intelligence systems because they do not carry a power of arrest. Therefore, they do not flag up through routine intelligence checks conducted prior to police visits. This may be a reason why the 'cross undertakings' were not noted on the police risk assessment nor raised as an issue once Sanjiv had been detained. Clearly, Sanjiv had breached his 'cross undertakings', and this was an opportunity to remind Hanita of her option, as a litigant in person, to seek redress through a return to the Family Court. Sadly, it is not possible to know to what extent Hanita understood her rights or what impact any potential lack of police advice had on Hanita not subsequently returning to the Family Court, given that she clearly knew about their existence (albeit factually incorrect in stating there was a power of arrest attached), and the consequences of their being breached is explained in full before they are issued.

8.3.4 The police took positive action in response to a potential risk Sanjiv may pose by arresting him to prevent a breach of the peace and making a child protection referral. Hanita had asked for help to remove her ex-husband which the police supported through the arrest. An arrest to prevent a Breach of the Peace is an effective temporary solution but cannot prevent the return of a perpetrator to the family home. However, this was the only option available at this time due to the grounds for a Domestic Violence Protection Notice[11] not having been met. The review welcomes the proposed continuing development of DVPN's, as outlined within the current 'Transforming Domestic Abuse Responses' Home Office consultation paper[12]. A widening of the grounds for their use to encompass all elements of the revised domestic abuse definition, rather than being restricted to acts, or threats, of violence, would provide greater opportunities for the police to directly support future domestic abuse victims who may also be in Hanita's

[11] Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs) were rolled out across all 43 police forces in England Wales from 8 March 2014. DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575363/DVPO_guidance_FINAL_3.pdf

[12] https://consult.justice.gov.uk/homeoffice-moj/domestic-abuse-consultation/supporting_documents/Transforming%20the%20response%20to%20domestic%20abuse.pdf

circumstances through the longer-term removal of abusive partners from a shared home.

8.3.5 ***Lesson 1***

The police attendance at the domestic abuse incident was an opportunity for Hanita to have been advised to seek redress concerning Sanjiv's breach of the 'cross undertakings' but there is no record that she received such advice from the police, or that it was included within risk assessments. There is a gap in the sharing of safeguarding information between the Family Court and the police which prevents the existence of 'cross undertakings' being known to the police and available within intelligence checks.

8.3.6 The police referral received by Children's Social Care, Early Help, in August 2015 was a good opportunity for Early Help services to seek to identify potential risk through examination of family background and family relationships. However, because the family was not previously known to Early Help and the incident did not reach the threshold of a high risk, the referral was recorded for information only, with no further agency checks made[13].

8.3.7 The verbal referral had provided much information relating to Hanita's circumstances but did not include the historical report of domestic abuse made in 2011. It cannot be assessed that having this information would have prompted a wider approach; but Social Care have assessed that the lack of case history was a key element in taking no further action. The police have reviewed this aspect and cannot state exactly what was passed to Early Help but are satisfied that the attending police officer did record this information on their report. At this time, in 2015, information had to be physically extracted from officers' reports to pass to Early Help; but this has now changed with the introduction of a new computer system, NICHE[14], which

[13] Recorded by Early Help as 'Advice Point'.

[14] The Niche RMS™ Police Records Management System is an incident-centric tool that manages information in relation to the core policing entities: people, locations, vehicles, organisations (businesses or other groups), incidents (or occurrences) and property/evidence.

extracts all the information recorded by attending officers onto a Public Protection Notice, which is passed to Early Help in its entirety.

8.3.8 Information known to have been received from the police informed Early Help of Sanjiv's previous conviction for drink-driving; that the couple had separated; and Hanita wanted her ex-husband out of the home. It was also clear that Pandita was worried about physical harm from Sanjiv. Professional curiosity was not exercised at this point to establish if there was other relevant information known to the police, including previous history or the outcome of the arrest; or if information was held by GP or schools. A GP check would have established Pandita had been self-harming the previous year and chosen not to engage with CAMHS. Informing Pandita's school would have alerted them to Pandita's home situation. Further contact was not made with Hanita for an ongoing risk assessment. The review notes that at this time, DASH was not routinely expected to be incorporated but that since December 2016, Children's Social Care's Duty and Assessment practice standards highlight the need for assessment tools to be used within referrals.

8.3.9 The response from Early Help was an opportunity to seek to identify the existence of domestic abuse within the family and provide on-going support, but this did not occur as it should have. In context, Children's Social Care have explained that in January 2015, Leicester City's Children's Services were subject to a Single Inspection Framework by OFSTED which measured the effectiveness of services to children in need and protection; and that the judgement was 'Inadequate'. Management oversight was identified as weak which meant that social workers were making decisions without systematic management oversight. OFSTED required an effective performance management framework to be embedded within practice and this was in its infancy in August 2015. Practitioners described workload in August 2015 to be very demanding with little time to reflect.

8.3.10 On the 17th January 2017, whilst Hanita was missing and potentially deceased, Children's Social Care received an urgent referral from Pandita's college. Leicester City Council Duty and Assessment (DASS), recorded the referral as a contact only and closed the case without further enquiries on the basis of it being a crime and not a child protection matter. DASS have reflected on this and accept the referral was managed superficially as a recording exercise due to their having been no investigation of the traumatic situation Pandita was now in. Had they done so they would have established that they held information in relation to the 2015 domestic abuse in the family and a GP check would have established previous self-harming in 2014. Triangulation of

this information, with the very recent history provided by the college, may have led to a fuller exploration of the immediate and ongoing risk and need. Professional curiosity was not exercised in relation to understanding the family background or Pandita's needs directly. Neither was there an assessment of suitability of family members to look after Pandita in the short, or longer term, given the absence of any person with parental responsibility now able to do so.

8.3.11 A multi-agency strategy meeting and section 47 child protection enquiry was an appropriate option at this point for Pandita. This would have ensured an holistic approach to risk assessment across agencies in support of Pandita at this difficult time.

8.3.12 The review notes the positive work undertaken by the Police Family Liaison Officer and Pandita's college at this time in support of Pandita and Aadinath.

8.3.13 ***Lesson 2***

Leicester City Council, Children's Services, did not sufficiently examine either referral and missed an opportunity to explore family dynamics that may have identified abuse; and to provide support to Hanita and Pandita.

8.3.14 In September 2016, when 17 years old, Pandita changed college and very quickly accessed their counselling services. The counselling service provided extended sessions which enabled a relationship to be built and Pandita disclosed stress relating to personal and home related issues, leading to suicidal ideation. They stated that when younger there had been domestic abuse by their Dad against Mum, which was better since the divorce, but that home was an unpleasant place due to Sanjiv remaining and being an alcoholic. They did not want home to know of their current situation.

8.3.15 As a young person and under 18years of age, this is a difficult situation for young people's counselling services. Risk management is fundamental to this role and Pandita's counsellor ensured the input of their designated safeguarding lead when there were clear concerns about suicidal ideation. Jointly they agreed it was necessary to inform Hanita and the GP of the situation, but this was refused by Pandita because they did not want their issues to be known at home. The college will only inform a GP without consent should there be a real and immediate risk, and it was assessed that there was no immediate risk because Pandita was speaking openly to them. Instead, Pandita agreed to coping strategies.

8.3.16 Pandita's college explained that the counselling service is bought as a service, with counsellor's subject to independent counselling governance. Counsellor's undertake full safeguarding training[15] and students sign a disclosure agreement before counselling. They are aware of the need to refer and whilst Pandita was potentially at risk of significant harm, they did have a good relationship with their counsellor that provided immediate protective elements. The college have assessed that judgments made at the time would be likely made again in similar circumstances, especially given the number of young people presenting with suicidal ideology.

8.3.17 It is a difficult balancing act working on the boundary of confidentiality in these circumstances and this review is satisfied that the college had Pandita at the heart of their approach.

8.3.18 ***Lesson 3***

Young people's counsellors work with many young people with suicidal ideation and have to make difficult decisions on when to refer to child protection services.

8.3.19 **Recommendation 1:**

Safer Leicester Partnership should share the findings of this review with the Leicester Safeguarding Children's Board to highlight all lessons learned through this review specific to children and young people.

8.3.20 **Recommendation 2:**

The Home Office should note the findings of this review as relevant to their development of DVPNs.

