NEWHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Nadira in 2013

Report Author

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Report Completed: 22 April 2015

The Newham Domestic Homicide Review Panel would like to express their sympathy to the family of the victim and their sincere condolences for the loss of a valued member of their family.

The independent chair and author of the Review would like to thank the family and friends who contributed to this Review when the criminal trial was only just completed and understandably their feelings of loss were once more keenly felt. The chair would also like to thank the Panel and authors of agency reports for their time and thoughtful deliberations which have contributed to the findings of this Review.

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NEWHAM DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Newham Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of a resident in their area.

1.2 Following a Police investigation and subsequent criminal trial the victim's husband and an accomplice were convicted of her murder. Her husband was sentenced to life imprisonment with a minimum tariff of 24 years. His accomplice received a life sentence with a minimum tariff of 30 years. The victim's husband appealed, but on 22 April 2015 his conviction and sentence were both upheld.

1.3 The Review process began with a meeting called by the Chair of the Newham Community Safety Partnership on 23 September 2013 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was then notified of this decision on 30 October 2013 as required by statute. The Review was concluded on 20 February 2015. This is over the statutory guidance timescale to complete a Review due to the criminal proceedings; logistical difficulties in contacting family members and coordinating with the availability of an interpreter, and gathering information from agencies. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

Agencies Participating in this Review

1.4 A total of 11 agencies were contacted and 4 responded has having had involvement with the individuals involved in this Review; 7 had no contact. Agencies participating in this case Review and the method of their contributions are:

- The London Borough of Newham Adult Services - chronology and Independent Management Review (IMR).
- GP Services - chronology & IMR
- East London NHS Foundation Trust for Mental Health Services - chronology & IMR
- Newham University Hospital NHS Foundation Trust – chronology & IMR
- Home Office Immigration Enforcement Department – Information
- London Borough of Newham Children's Services - Information

Family and friends have also contributed to this Review.

1.5 To protect the identity and maintain the confidentiality of the victim, perpetrator, and their family members pseudonyms have been used throughout the Review. They are:

The victim: Nadira aged 43 years at the time of her death. She was originally from Pakistan. She was naturalised as a British citizen.

The perpetrator: Rahim aged 64 years at the time of the homicide, was originally from Kenya and was a British citizen from birth.

1.6 **Purpose and Terms of Reference for the Review:**

The purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- To seek to establish whether the events leading to the homicide could have been predicted or prevented.
- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

Specific Terms of Reference for the Review:

1. To examine agencies contact with the victim and the alleged perpetrator between January 2001 and the time of the victim's death. Agencies with knowledge of the victim and alleged perpetrator in the years preceding this timescale are to provide a brief summary of that involvement. Any interaction with family members or friends which have relevance to the scope of this review should also be included.

2. Agencies which had involvement with the victim and the alleged perpetrator to assess whether the services provided offered appropriate support, interventions, and resources, including communication resources. Assessments should include consideration of any organisational and/or frontline practice level factors which influenced or impacted upon service delivery.

3. To assess whether agencies have the relevant domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

4. To examine the training and knowledge of staff who had contact with the victim and the alleged perpetrator in the identification of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to MARAC and to appropriate specialist domestic abuse services.

5. Examine the effectiveness of single and inter-agency communication and information sharing both verbal and written.

6. To determine if there are any barriers which may have affected the victim's ability to disclose abuse or to seeking advice and support.

1.7 The Overview report author was responsible for contacting family and friends to invite their contribution to the Review. This was done both directly and with the assistance Aanchal Women's Aid and an interpreter provided by their service.

1.8 **Agency Contact and Information from the Review Process:**

1.9 Nadira first came to the United Kingdom (UK) in 2001 when she is recorded as entering the country as the wife of Rahim's son from his first marriage. However, she never lived with his son, but with Rahim. In 2006 she went back to Pakistan and returned to the UK as the wife of Rahim. Nadira had a different name on re-entry to the county which for a time complicated agencies information gathering.

1.10 Rahim was first known to an agency in 1972 when he accessed Health services. In 1994 he had contact with the Police when he was charged with unlawful sexual intercourse with a girl under 16 years which resulted in the birth of a baby which he abandoned in a nearby hospital. When he met Nadira he was a widower. His first wife is thought to have been poisoned by a family member in Pakistan. Members of the family report that his marriage to Nadira was arranged though a family friend.