[15] https://www.wge.ac.uk/assets/uploads/2017/10/Safeguarding-Young-People-Policy.pdf

8.4 Opportunities for Multi-Agency Working

8.4.1 The first opportunity for multi-agency working was by the GP at point of Pandita presenting with self-harming, stress and anxiety and subsequent referral to CAMHS. CAMHS ensured the GP and school was updated by letter, and this enabled the GP to seek to understand why Pandita had chosen not to attend. Pandita did not subsequently see the GP for issues of stress and self-harming and therefore a threshold for referral to Children's Social Care, and further opportunity for multi-agency working, was not met.

8.4.2 Pandita was known to be stressed and withdrawn. The sharing of information between GP and schools, as a protective factor, was considered by this review. CAMHS demonstrated good practice by recording having sent a letter to Pandita's school to inform them about the appointment but there is no record of it having been received on school or school nurse records.

8.4.3 The school nurse service explained that where they receive a letter from CAMHS, they will check their system. Unless the school have raised individual concerns to the school nurse with regards to a young person, the school nurses do not actively telephone the school in relation to each information request or add a new record on their systems. A gold standard approach would be to contact the school for each information request received. However, current commissioning arrangements do not allow this to happen due to the current workforce capacity of 20 school nurses for the school population in Leicester City of approximately 44,000 pupils. The school nurse service has highlighted that each school has a named school nurse allocated to them as a contact point, and that any concerns a school may have in relation to a child or young person can be escalated through that link. However, in this case, the school were not informed of any concerns to be able to consider escalation. It would be helpful if the receipt of letters from partner agencies such as CAMHS were recorded for the future consideration of safeguarding concerns, where they may be needed.

8.4.4 There is no evidence that the school was aware of Pandita's health needs from the GP. GP's locally, do not routinely share information with schools. They do not receive information routinely from the police or social care where domestic abuse has been reported (unless consulted within child protection procedures), and so was unaware that Hanita had reported as a victim. Should a case reach the threshold for MARAC, the GP may be aware and invited to contribute where the MARAC deems this to be necessary[16]. The review notes that locally, GP training does not encompass the IRIS[17] programme. However, the development of locally commissioned training targeted at GPs is welcome. This is provided in collaboration with dedicated domestic abuse specialists[18] and aims to enhance the identification of domestic abuse through the introduction of a GP policy on domestic abuse and information sharing.

8.4.5 In consequence overall, Pandita's school held no background information that may have directly prompted professionals to understand more about their personal and home situation. This in turn prevented any information being passed to Pandita's sixth form college that would have assisted their counsellors when working with them in crisis. The ability to access or be informed about safeguarding information is vital to effective child protection and the identification of domestic abuse. Specifically, in this case, the knowledge of the known domestic abuse and Pandita's self-harming, may have enhanced opportunities for disclosure of domestic abuse when interacting with Hanita at parents' evenings or when interacting with Pandita. The review welcomes Pandita's school having reflected on this and is now

[16] Leicester City CCG advises that GPs are not routinely notified about all cases that meet the criteria for a MARAC. The MARAC meeting decides if the GP needs to know, influenced by the Leicester Partnership Trust Domestic Abuse Nurse. MARAC writes to GPs when:

- The meeting decides notifying the GP is appropriate
- The individuals are not engaging with services to support them
- The perpetrator is a risk to individuals/ during consultations

[17] http://www.irisdomesticviolence.org.uk/iris/

[18] UAVA launched Feb 2018

ensuring domestic abuse help line notices are placed within the ladies' toilets. The review would also promote the same approach within men's toilets.

8.4.6 The review also welcomes the local development of domestic abuse services in Leicester with the implementation of Operation Encompass[19]. This requires the police to inform social care on each occasion that domestic abuse is reported where a school age child is affected, or present at the address in any way. Social care will then directly inform the relevant school. An intention of this scheme is also to raise awareness of domestic abuse. All designated school safeguarding leads have received information on pathways for local services available for domestic abuse, including a children and young people specific service they can directly refer into, and the availability of healthy relationship sessions.

8.4.7 ***Lesson 4***

Opportunities for multi-agency working could be enhanced through more effective information sharing between GPs, schools and the school nurse. High volumes of young people coming to the notice of school nurses is preventing the recording and sharing of safeguarding information that may assist schools to monitor welfare. This is particularly important in support of Operation Encompass within Leicester City which seeks to raise awareness of domestic abuse within schools and enhance multi-agency information sharing.

8.4.8 There is no evidence that Hanita was eligible to be considered for MARAC through information held by agencies. However, information passed by Hanita to the family court concerning threats made to kill her by Sanjiv may have placed her at a high risk of harm had she been risk assessed against that

[19] Op Encompass commenced in Leicester City in February 2018. It is an initiative that enhances communication between the police and schools where a child is at risk from domestic abuse. It joins up information sharing through the involvement of social care. It works by the passing of information each morning to social care, who then speak directly to the school of an affected child, to inform them. http://www.lcitylscb.org/information-for-practitioners/operation-encompass/

information. There is a disparity of information held by the Family Court, to that which was known to core safeguarding agencies.

8.4.9 A District Judge within the Family Court outlined they receive much training on domestic abuse through Judicial training and are advised through Practice Direction 12J[20], as revised in November 2017, which provides guidance on cases where domestic abuse is a feature. The District Judge clearly had an understanding of all elements of domestic abuse including coercive control. The District Judge advised they are aware of MARAC but not the role of IDVA. They do not see their role as one of referring to either and do not use DASH, although they are aware of it. The District Judges have no direct links to safeguarding and was not aware of domestic homicide reviews. They are not funded to attend training provided by safeguarding agencies. There exists a local Family Justice Board on which the Designated Family Judge sits and this may be a forum for sharing of information. The District Judge was not aware of the Civil and Criminal Justice Working Group that exists in Leicester City.

8.4.10 Family solicitors who represent their clients at Family Court work independently from safeguarding agencies. They are privy to very private information and work with clients at point of separation in divorce cases. They are, therefore, in a unique position to identify victims of domestic abuse, particularly when victims are at their most vulnerable.

8.4.11 In terms of risk management, the review has been informed there would never be an occasion where a lawyer would contact the police, or other safeguarding options for their client, without client consent, because in their opinion, this could be against the client's instructions, would breach client confidentiality, could impact the client's physical and emotional wellbeing and could lead to the client being harmed should such disclosure become known. They are aware of DASH, IDVA and MARAC but would not access them directly without consent.

[20] https://www.familylaw.co.uk/news_and_comment/revised-practice-direction-12j-child-arrangements-and-contact-orders-domestic-abuse-and-harm#.WzUBJqdKiUk

8.4.12 From discussion with the family lawyer and the Adult Safeguarding Team, the review has ascertained that locally, family lawyers are not engaged with local safeguarding forums. It should be noted that the review has not looked at this aspect specifically to ascertain in detail if any, indeed are. Currently, family lawyers do not receive information relating to the findings of DHR's but would welcome the opportunity to do so. They do, though, receive newsletters and updates on general matters from the Family Court.

8.4.13 The family lawyer outlined that lawyers receive training on domestic abuse law when in initial legal training and receive any updates, routinely through their own network. They have access to a domestic abuse screening checklist[21], which provides guidance on eliciting sensitive information. However, they are not currently invited to local authority domestic abuse training.

8.4.14 A representative from the Domestic and Sexual Violence Team within the City Council attends the quarterly meeting of the Civil and Criminal Justice Working Group, as does a representative from the local Family Justice Board. This would appear to be an appropriate forum to develop links with family lawyers and to develop local understanding and thresholds for identifying and managing victims of domestic abuse.

8.4.15 **Recommendation 3:**

The Safer Leicester Partnership should consider developing links to District Judges who work with domestic abuse victims in the Family Court, through the Family Justice Board or Civil and Criminal Justice Working Group, to ensure a shared understanding of coercive and controlling behaviour, and the agreement to use of undertakings, both of which impact on victim safety and decision making.

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[21] Resolution http://www.resolution.org.uk/ About Resolution

Resolution's 6,500 members are family lawyers and other professionals committed to the constructive resolution of family disputes. Members follow a Code of Practice that promotes a non-confrontational approach to family problems. Our members encourage solutions that consider the needs of the whole family - and in particular the best interests of children.

8.4.16 **Recommendation 4:**

The Safer Leicester Partnership should develop the inclusion of family lawyers who work with domestic abuse victims in the Family Court, within safeguarding training and information sharing protocols.

8.5 Housing and Family Court Issues

8.5.1 A fundamental factor in the death of Hanita was that, although divorced, their property was co-owned and Sanjiv continued to live in the family home. At the point where the property was sold and he lost the legal right to remain, Hanita was killed by Sanjiv at point of final separation, Sanjiv having made no attempt to leave. Whilst acknowledging that Sanjiv's on-going actions amounted to domestic abuse through coercion and control and Hanita's death occurred as a direct result of the violent domestic abuse perpetrated by Sanjiv at point of final separation, this review has examined the circumstances of their continued co-occupancy, and associated housing issues, as a specific element. Previous DHR's in Leicester City have identified unstable housing to be the most common factor identified[22] [23], and so this has prompted curiosity within the review to consider if there is something specific about on-going shared accommodation, in addition to the known risks at point of separation, that can trigger homicide. Whilst not distracting from issues of coercion and control, understanding this element may enhance the development of domestic abuse services given that currently, housing status is not a specific

[22] Sexual and Domestic Violence and Abuse Needs Assessment for Leicester, Leicestershire & Rutland October 2017: In the review of Leicester domestic homicide reviews, the most common factor was unstable housing.

[23] Analysis of Leicester city DHRs (conducted in 2017) was that whilst the number of DHRs was limited, in each of them accommodation appeared to be a significant factor in the homicide, falling into one of three categories:

i. Victim homeless or in temporary / unstable accommodation and staying with perpetrator
ii. Perpetrator homeless or in temporary / unstable accommodation and staying with victim

Victim and perpetrator married and living together but if the victim were to leave, one or both would need to find new accommodation.

risk indicator for domestic homicide. It would be beneficial for detailed analysis to be captured nationally in all DHR's to provide an evidence base for consideration of housing as an additional risk indicator.

8.5.2 ***Lesson 5***

Unstable housing has been identified as the most common factor in local DHRs and in Hanita's death, co-occupation of the family home post-divorce was a key issue in the circumstances of her homicide.

8.5.3 The review has had sight of Occupation and Non-Molestation Order applications in which Hanita cites: violent behaviour; controlling behaviour; throwing around of objects; frightening Pandita; and on two occasions threatening to kill her with a knife.

8.5.4 A Decree Nisi was granted on the 5th March 2014 on the grounds of Sanjiv's unreasonable behaviour. In May 2014, Hanita filed papers at the Leicester Family Court seeking an Occupation Order, which would remove Sanjiv from the home. In July 2014, Sanjiv vehemently denied all the accusations made against him and an Occupation order not granted. Instead 'cross undertakings'[24] were suggested as a way forward. This was rejected by Hanita initially, who was not represented by a legal advisor in court, but subsequently agreed to on the basis that there had been no incidents since the divorce commenced in March 2013. The case transferred to the Magistrates Court[25], in September, to hear instead a Non-Molestation Order, as offered by the District Judge. The case in September could not be heard as a contested case because Sanjiv did not have an interpreter. The matter could either be adjourned or, due to there having been no evidence heard that may have supported a Non-Molestation Order, Hanita, who again was not legally

[24] Cross Undertakings https://www.legislation.gov.uk/ukpga/1996/27/section/46 An undertaking is an option that allows the parties to settle their dispute without a full hearing. It is a promise made to the court to do, or not to do, certain things. Cross undertakings are where they are agreed by both parties.

[25] In its capacity as a Family Court

represented, accepted the continuance of cross undertakings in lieu of continuing with a Non- Molestation Order at a later date. Promises were made to the court that there would not be any further arguments. Instead Hanita would make an application for a Financial Order to resolve the financial situation.

8.5.5 The review welcomes the diligent search conducted by Her Majesty's Court Service (HMCTS) that has discovered the tape recording of the July hearing. It also welcomes the additional assessment and input to the review made by the HMCTS and, independently, a District Judge; both having listened to the recording. The review author has also listened to the tape. It is noted that the tape recording of the September hearing is not available, this having been destroyed routinely through data handling processes.

8.5.6 The review author notes that, having listened to the tape, Hanita was unrepresented by a lawyer and did not say very much through the proceedings. She was very quiet. HMCTS assess that there appears not to have been an enquiry with Hanita as to the reasons for her acting as a litigant in person. HMCTS further advises that the family court is bound by the overarching objective to deal with cases justly, having regard to any welfare issues involved. When dealing with cases justly this includes ensuring there is equality of arms[26].

8.5.7 The District Judge has assessed that the presiding District Judge at the time made valid decisions based on facts heard in the hearing. Hanita stated that there had been no violence since March 2013 and Sanjiv vehemently denied the accusations of domestic abuse, stating that Hanita shouted at him. Sanjiv was represented and his legal advisor informed the court that Hanita's allegations were 'wholly frivolous'. Hanita did not offer any further evidence at this time. In her subsequent statement filed on the 30th July, Hanita then outlined the threats to kill her, by Sanjiv with a knife.

[26] S1(1) and (2) Family Procedure Rules 2010

8.5.8 As such, with little supporting evidence to progress an Occupation Order, the presiding District Judge suggested a Non-Molestation Order as a way forward, which was agreed by Hanita. This is an unusual way forward where a couple live together because of the difficulties of directing an order not to contact or communicate with the other whilst living in the same house. However, the assessing Circuit Judge is of the opinion that the presiding Judge offered this as a way to provide some protection to Hanita. Likewise, to try and regulate their joint occupation of the property until the application could be tried at a contested hearing, the District Judge invited them to both give an undertaking not to be violent, threaten violence or intimidate the other in the interim; which they both agreed to do.

8.5.9 HMCTS have informed the review that the legal tests for obtaining an occupation order or a non-molestation order are different. The court is required, when dealing with an occupation order, to consider all the circumstances as well as what is commonly called the balance of harm test (is significant harm likely to be suffered by one or other of the parties and/or a child?)[27]. When dealing with a non-molestation order the court must have regard to all the circumstances including the need to secure the health, safety and well-being of an applicant and any relevant child[28]. In both cases the evidential test is on a balance of probabilities. Further, the restriction on accepting undertakings from any party to the proceedings, where violence is a feature, applies to both occupation and non-molestation orders[29]. In this case, HMCTS state that the statements heard within the July hearing, indicate there are disputed facts as to the allegations of domestic abuse, with Hanita stating that she is in fear of Sanjiv and Sanjiv dismissing her allegations as 'wholly frivolous'; and that Hanita is abusive to him. HMCTS have assessed that neither the District Judge or the Magistrates made any findings of fact on evidence to ascertain the factual basis upon which to consider 'significant harm' and/or whether there was a threat or use of violence.

[27] S33(6) (7) Family Law Act 1996

[28] S42(5) Family Law Act 1996

[29] S46 Family Law Act 1996

8.5.10 In relation to the impact that had on the suitability for 'cross undertakings' to be issued as a way forward, HMCTS state that because there was no inquisitorial hearing and decision making relied on court heard representations, there was no finding based on evidence and as such, it cannot be assessed by themselves, or the review, whether the use of cross undertakings was appropriate or not. Their issuing is at the discretion of the court. The assessing Circuit Judge goes further to state that it is more likely than not, that the lack of any violence since March 2013 was the significant factor in the undertakings being accepted as appropriate, given that the court does not make such orders automatically and must be satisfied on evidence, that they should be made. If the applicant accepts that there has been no actual or threatened violence for 15 months then undertakings are an appropriate disposal. However, the review would add that the behaviours exhibited by Sanjiv were clearly coercive and controlling and that this was not considered during decision- making. A greater focus on this element when agreeing undertakings would enhance victim safety in the future.

8.5.11 At the Magistrates Court in September, a contested hearing was scheduled but Sanjiv did not have an independent interpreter and so the contested hearing could not go ahead. The options were to defer to a later date, or for both parties to continue with the cross undertakings, which Hanita agreed to. At the previous hearing in July Sanjiv had not had an independent interpreter but instead his solicitor ensured he understood what was said. It is clear from the July recording that Sanjiv was represented by a lawyer who was able to assert his position whereas Hanita said very little. Interestingly, it is apparent at the commencement of the hearing in July, that there had been issues in being able to serve the court summons on Sanjiv, who reported not to have received it until the day before, despite having always lived at the family home. This is in line with family members informing the review of Sanjiv's delaying tactics and disruption when selling the family home; thereby potentially demonstrating coercive and controlling behaviour. The lack of a properly court appointed interpreter in September prevented the hearing from being heard and prevented Hanita submitting her evidence of violent acts perpetrated by Sanjiv.

8.5.12 The assessing Circuit Judge agrees that had there been a contested hearing and Hanita's evidence accepted, a non-molestation order may well have been made. However, it is pointed out that had the order been made, it is usually only for a 12-month period.