1.11 Police were next involved with Rahim in 2000 when he was arrested and bailed for a traffic offence, having a sharpened file in his pocket and refusing to give his details. He was processed for the offence according to procedures in place at the time. Further involvement with the Police took place in 2001 when they were called to a domestic incident. Nadira had discovered that Rahim was having an affair and a confrontation took place between Nadira and the other woman. All parties refused to substantiate any allegations against one another. A follow-up letter was sent to Nadira with details of support service by the Police Community Safety Unit as phone contact was unsuccessful. A referral appears to have been made to the Domestic Violence team for Independent Domestic Violence Advocate (IDVA) support, but no service appears to have been given. Due to the time which has elapsed detailed records are no longer available. There was no indication that domestic abuse was taking place between Rahim and Nadira; the incident arose due to his infidelity. The last Police contact with the family prior to the fatal incident was in 2006 concerning an argument between Rahim and one of his adult sons from his first marriage. This was assessed as low risk and resolved according to procedures.

1.12 The Borough Council's housing benefit department was appropriately informed by the family about their change of names and when Nadira was working part time, they were also aware that she had two dates of birth and national insurance numbers. Rahim changed his name in 2008 to a name reflecting his Islamic faith and provided an affidavit to evidence the change. No evidence was found of any fraudulent attempts to manipulate the Council's system. There was no interaction with the couple which might relate to domestic abuse or where suspicions of such might be raised.

1.13 During the timescale under review the family moved home 8 times; 3 of the moves were back to the same address. These moves also resulted in moves of GP practice. Nadira had limited English and she was accompanied by Rahim acting as

her interpreter at a majority of GP appointments. The couple had two children during the review period and the Health Visiting Services to the family was routine and no concerns were raised from the visits, although there are gaps in records which is a concern. Around 2006 there was a shortage of health visitors and a move from paper to electronic records along with a change in IT systems. The Community Health Individual Management Review (IMR) author believes all these factors had a detrimental impact on the service. The IMR also raised the fact that the RIO database used by the service does not have family records and fathers are not routinely linked to their children, a problem highlighted in recent Serious Case Reviews which is in the process of being addressed. Health visitors are now almost universally including the details of the father on the 'family management' page in RIO.

1.14 The family members consulted various GPs depending on where they lived. There was nothing of immediate note relating to their appointments, and although Nadira did not present with any injuries which might obviously hint as being related to the effects of physical abuse, she was seen with a perforated eardrum which can be an injury associated with abuse[1]. This could have been a result of being hit around the head by Rahim whilst she was in Pakistan in 2012, an incident which was reported by contributors to this review. Other conditions, such as hair loss from which she suffered can be caused by anxiety which might be due to experiencing abuse or coercive control, but equally can have other health related causes. Nadira had gastrointestinal problems which could also be linked to the effects of abuse. Research has found that there is a relationship between abuse and gastrointestinal illness and poor outcomes[2], and sleep problems and depression from which she also suffered for a short time are not uncommon symptoms of domestic abuse. However, there is nothing in GP notes to indicate that possible domestic abuse was discussed as an underlying cause for her symptoms, but given that her husband accompanied her to a majority of appointments this would not have been appropriate or possible. Nadira also had a miscarriage in 2007, but there appears to be no exploration by hospital or GP as to whether any external factors such as domestic abuse might have caused this; domestic abuse can escalate in pregnancy and miscarriage can result[3].

1.15 On 30 January 2013 Rahim came home and found Nadira unresponsive on the sofa. She was taken to hospital by ambulance with a suspected overdose of prescribed medication and assessed by the on call psychiatrist. Nadira reported being low in mood for the past 5 to 6 months, and had trouble sleeping "thinking about things". Nadira was seen alone for part of the assessment and the psychiatrist asked about any history of domestic violence or abuse, however Nadira denied experiencing abuse. She revealed that she was worried and anxious about a visit to Pakistan planned for 2 months time; her mother was unwell and they were going to her brother's wedding. Nadira added that "there might be some family problems".