8.5.13 HMCTS conclude that, in their opinion, there should have been an inquisitorial hearing and certainly more investigation than was conducted rather than an acceptance that the undertakings, as made by the judge, were the right way to deal with the application. They feel that a properly conducted inquisitorial hearing may well have identified a factual basis upon which to conclude that Hanita (and her son) was suffering significant harm because of domestic abuse; which might have entitled her to an injunctive order. The element of significant harm may have included a finding that Sanjiv had used or threatened violence against Hanita and, or, her child and as such that finding would have precluded the court from accepting undertakings in this matter. They believe that the overriding objective was not given sufficient priority and in particular the equality of arms.

8.5.14 In relation to the application of Practice Direction 12J, the assessing Circuit Judge is of the firm opinion that District Judges and Justices are well aware of its provisions and understand that domestic abuse includes coercion and control. However, they affirm that Practice Direction 12J applies to proceedings under the Children Act 1989 or the Adoption and Children Act 2002 but that it does not apply to proceedings for an injunction under the Family Law Act 1996 and so did not apply to Hanita's application.

8.5.15 HMCTS agree that this direction does not apply per se to applications submitted under the Family Law Act 1996[30]. However, in these circumstances, they are of the opinion that Practice 12J should have been applied given its significance to matters of domestic abuse. However, it points out that the direction in use at the time in 2014 has been significantly enhanced with an update in 2017. The direction in 2014 provided far less guidance than it does now. Domestic abuse training for court staff was in place in 2014 but updated

[30] HMCTS state that this Practice Direction applies to any family proceedings in the Family Court under the relevant parts of the Children Act 1989 or the relevant parts of the Adoption and Children Act 2002 in which an application is made for a child arrangement order, or in which any question arises about where a child should live, or about contact between the child and a parent or other family member, where the court considers that an order should be made.

recently to include more emphasis on injunctive provisions within the Family Law Act 1996.

8.5.16 Clearly there are differing opinions depending on perspective. The Judiciary are an independent body and make decisions based on what they hear through a proceeding. HMCTS manage court procedure which can impact on the outcome of a hearing. In this case, the lack of an independent interpreter directly impacted on Hanita's ability to be heard. HMCTS have, helpfully, reviewed the availability of an interpreter for Sanjiv. At no point did he have access to an independent, properly appointed, interpreter. HMCTS have informed the review that the system of obtaining interpreters has been updated across both criminal and family jurisdictions and the obtaining of an interpreter quickly should be reviewed and widely disseminated across all tiers of judiciary.

8.5.17 In relation to the application of Practice Direction 12J, it is not intended to be applied to applications made though the Family Law Act 1996 per se. However, where Hanita lived, and who with, was a factor that impacted on her child, Pandita. Hanita stated that she and Pandita remained in fear of Sanjiv through coercive and controlling behaviour despite there having been no actual acts of violence since 2013. In her subsequent statement she outlined allegations of serious previous domestic abuse. The assessing Circuit Judge is clear that Practice Direction 12J did not apply to Hanita's case. In contrast, the District Judge interviewed by the review reflected his opinion that following the update of Practice Direction 12J[31], Judges will now routinely consider the full facts and investigate circumstances of domestic abuse, often erring on the side of caution to grant requested orders where victims and children are affected, before hearing the full facts and stating the findings at a later hearing. HMCTS were of the opinion that due to the legal requirement to establish issues of 'significant harm' and welfare matters for Hanita and Pandita, Practice Direction 12J should have applied in Hanita's applications for protective orders. It would seem to the review to be common sense that in

[31] Practice 12J updated December 2017: https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12j

circumstances of alleged domestic abuse in a Family Court where the victim is seeking a protective order, that victims should be provided with this additional supportive provision, especially where the welfare of a child is a factor.

8.5.18 This case was complicated and for the ordinary person, court matters and procedure are complicated. It is hard to see how Hanita would have understood the complexities of her circumstances in legal terms given the differing opinions of key professionals who work in the field. A legal advisor for Hanita may have helped to mitigate the complicated circumstances and provided advice and guidance as well as, crucially, a voice. A legal advisor could also help to explain what the impact of any decisions made by a court may have had on her and her child. The decision by Hanita to agree to the cross undertakings instead of adjourning to a contested hearing may have prevented her obtaining a protective order. It is disappointing that Hanita was acting as a litigant in person, especially when, as a victim of domestic abuse, she should have had access to legal aid[32]. This contrasts with the fact that Sanjiv was fully represented throughout. When one party is unrepresented in proceedings and the other is represented, this can affect the outcome when matters are agreed between them rather than being determined by the court.

8.5.19 In this case, although the review cannot ascertain fully why Hanita was not represented, there was no obvious enquiry made by the District Judge in July to seek to understand this or to provide advice in the obtaining of legal aid. 'Equality of arms' was not considered. Also, whilst the review cannot fully ascertain the impact, there is a real chance this element was enough to tip the balance in favour of the represented party, with the potential for Hanita not having fully understood the limited nature of the protection she had been afforded.

8.5.20 Due to there being no power of arrest, the police are not currently informed of the existence of agreed cross undertakings. However, HMCTS and the District Judge interviewed, agreed it would be good practice to do so. The

[32] Legal Aid, Sentencing and Punishment of Offenders Act 2012
http://www.legislation.gov.uk/ukpga/2012/10/schedule/1/enacted?view=interweave

consequences for breaching cross undertakings is to be held in contempt of court and fined; and it is for the victim to return to court to instigate proceedings. Both parties are clearly informed of the consequences of breaching before they are agreed.

8.5.21 On reporting the domestic abuse incident to the police in 2015, and expressing her wish to have Sanjiv removed, the police did not have access to safeguarding intelligence in relation to the 'cross undertakings'. Sharing this intelligence may have provided an opportunity for Hanita to receive advice about her option of returning to the Family Court to seek a further Non-Molestation / Occupation Order, against the breach of the 'cross undertakings' and continuing evidence of on-going domestic abuse. Hanita could have sought redress where the cross undertakings had been breached. Unfortunately, although the review is aware that Hanita knew about the 'cross undertakings', it has not been possible to ascertain what Hanita knew in relation to her rights on this matter.

8.5.22 A critical time for domestic abuse victims is at point of separation[33], a key point at which the Family Court engages. Eventually, Hanita's sister agreed to purchase the property to allow Hanita to free herself from Sanjiv. This was not an amicable situation. At his trial, on public record, Sanjiv admitted that he hadn't wanted a divorce and he didn't want to leave the home or explain to his family what had happened; and he didn't want to live alone. This was a volatile situation which the trial Judge described as a 'powder keg'. Hanita had no legal protection at the point of separation. Whilst it cannot be assessed that the provision of a protective order would have prevented this situation from continuing until separation, especially as a non-molestation order generally lasts for a 12-month period, it is apparent that Hanita was managing the situation without the support of legal advice or protective orders to which she may have been entitled.

[33] Associated Risk Factor is a woman who is separated (Smith et al. 2011) – there is an elevated risk of abuse around the time of separation (Richards 2004).

8.5.23 The review has established that at the commencement of a DHR, the Family Court records are not routinely included in an initial request for disclosure of known information concerning the affected families. The information known to the Family Court in this case has been a very important source of learning. It would be prudent for local safeguarding information sharing protocols to ensure the need for the Family Court to be included within requests for agency held information at the earliest point, to ensure they retain their records. HMCTS advise that records relating to hearings are destroyed in a timely manner in line with their responsibilities to manage data. As such, they would advise an early approach to secure all relevant information as soon as there may be a known need for it.

8.5.24 ***Lesson 6***

Hanita was a victim of domestic abuse who failed to secure a protective order due to the complexities of her legal situation. A key factor was that she was unrepresented and this, being unchallenged, created an 'inequality of arms'.

8.5.25 ***Lesson 7***

The processes within the Family Court are complex with differing professionals working in the field having differing expectations of the application of relevant law and protective measures. This impacts on outcomes for victims.

8.5.26 ***Lesson 8***

The contested hearing which would have enabled Hanita to establish the existence of domestic abuse could not go ahead because Sanjiv was not provided with an independent court appointed interpreter.

8.5.27 ***Lesson 9***

Local Family Court lawyers and Family Court District Judges who work with victims of domestic abuse are appropriately independent of statutory agencies and locally, not routinely engaged with local safeguarding agencies and policies. Developing links and sharing information between safeguarding and the local Family Court network via the existing Civil and Criminal Justice Working Group, or Family Justice Board, may enhance the safety of domestic abuse victims, particularly those who may present as high risk. To directly enhance

victim safety, where protective orders and cross-undertakings have been agreed, information sharing is essential where domestic abuse is a feature.

8.5.28 ***Lesson 10***

Family Courts hold important and relevant information that may benefit a Domestic Homicide Review. The need to review the information they hold should be routinely requested at the earliest opportunity, subject to Data Protection issues.

8.5.29 **Recommendation 5:**

The Safer Leicester Partnership should consider sharing the findings of this review with the Home Office in support of understanding the complexity of applying for protective orders for victims and for consideration of detailed housing analysis being captured in DHR's nationally, for potential inclusion as a contributing factor in domestic abuse risk assessments.

8.5.30 **Recommendation 6:**

The Safer Leicester Partnership should develop information sharing protocols with the Family Court to enhance the safety of victims of domestic abuse, and their children.

8.6 Potential Barriers to Accessing Services including Culture and Belief

8.6.1 Hanita was of South Asian heritage, identifying as a practising Hindu. She was UK born and had an arranged marriage with Sanjiv who was born in India. After the marriage, Hanita returned to the UK until her husband was able to join her. In terms of ability to understand and speak English, it is known that Sanjiv attended an 'English for Speakers of Other Language' course, (ESOL), in mid-2003. In the family home, Gujarati was spoken due to Sanjiv not being fluent in English and he required support from Interpreters through interactions with the police and through the criminal justice process. Hanita was fluent in English.

8.6.2 The Hindu Priest spoke generally as had had no direct contact with Hanita or Sanjiv. The Priest advised that such arranged marriages are still common and that this can cause unrest in a marriage due to conflicting cultures and attitudes. Males and females are considered equal and divorce is not frowned upon in their culture if a relationship has completely broken down. The priest believes domestic abuse is low in their community because on marriage, a

woman gives up her family to live in the husbands' household and because of that, men have to look after their wives. The priest is aware of 2 or 3 cases of domestic abuse in a year and when this is shared with him, he is not allowed to ask private questions but can give spiritual guidance. There is no women's lead at the temple, all concerns go through the priest. The priest is aware that he can signpost to the local police but he has never had cause to do so[34].

8.6.3 Hanita was provided with information about local domestic abuse services from the police on two occasions. However, she did not seek additional support or report other occasions of domestic abuse that have now come to light as a result of the police investigation, and as she described to the family court. However, the review has found no evidence that Hanita was not able to access domestic abuse services had she chosen to. She was able to access support services for Pandita and she regularly attended her GP when she needed to. It is highly likely that Hanita simply did not identify herself to be a victim of domestic abuse or consider that Sanjiv would pose such a threat to her; she had expressed her doubts that Sanjiv would ever kill her to her child. Many victims fail to view their experience as domestic abuse, especially those in relationships subject to coercive control, as it was for Hanita given that she was subjected to continuous psychological, financial and emotional abuse. The one occasion she sought support through the courts resulted in an inability to obtain protective orders. Hanita kept her issues to herself and told very few people about it. Had she, or her friends and family been able to view Hanita's situation as domestic abuse, she may have felt more confident to seek help from specialist domestic abuse services or her GP. They would then have been in a position to give her advice, support and information about her options and design an appropriate safety plan. Lack of identification as a victim of domestic abuse is a key barrier to accessing services. This makes it

[34] The Safer Leicester Partnership (SLP) is developing understanding of 'spiritual guidance' and developing links to Community Champions. The SLP have held a number of events aimed at bringing faith leaders together and are delivering a one-day event in November 2019 around the theme of 'Intimate Partner Abuse in Faith Communities and its Impact on Families and the Wider Communities – Negotiating a Way Forward'. In addition, an SLP steering group exists, consisting of BME community champions and mentors, in which the learning from this review will be shared.

even more important that agencies have access to all safeguarding information to be able to identify risk whenever they come into contact with victims of domestic abuse. It is incumbent upon agencies to be aware of the enhanced risks faced by victims at point of separation within information gathering, planning and risk assessments, especially where coercion and control may be a feature.

8.6.4 A lack of awareness of the enhanced dangers victims of domestic abuse face at point of separation is also a barrier to accessing services. Given that Hanita most probably did not identify, or present, as a domestic abuse victim, it is highly unlikely she, or her family and friends, would have any knowledge of the enhanced risks that exist at separation. However, post separation violence and abuse is an issue for a significant number of victims of domestic abuse (and their children). One research study[35] showed that 76% of women who had separated suffered further abuse and harassment from their former partner, with child contact being a particular point of vulnerability.

8.6.5 ***Lesson 11***

It is highly likely that Hanita, whilst being subjected to on-going coercive control, did not identify as a victim of domestic abuse, or understand the enhanced risks faced at point of separation. Lack of identification and understanding of associated risks is a barrier that may prevent victims of domestic abuse accessing protective services. Likewise, agencies must consider the enhanced risks potential victims of domestic abuse face at point of separation and professionally enquire when planning and conducting risk assessments.

8.6.6 The recording of a primary language and identification of ethnicity by agencies is essential to preventing barriers. It ensures services can be effectively provided and people with protected characteristics identified, in

[35] Humphreys, C and Thiara R: Neither Justice nor protection: women's experiences of post-separation violence, Journal of Social Welfare and Family Law, Volume 25, Issue 3, 2003 and www.womensaid.org.uk/domestic-violence-articles.asp

compliance with Public Sector Duties under the Equality Act 2010[36]. Whilst full ethnicity and preferred language was recorded by the police on attending the domestic abuse report in 2015, this was prior to the development of the Public Protection Notice and so they cannot be sure this was passed to Children's Social Care. However, Children's Social Care then closed the referral without this information being gained or recorded, in contravention of their expected standards as defined by Leicester City Children's Services procedures. Children's Social Care explained that this was a frequent omission at this time and accept that consideration of diversity in client assessment is of critical importance to planning and supportive intervention.

8.6.7 Children's Social Care state there is extensive training to raise knowledge, understanding and practice standards relating to a multi-agency approach to domestic abuse generally. However, they believe it to be limited in terms of identity, religion and culture within domestic abuse in the multi-agency approach to assessment and support intervention. They have analysed that this may have influenced their attitudes and response in this case. Sanjiv's motivation to murder Hanita is not known, but issues of ethnicity, faith, culture and religion need to be understood within training and application of safeguarding practice to effectively assess and intervene to protect children and non-abusing parents. Practitioners need to have a thorough understanding and confidence to approach identity, faith, religion and cultural issues to enable those with protected characteristics to be as able as others to access services, as identified within the Sexual and Violent Needs Assessment for Leicester, Leicestershire and Rutland[37]. The review notes the updated

[36] https://www.gov.uk/guidance/equality-act-2010-guidance

[37] *People with some protected characteristics appear to be less likely to access local services than others. This does differ across the services and over time, but the biggest gaps of engagement locally seem to be:*

Those aged over 55

Those currently married

Those identifying as Indian Asian/Asian British (in Leicester only. Across the entire area it is just under census levels)

Those identifying as Christian

Leicester City Council and UAVA Domestic & Sexual Violence Training Programme for April 2018 – March 2019, which includes specific training in understanding domestic abuse within BME communities[38] and encompasses the concerns raised within this review.

8.6.8 ***Lesson 12***

Practitioners should access training to understand the importance of identity, faith, religious and cultural issues within assessment and application of support interventions for domestic abuse to encourage reporting of domestic abuse.

8.6.9 The way in which appointments are managed can be a barrier to engagement. In this case Pandita refused to allow their counsellor to refer to their parents or GP having expressly stated that they did not want their parents to know about their issues. Given that Pandita did not speak to their GP alone and that the letter offering the CAMH's appointment was addressed to their parents, it is a reasonable assumption to accept that they believed their parents would have found out, had they been referred to the GP.

8.6.10 ***Lesson13***

There may be a barrier preventing young people accessing services where they are concerned that confidentiality will be breached. Services need to ascertain and be sensitive to young people's concerns, to encourage engagement.