1.16 Nadira was referred to the Community Mental Health Team and received a first home visit the following day by a male mental health nurse without an interpreter; Rahim was present. They both reported that they had had an argument the

[1] Shipway L (2004) *Domestic Violence. A handbook for health professionals*, London, Routledge
[2] Drossman D A (1995) 'Sexual and physical abuse and gastrointestinal illness: Review and recommendations' *Annaals of Internal Medicine 123(10):782-794*cited in Taylor-Browne J (ed) (2001) *What works in reducing domestic violence?* London, Whiting & Birch
[3] Dept of Health *Conference Report: Domestic Violence A Health Response: Working in a Wider Partnership* (2000)

morning of her overdose attempt and he had threatened to leave. Nadira felt very suspicious of her husband since he said he would leave. She was tearful and regretted her actions, but had wanted to die at the time. Risk assessment was to be continued as inadequate information was available at the time, and the presence of an Urdu speaking staff member was to be recommended. However, no Urdu speaker could be found and a Hindi speaking support worker was assigned as the two languages share similarities.

1.17 The Community Mental Health Team's involvement with Nadira lasted 13 days. She had a medical review by the Home Treatment Team psychiatrist and community mental health nurse and she was again seen on her own for part of the review, but she was not asked about domestic abuse again. When questioned Nadira was remorseful concerning her overdose attempt; she had taken it impulsively following an argument with her husband. Rahim added that Nadira had been suspicious that he was having an affair with one of her relatives in Pakistan. This had started when she noticed phone calls from that person's number on his phone. Rahim said he had disconnected the phone to prevent further arguments, and he advised Nadira to speak to him if she had these suspicions again. Nadira strongly denied any suicidal thoughts and identified her children and her husband as her main protective factors. It was agreed that she could be discharged. No follow up or medication was felt to be necessary. Information in the form of a discharge summary to her GP could not be found during the Serious Incident Review and the authors of that Review concluded that this was never written.

1.18 The GP practice with whom she was then registered was aware of Nadira's suicide attempt via the hospital discharge summary which contained the information that the East London NHS Foundation Trust Community Mental Health Services would be providing follow up care in the community. Nadira and Rahim also saw the GP themselves shortly after her discharge from the Community Mental Health Team. The GP did not have information from Community Mental Health as no discharge summary from that service was sent. The possibility of domestic abuse as a contributory factor for her depression and the suicide attempt appears not to have been considered, despite the links which have been found to exist, nor the fact that domestic violence and forced marriage has been found to be a major factor in 49% of suicide attempts made by black women compared to 22% of suicide attempts by white women.[4]

1.19 Nadira was last seen by her GP in June 2013 when she had a follow up appointment for a relatively minor physical condition for which she had previously been treated. The notes state 'seen with husband as doesn't speak English'. During the appointment Nadira discussed her wish to have another baby and she was given pregnancy advice.

1.20 At the time of their involvement none of the contributing agencies to this Review had any knowledge or suspicion of domestic abuse in Nadira and Rahim's relationship, and there were no concerns raised by Health or schools regarding the children. However, there appears to be very few occasions when Nadira was seen alone and in a situation which may have been conducive to any disclosure of abuse.

[4]Newham Asian Women's Project. Silent Scream. Young Asian Women and Self-Harm: A Handbook for Professionals.London: Newham Asian Women's Project, 2004 cited in *Asian Women, Domestic Violence and Mental Health A Toolkit for Health Professionals,* EACH & Government Office for London, February 2009

1.21 The day before her death two family members and a friend report receiving phone calls from Nadira. One family member recalled that they felt that Nadira was upset, but she denied anything was wrong when asked. It was a short call of 2 to 3 minutes. The other family member could not take the call as they were at work, but noted the missed call. A friend was called whilst out shopping and thought Nadira sounded very low, but when they asked if she was alright she assured them she was. They arranged to phone her next day to talk further from home, but when they phoned next day there was no answer.

1.22 The next occasion an agency had contact with Nadira and her family was on the day she died. Rahim had left home with the children for school, but the eldest returned home to collect school work they had left behind, and the child found their mother's body. She had suffered multiple stab wounds. A neighbour called an ambulance and this was quickly followed by the attendance of the Police.

1.23 Following inquiries the Police arrested Rahim and a third party. They were charged with Nadira's murder. Both pleaded not guilty. At the trial it was revealed that Rahim had paid the third party to commit the crime. He assisted the murderer to enter their home by leaving a public access door ajar as he left for the children's school. The judge noted a number of aggravating factors; the significant planning and premeditation; the ferocity of the attack and the suffering endured; the use of a knife to commit murder for gain; Rahim's betrayal of his wife's trust and the traumatic experience of her final moments, including her child's arrival at the scene shortly after the attack. The judge determined that the crime would be considered a murder for gain in respect of both defendants. During the court proceedings it was also revealed that Rahim was having an affair with a relative of Nadira's in Pakistan. He was also in debt, and Nadira had a substantial amount of savings in the home as a result of her membership in a community savings scheme. These circumstances were thought to be his motive for arranging for his accomplice to enter the couple's home to steal and murder Nadira.

2 Key Issues Arising from the Review:

2.1 There is no evidence to suggest that any family members had difficulty accessing mainstream services, however, at different times Nadira is described as having poor English and requiring an interpreter, but the use of interpreters does not appear to have taken place; Nadira's husband was regularly used at appointments for this purpose which inevitably has consequences for how candid she could be at such times. At various times GP notes record her poor English and at others there is no comment. One explanation for this is that the GP she was seeing spoke Urdu. Some of the surgeries were large practices and the IMR author found that it was not always clear from the records which GP Nadira was seeing and whether the GP did speak Urdu. However, the IMR for the GP practices points out that in GP practice it is considered the responsibility of the patient to bring an interpreter with them. This expectation reduces further the chances that a woman will disclose sensitive information such as domestic abuse, especially where her standing in the community could be affected if confidentiality was breached. The use of independent interpreters is difficult for GP practices, but as part of their training they have been given suggestions as to how to separate a woman from her "interpreter" and talk to her on her own where possible, although how this can be done if no staff speak her language is difficult to imagine.

2.2 It must be recognised however, that realistically the use of interpreters on a routine basis is not practicable, both in terms of cost and availability, therefore empowering women to learn English, as Nadira had been doing through classes, is also empowering them with ability to fully access services in private and confidence. Social isolation can be a factor for some Pakistani women especially if she does not speak English[5], and it is clear that Nadira's English was not sufficiently advanced for her not to require an interpreter for detailed communication such as at medical appointments. Lack of English also makes seeking help from outside agencies by telephone or in person very difficult.

2.3 Observations by contributors to the Review are that Nadira was a very private person who would not share personal concerns. They also suggest that cultural expectations may have played some part in Nadira's reluctance to use support services or give consideration to leaving the relationship, despite her acute unhappiness on discovering her husband's extra-marital affair. She also wanted her children to grow up with a father, and a friend said she did not believe she would be able to manage on her own. How she appeared within her community was important to her, and as one friend explained, women in her culture are often blamed for the failure of a marriage even if she is blameless. This type of cultural pressure is borne out by Home Office research[6] among Pakistani women in Newham which outlines the negative impact on a woman's respectability and personal honour which is dependent on her marital status; there may also be a fear of transferring her 'dishonour' to her children or other family members.

2.4 The Mental Health Serious Incident Review pointed out that "despite the known high prevalence rates both within the borough and in women presenting with mental health problems" the care pathways followed by Psychiatric Acute Community Team (PACT) do not lend themselves to exploring domestic abuse with patients. This clearly indicates that the care pathway followed at the time was not fit for purpose in this respect. The Serious Incident Review recognises this and it has been identified as an early learning point in their report leading to a recommendation for a prompting system of 'routine enquiry' about domestic abuse. Such a system however, needs to be backed up with sufficiently in-depth training to enable a practitioner to use appropriately sensitive methods when asking about domestic abuse. The service also needs to appreciate that in many cases a disclosure of abuse will not be revealed at a first or even second meeting, and that a relationship of trust may need to be built between a practitioner and a service user before they have the confidence to discuss such matters.

2.5 Domestic abuse training of suitable depth was lacking within Health providers. At the time of the Review domestic abuse was included in hospital, GP and Community Health Safeguarding Children and Adults training. It is helpfully recognised in the combined IMR covering these services that domestic abuse training as it is constituted within Safeguarding training may not be specific (or in depth) enough to meet all practitioners' needs, and the author of this report concurs with this view. However, if staff are to be expected to routinely ask about domestic abuse in their assessments, they will need to develop the skills to identify signs and sensitively enquire about a service user's experiences beforehand. Training needs to be tailored to meet these specific skills as well as taking into account the make-up of the local community and the various cultural contexts which might arise.