8.6.11 Alcohol was not a direct element in the homicide but Sanjiv was known to drink excessively, having received a conviction for drink driving and was observed to be drunk by the police on two occasions. Hanita reported concerns of escalating alcohol abuse, to which the police provided information about alcohol awareness. Pandita also reported their father being an alcoholic to their counsellors. In terms of deeper agency

[38] http://www.uava.org.uk/professionals/training/

understanding of alcohol as a specific issue, agencies could not have been expected to identify and engage with Sanjiv further given that he failed to disclose his true level of drinking; either when defending a non -molestation order or on telling his GP during a routine health check that he only imbibed 6 units of alcohol a week. Research published by 'Drink Aware UK'[39] highlights the disparity between self-disclosed alcohol consumption and the volume purchased nationally, as collated by Her Majesty's Revenue and Customs. However, Drink Aware accepts the only way to establish alcohol consumption is to ask individuals. Therefore, whilst it is a positive step to routinely enquire as to alcohol consumption and to provide alcohol support information, a direct barrier to engagement is the non-disclosure of the true amount consumed.

8.6.12 A direct barrier to accessing domestic abuse support services is the inability to identify domestic abuse in others. This review did consult with Hanita's employer but could establish no relevant learning, due mainly to Hanita's employers being certain that they were not aware that Hanita was a victim of domestic abuse because Hanita did not expressly say so. They were aware of Hanita's circumstances and that her sister was buying their family home but did not wish to enter dialogue on this aspect. As such, the review was not able to utilise this opportunity to potentially learn lessons in relation to employers and domestic abuse.

8.6.13 However, the review is aware that Public Health England has published a comprehensive domestic abuse tool kit for employers[40] in June 2018 and would recommend that this is circulated widely within the local business community through the regional Chamber of Commerce.

[39] https://www.drinkaware.co.uk/research/our-research-and-evaluation-reports/how-much-does-the-uk-really-drink/

[40] Domestic Abuse – a Toolkit for Employers
https://wellbeing.bitc.org.uk/sites/default/files/bitc_phe_domestic_abuse_toolkit-v3-compressed.pdf

8.6.14 **Recommendation 7:**

The Safer Leicester Partnership should continue the awareness work commenced with faith leaders in Leicester City to further explore and inform shared understanding of the community approach in relation to 'spiritual guidance' in matters of domestic abuse.

8.6.15 **Recommendation 8:**

The Safer Leicester Partnership should promote the existence of the revised domestic and sexual violence training programme, especially in relation to understanding and responding to issues of coercive and controlling behaviour and encourage practitioners to undertake specific training in relation to faith, culture, religion and identity within domestic abuse.

8.6.16 **Recommendation 9:**

The Safer Leicester Partnership should share the Public Health England publication 'Domestic Abuse – a Toolkit for Employers' with the regional Chamber of Commerce, for wide dissemination within the business community.

8.6.17 **Recommendation 10:**

The Safer Leicester Partnership should ensure the learning points from this review are disseminated widely and incorporated within domestic abuse practice development.

9. CONCLUSIONS

9.1 Hanita was the tragic victim of a domestic homicide perpetrated by her ex-husband, Sanjiv. Hanita and Sanjiv continued to live together following their divorce in March 2014 and during this time, Hanita was subjected to continuing domestic abuse in the form of coercive control; Sanjiv abusing her financially, emotionally and psychologically. Sanjiv maintained control over Hanita by refusing to move out of the family home, knowing that Hanita could not afford to move out, and was very disruptive and verbally abusive to Hanita and Pandita. The trial Judge described their housing situation as being a 'powder keg', with Sanjiv being reluctant to accept the divorce and not

wanting to 'lose face'. When Hanita found a successful way to remove Sanjiv, he killed her at point of final separation.

9.2 There had been opportunities for Sanjiv to have left the family home, most notably at point of divorce in 2014. Hanita believed she would keep the home but as both were joint owners, this was not possible for economic reasons. Hanita applied to the Family Court for an Occupation Order under the Family Law Act 1996, but this was not successful at a hearing in July 2014. Sanjiv vehemently denied the allegations of abuse and accused Hanita of being abusive. The District Judge offered Hanita the option to apply for non-molestation order instead and both Hanita and Sanjiv agreed to cross undertakings, not to be abusive to each other, whilst they lived together in advance of a contested hearing.

9.3 Procedurally, a District Judge presided over the Family Court in July. Hanita was not able to provide sufficient evidence for an Occupation Order and the case continued as an application for a non-molestation order; unusually given the couple were to remain living in the house. To provide some interim protection, the court offered the cross undertakings which each agreed to. Hanita was not legally represented and was not in receipt of legal aid, which as a victim of domestic abuse, she could have been. No enquiries were made by the court to ascertain why Hanita was acting as a litigant in person. The review has listened to the tape recording of the hearing and Hanita says very little through the proceedings, whereas Sanjiv, being represented, is able to have his voice heard; arguably resulting in an 'inequality of arms'.

9.4 Practice Direction 12J provides protection for domestic abuse victims in the Family Court where proceedings under the Children Act 1989 are being heard; but doesn't apply, per se, to applications made under the Family Law Act 1996. This is an area of complexity and confusion with differing opinions as to when Practice Direction 12J should be applied, especially post its revision in 2017 which has an emphasis on applications for protective orders. Hanita was a victim of domestic abuse with concerns for the welfare of her child and Practice Direction 12J was not applied in her case, resulting in a lack of wider consideration of issues of 'significant harm' for herself and her child which may have provided more information as to her circumstances.

9.5 The hearing at the Magistrates Court in September 2014 could not go ahead because Sanjiv, for whom English is not his first language, had not been appointed an independent court interpreter. This prevented Hanita's revised

statement, in which she had outlined serious domestic violence, including threats to kill her, being heard. Hanita had the option to return at a later date for a full hearing or to accept the continuation of cross undertakings. She chose to accept their continuance and the matter was ended. Hanita was to apply for a Financial Order but she did not do so and the review has been unable to ascertain why she did not.

9.6 Cross undertakings are not appropriate under the Family Law Act 1996 where a respondent has used or threatened violence and where it may be necessary to make a non-molestation order. On the evidence heard by the District Judge and Magistrates, the agreement to the use of cross undertakings as an interim protective measure was a matter for their discretion. However, at no point did the court consider the existence of coercive or controlling behaviour, or hear Hanita's evidence, therefore she had been unable to prove the circumstances of her domestic abuse. Had she done so, she would very likely have been granted a non-molestation order and in those circumstances, the cross undertakings no longer an option. The review cannot see how Hanita could have understood the complexities of the law and procedure in the Family Court and been able to fully understand the impact of not proceeding to a further contested hearing. The fact she was unrepresented may have tipped the balance in favour of Sanjiv, who was then able to exert further control over Hanita.

9.7 Information held by agencies was not sufficient to identify Hanita as a high-risk victim or be eligible for MARAC. However, information known to the Family Court, albeit not heard in open court, was sufficiently serious in nature to potentially raise Hanita to a high- risk status. This disparity of information is a concern and the greater sharing of safeguarding information between the Family Court and safeguarding agencies, whilst acknowledging that there is no legal requirement to do so, would benefit future victims of domestic abuse. Providing victims of domestic abuse with the protective elements of Practice Direction 12J would also enhance victim safety and provide for a wider examination of the facts.

9.8 The Family Court do not currently share information with the police or other safeguarding agencies concerning the existence of 'Cross-Undertakings,' or the consequences should they be breached, in the way they do for non-molestation orders. Sharing this information will enhance the safety of victims of domestic abuse and their children. Family Court Judges and family lawyers work independently, as their role dictates, and currently are not aware of the existence of Domestic Homicide Reviews. Family lawyers will not consider

making a routine safeguarding referral for reasons of client safety and confidentiality. Whilst IDVA's are a feature of domestic abuse courts locally, the Family Court do not see it as their role to make a direct referral to a MARAC. Greater liaison and joint understanding between themselves and local safeguarding agencies and policies would enhance the safety of victims of domestic abuse and their children.

9.9 In terms of agency support, the police received two reports of domestic abuse; 2011 and 2015. In neither report was there evidence of a crime to support a prosecution or to issue a caution. However, robust risk assessments had been undertaken and support advice given to both Hanita and Sanjiv. Neither accessed support services in the community or elsewhere. Hanita did not report to the police the level of abuse she disclosed to the Family Court in 2014. Hanita did not report abuse to any agency post 2015, although the review is aware that domestic abuse continued in the form of coercive control, disruptive behaviour, harassment and verbal abuse. It is highly likely that she did not identify herself as a victim of domestic abuse, but this cannot be established.

9.10 The police provided an opportunity to remove Sanjiv for a short period of time through a pro-active arrest. A Domestic Violence Protection Notice was not an option because the grounds for consideration had not been met, there being no evidence of violence or threats of violence at that time. The revision of the grounds for their use to include the coercive and controlling elements of domestic abuse would provide greater support to victims of domestic abuse and their children. The existence of the 'cross undertakings' were not known to the police at the point of that arrest. Being aware of this information will enhance the safety of domestic abuse victims and their children.

9.11 Overall, whilst there had been opportunities for further engagement with the family and improvements made to the management of child protection referrals, safeguarding agencies could not have understood the risk posed by Sanjiv, based on the information they held. A key issue was the existence of on-going domestic abuse in the form of coercive control exercised whilst sharing the family home, post-divorce, within volatile and abusive living arrangements. Hanita largely managed this situation on her own, choosing not to share the facts with friends or family or seek agency support except for one occasion, post-divorce, when she sought the granting of protective orders through the Family Court. However, she failed, and the circumstances of her domestic abuse remained unidentified through the complex court processes.

Instead of the granting of protective injunctions that may have provided a level of direct protection, Hanita was subject to counter allegations of abusive shouting which resulted in her agreeing not to be abusive towards to Sanjiv, a perpetrator; thereby allowing him to further exert controlling and coercive behaviour towards her.

10. LESSONS LEARNED

10.1 ***Lesson 1***

The police attendance at the domestic abuse incident was an opportunity for Hanita to have been advised to seek redress concerning Sanjiv's breach of the 'cross undertakings' but there is no record that she received such advice or that it was included within risk assessments. There is a gap in the sharing of safeguarding information between the Family Court and the police which prevents the existence of 'cross undertakings' being known to the police and available within intelligence checks.

10.2 ***Lesson 2***

Leicester City Council Children's Services, did not sufficiently examine either referral and missed an opportunity to explore family dynamics that may have identified abuse; and to provide support to Hanita and Pandita.

10.3 ***Lesson 3***

Young people's counsellors work with many young people with suicidal ideation and have to make difficult decisions on when to refer to child protection services.

10.4 ***Lesson 4***

Opportunities for multi-agency working could be enhanced through more effective information sharing between GP's, schools and the school nurse. High volumes of young people coming to the notice of school nurses is preventing the recording and sharing of safeguarding information that may assist schools to monitor welfare. This is particularly important in support of Operation Encompass within Leicester City which seeks to raise awareness of domestic abuse within schools and enhance multi-agency information sharing.

10.5 ***Lesson 5***

Unstable housing has been identified as the most common factor in local DHRs and in Hanita's death, co-occupation of the family home post-divorce was a key issue in the circumstances of her homicide.

10.6 ***Lesson 6***

Hanita was a victim of domestic abuse who failed to secure a protective order due to the complexities of her legal situation. A key factor was that she was unrepresented and this, being unchallenged, created an 'inequality of arms'.

10.7 ***Lesson 7***

The processes within the Family Court are complex with differing professionals working in the field having differing expectations of the application of relevant law and protective measures. This impacts on outcomes for victims.

10.8 ***Lesson 8***

The contested hearing which would have enabled Hanita to establish the existence of domestic abuse could not go ahead because Sanjiv was not provided with an independent court appointed interpreter.

10.9 ***Lesson 9***

Local Family Court lawyers and Family Court District Judges who work with victims of domestic abuse are, appropriately, independent of statutory agencies. Locally, there is no engagement between them and local safeguarding agencies and policies. Developing links and sharing information between safeguarding and the local Family Court network via the existing Civil and Criminal Justice Working Group, or Family Justice Board, may enhance the safety of domestic abuse victims, particularly those who may present as high risk. To directly enhance victim safety, where protective orders and cross-undertakings have been agreed, information sharing is essential where domestic abuse is a feature.

10.10 ***Lesson 10***

Family Courts hold important and relevant information that may benefit a Domestic Homicide Review. The need to review the information they hold should be routinely requested at the earliest opportunity, subject to Data Protection issues.

10.11 ***Lesson 11***

It is highly likely that Hanita, whilst being subjected to on-going coercive control, did not identify as a victim of domestic abuse, or understand the enhanced risks faced at point of separation. Lack of identification and understanding of associated risks is a barrier that may prevent victims of domestic abuse accessing protective services. Likewise, agencies must consider the enhanced risks potential victims of domestic abuse face at point of separation and professionally enquire when planning and conducting risk assessments.

10.12 ***Lesson 12***

Practitioners should access training to understand the importance of identity, faith, religious and cultural issues within assessment and application of support interventions for domestic abuse to encourage reporting of domestic abuse.

10.13 ***Lesson 13***

There may be a barrier preventing young people accessing services where they are concerned that confidentiality will be breached. Services need to ascertain and be sensitive to young people's concerns, to encourage engagement.

11. GOOD PRACTICE IDENTIFIED

11.1 On transferring to College 2, Pandita very quickly felt able to engage with counsellors and a very supportive relationship was established. The college provided direct support to Pandita and when in crisis at losing their Mother and risk of suicide escalated, took proactive steps to safeguard by referring to Children's Social Care and speaking directly to the police and PCSO.

11.2 The police demonstrated creative thinking when they took positive action and arrested Sanjiv to prevent a Breach of the Peace, thereby providing a short protective space for Hanita and Pandita.

11.3 The police very quickly designated Hanita as a high-risk missing person which enabled resources to be allocated expeditiously and enabled the securing of forensic evidence that led to the early arrest and conviction of Sanjiv. The police also demonstrated good practice by allocating a Family Liaison Officer (FLO), to Pandita immediately when Hanita was found to be deceased. They understood Pandita's mental state and provided direct support from the FLO.

11.4 Pandita's GP demonstrated good practice in safeguarding when contacting directly by telephone to try to ascertain reasons for non-engagement with CAMHS.

11.5 It is apparent that Pandita's and Aadinath's schools were able to contribute much information to the review from actually remembering the children and provided a very helpful perspective of their time at school through to college.

11.6 CAMHS provided multiple opportunities for Pandita to engage and sent a copy letter of appointment to the School Nurse.

12. DEVELOPMENTS SINCE THE SCOPING PERIOD

12.1 Since the review began, Leicester, Leicestershire and Rutland CCG's have developed a Domestic and Sexual Violence and Abuse policy which has been made widely available to GP's. Safeguarding specialists within the CCG's have completed a 'Train the Trainer' DSVA course and roll out of DVA training to GP's has commenced.

12.2 Revised UAVA and Leicester City Council Domestic and Sexual Violence Training programme for April 2018 to March 2019 incorporates specific training for understanding domestic abuse within BME groups.

12.3 Introduction in June 2018 of the Public Health England publication 'Domestic Abuse – Toolkit for Employers'.

12.4 Leicester Safeguarding Adults Board have initiated liaison with Family lawyers through direct contact at the Civil and Criminal Justice Working Group.

12.5 The Safer Leicester Partnership is engaged with local Faith Leaders and Community Mentors to develop shared understanding of domestic abuse in faith communities.

13. RECOMMENDATIONS

This review recognises that the identified learning points may have been addressed by recommendations in recent reviews with actions already underway or completed.

13.1 **Recommendation 1:**

Safer Leicester Partnership should share the findings of this review with the Leicester Safeguarding Children's Board to highlight all lessons learned through this review specific to children and young people.

13.2 **Recommendation 2:**

The Home Office should note the findings of this review as relevant to their development of DVPN's.

13.3 **Recommendation 3:**

The Safer Leicester Partnership should develop links to District Judges who work with domestic abuse victims in the Family Court, through the Family Justice Board or Civil and Criminal Justice Working Group. In particular to ensure a shared understanding of coercive and controlling behaviour, and the agreement to use of undertakings, both of which impact on victim safety and decision making.

13.4 **Recommendation 4:**

The Safer Leicester Partnership should develop the inclusion of family lawyers who work with domestic abuse victims in the Family Court, within safeguarding training and information sharing.

13.5 **Recommendation 5:**

The Safer Leicester Partnership should consider sharing the findings of this review with the Home Office in support of understanding the complexity of applying for protective orders for victims and for consideration of detailed housing analysis being captured in DHR's nationally, for potential inclusion as a contributing factor in domestic abuse risk assessments.

13.6 **Recommendation 6:**

The Safer Leicester Partnership should share the findings of this review and develop information sharing protocols with the Family Court to enhance the safety of victims of domestic abuse, and their children.

13.7 **Recommendation 7:**

The Safer Leicester Partnership should continue the awareness work commenced with faith leaders in Leicester City to further explore and inform shared understanding of the community approach in relation to 'spiritual guidance' in matters of domestic abuse.

13.8 **Recommendation 8:**

The Safer Leicester Partnership should promote the existence of the revised domestic and sexual violence training programme, especially in relation to understanding and responding to issues of coercive and controlling behaviour, and encourage practitioners to undertake specific training in relation to faith, culture, religion and identity within domestic abuse.

13.9 **Recommendation 9:**

The Safer Leicester Partnership should share the Public Health England publication 'Domestic Abuse – a Toolkit for Employers' with the regional Chamber of Commerce, for wide dissemination within the business community.

13.10 **Recommendation 10:**

The Safer Leicester Partnership should ensure the learning points from this review are disseminated widely and incorporated within domestic abuse practice development.

14. GLOSSARY

Acronym/ Abbreviation	Full title
ASC	Adult Social Care
CAADA	Co-ordinated Action Against Domestic Abuse
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
DASH	Domestic abuse, stalking, harassment and honour-based violence
DHR	Domestic Homicide Review
DLNR CRC	Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company
DNA	Deoxyribonucleic acid
DSH	Deliberate Self Harm
DSV	Domestic and Sexual Violence
ED	Emergency Department
EMAS	East Midlands Ambulance Service
FLO	Family Liaison Officer
FreeVA	Free from Violence and Abuse
GP	General Practitioner
HO	Home Office
HOS	Housing Options Service
IAPT	Improving Access to Psychological Therapy Services
IMR	Individual Management Report
LPT	Leicestershire Partnership Trust
LRI	Leicester Royal Infirmary
LSAB	Leicester Safeguarding Adults Board
NHS	National Health Service
QA	Quality Assurance
SIO	Senior Investigating Officer
SLP	Safer Leicester Partnership (Leicester's Community Safety Partnership)
SMART	Specific, measurable, achievable, realistic and timely
SSAFA	Soldiers' and Sailors' Families Association
UAVA	United Against Violence and Abuse
UCC	Urgent Care Centre, run by George Eliot Hospital NHS Trust
UHL	University Hospitals of Leicester
WALL	Women's Aid Leicestershire Ltd.

Appendices

Appendix 1: Terms of Reference and Project Plan

LEICESTER SAFEGUARDING

ADULTS BOARD

DOMESTIC HOMICIDE REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: Hanita

Date of birth : removed

Date of death : removed

1. Introduction:

1.1 This Domestic Homicide Review is commissioned by Leicester Safeguarding Adults Board on behalf of the Safer Leicester Partnership in response to the death of Hanita. Hanita was killed by her ex-husband, at the family home in Leicester. There had been little contact with agencies prior to her death. Also living at the address was Hanita and her child Pandita. Their elder child, Aadinath, lives out of the area. Hanita's sister, Paramita, has had significant involvement with the family.

1.2 Following their marriage in 1988, the couple moved into their current property in Leicester. They divorced in 2012 but remained living under the same roof, Post murder, both children reported that the ex-husband verbally and physically assaulted the whole family. However, only two domestic incidents have ever been reported to Leicestershire Police, in 2011 and 2015.

1.3 The Safer Leicester Partnership is keen to establish how agencies may have worked individually and together to better safeguard Hanita. In particular, it wants to explore whether there were missed opportunities to have engaged with the family. The review will explore whether there were any barriers to Hanita accessing services and if so, what can be done to raise awareness of services available to victims of domestic violence and abuse.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

2.2 The purpose of the DHR is to:

a) 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;
b) 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;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject Hanita: Date of Birth: removed

4.2 Scoping period: from 01.08.14 [the time of the referral regarding Pandita for depression symptoms] to date of death.

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period, including an account of what is known about behavioural, social or emotional difficulties of the two children. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Police
- Education
- Ambulance
- GP
- Children's Social Care

5.2 Agencies are requested to use the attached Report Template.

5.3 Summary reports are requested from:

- CAMHS
- Hanita's employer
- Hanita's place of worship

6. Areas for consideration:

6.1 What is known about the nature or level of alcohol use by Sanjiv?

6.2 Were there missed opportunities to exercise professional curiosity?

6.3 Could communication and information sharing have been improved during the scoping period?

6.4 How accessible were support services that may have been available to the family? How responsive were they?

6.5 How well understood was the family's community's approach to / recognition of domestic violence?

6.6 Were opportunities missed to spot potential indicators or abuse and to identify risk at any stage?

6.7 Was consideration given to issues of culture, race, religion or belief? What role, if any, did issues of language play?

6.8 What were the barriers to Hanita accessing support relating to alcohol misuse or anger management?

6.9 Identify examples of good practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. LSAB has already informed the family that this Review is being undertaken. The independent lead reviewer will follow up by making contact with Pandita, Aadinath & Sanjiv who will be consulted on the terms of reference for the review (subject to consultation re : criminal process).

7.2 Further contact will be made to invite participation in the form of a home visit, interview, correspondence or telephone conversation prior to the Learning Event. Contributions will be woven into the text of the Overview Report and she will be given feedback at the end of the process.

8. Timetable for Domestic Homicide Review:

Timetable for Case Review:

Scoping Meeting and panel 1	24 April 2017
Letters to Agencies	26 June 2017
Agency Report Authors' Briefing	17 July 2017 at 12.15pm
Engagement with family	Begin July 2017 once authorized

Agency Reports submitted to LSAB	20 September 2017
Agency Reports quality assured by Chair	20-25 September 2017
Agency Reports distributed	27 September 2017
Learning Event inc Panel 2	7th February 2018
First draft of Overview Report to LSAB	24th February 2018
Recall Event inc Panel 3	14th March 2018
Second draft of Overview Report to LSAB	29th June 2018
Presentation to LSAB and sign off panel 3	8th August 2018

Version 4: 15.05.2017

Appendix 2: Single Agency Recommendations

1 GP1

Reminder to all GPs to detail causes of injuries in consultations.

2 Leicester City Council Education and Children's Services:

Children's Services should ensure that:

Practitioners are aware of their statutory requirement for assessment, and personal curiosity, where a child and young person meets the provision and care cannot be provided by persons with parental responsibility.

3 Both children and adults workers comply with multi-agency procedures to ascertain and record the ethnicity, religious practice and language of families they are involved with and that this is thoroughly considered in the context of assessment of need or risk; and in planning intervention and support.

4 **College 1**

Details of Attendance interventions to be logged and filed more efficiently for leavers.

5 **Her Majesty's Court & Tribunal Service**

The obtaining of an immediate independent, properly appointed, interpreter, should be reviewed by the local judiciary.

Appendix 3: Domestic & sexual Violence Local Service Offer[41]

United Against Violence and Abuse (UAVA) is a consortium of three local specialist providers of domestic abuse and sexual violence services.

UAVA provides co-ordinated domestic and sexual violence services in Leicester for any male or female over the age of 13. The three services that make up the consortium are:

Services available:

UAVA Helpline – 0808 80 200 28

Open 8am to 8pm, Monday to Saturday. providing support in different languages.

IDVA Crisis Intervention

Providing specialist Independent Domestic Violence Advisor (IDVA) Services. The IDVA team offers short term, intensive support and advocacy which focuses on risk and managing risks. Priority is given to ensuring the safety of victims and their children, presenting victims views at Multi Agency Risk Assessment Conferences (MARAC) and Specialist Domestic Violence Courts (SDVC).

[41] Current at June 2018

ISVA Intervention

This service is for anyone, male or female, living in LLR, aged 13+ who has experienced rape and/ or sexual assault. This could be as a result of a recent incident or something that has happened in the past.

Outreach

Once the immediate risks and threat of abuse is addressed the Engagement and Recovery team will provide emotional, practical, therapeutic support and counselling options alongside group work interventions to ensure victims continue to feel safe and secure, make informed choices and take back control.

No More Abuse

A new domestic and sexual abuse website for children and young people in Leicester.

City Family Service

Providing a range of services for 0 to 18 year olds and their families living in Leicester City. Support includes one to one interventions with children and young people, group work and support for parents and carers.

Safe Home & Refuge Services

Providing advice and support victims to make informed decisions about housing options, as well as temporary safe refuge accommodation and support to live safely in their own homes.

City Perpetrator Programme

The Jenkins Centre provides interventions for men and women who WANT help to stop using abusive behaviours towards an intimate (ex)partner. Also providing an interventions programme for young people aged 13-18yrs who are using abusive behaviours towards a partner, parent or carer.

The interventions programme consists of a 24 week group programme for adult, male, heterosexual English speakers and our individual interventions programme is reserved for people in same-sex relationships, women using violence and non-English speakers.