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[5] Ibid

[6] Choudry S (1996) Research Findings No 43 *Pakistani Women's Experience of Domestic Violence in Great Britain*, Home Office Research and Statistics Directorate

2.6 The Serious Incident Report identified a service delivery problem in respect of the use of a male nurse working alone when the Mental Health Community Team first visit took place to Nadira. This was insensitive considering a) that Nadira was a Muslim woman from a culture where meeting with a man on her own might not be allowed by her husband, although the nurse did not request this, and b) it is likely that Nadira would be much less likely to disclose intimate information about her marriage to an unaccompanied male nurse. This raises the issue of greater consideration being given to the matter of gender and culture when allocating staff to work with service users.

2.7 Flaws were identified in the system for sending discharge summaries to GPs from the Community Mental Health Team. Such an oversight leaves GPs without the information they need for the continuity of care of their patients in the community. Steps have already been taken to remedy this via the Mental Health Serious Incident Review.

2.8 None of Nadira's friends could identify changes which would have made a difference and which might have resulted in her leaving Rahim in the confidence that she could manage outside the marriage. Nadira's was a very private person who kept how she was really feeling to herself. Her desire to maintain her marriage for the sake of her children and her family honour, limited the opportunities others had to intervene with help and support. Nevertheless, inaction is not an option. Nadira will not be the only woman experiencing these feelings, therefore the learning we must take from this is the need to be creative in how preventative messages and information about support is distributed, including helping victims, families, and friends to recognise what domestic abuse is, and be assured that accessible and appropriate support services are available to serve the local community and well publicised.

3 Conclusions:

3.1 From the information known to agencies that had contact with the family the murder of Nadira was not predictable, and given the lack of knowledge they had about her relationship with her husband and his situation nor could they have done anything to prevent it. Two relatives interviewed for this Review were aware of two incidents of physical assault and verbal arguments between the couple, but none of her close friends in her local neighbourhood were aware of any domestic abuse and they were all shocked by her death.

3.2 Two very important social and cultural patriarchal constructs are seen at play in this case which caused Nadira to be silent about her relationship with her husband, and which invisibly controlled and silenced her: *Izzat* (honour) and *Sharam* (shame). As a contributor to the Review commented the failure of a marriage in Nadira's culture is seen as the woman's responsibility and blame tends to fall mostly on women; their honour is retained through conforming to prescribed roles and practices, and actions which may be seen as 'transgressions' will bring dishonour on them and their family.[7] From the observations of Nadira's friends, her wish and need to keep her family

[7] Imam, U. F. (1999) 'South Asian young women's experiences of violence and abuse', in J. Pitchard and H. Kemshall (eds) *Good Practice in Working with Violence*. London: Jessica Kingsley. Cited in Izzidien S (2008)" I can't tell people what is happening at home" Domestic abuse within South Asian communities: the specific needs of women, children and young people June 2008

honour intact within her community, plus her wish to keep her family together for her children's sake, appears to have played a major part in keeping her in the relationship and silent about what may have been taking place away from the view of friends in her neighbourhood. This formed a significant barrier to her accessing help and support.

4 Recommendations:

4.1 The following recommendations arise from agencies IMRs and from the lessons learnt from this Overview Report.

4.2 As training was a recommendation common to all Health IMRs this issue has been combined into one recommendation for the Sector. Recommendations from the Mental Health Serious Incident Review Report have been incorporated into Recommendation 3 and Recommendation 4.

4.3 **Recommendation 1: Multi-Agency**:

A domestic abuse awareness campaign aimed at increasing the numbers accessing help should be undertaken in the Borough in a format which is accessible to the local community. In consultation with local voluntary sector partners a particular focus should be given to creative ways of accessing BME groups and those known to experience particular barriers to accessing support. The campaign should aim to complete the design stage by April 2015 to begin implementation by June 2015.

4.4 **Recommendation 2: All Sectors of Health**

Agencies to ensure the implementation and publicising of existing guidance and best practice in the use of interpreters, and to ensure that service users/patients are seen for assessments, and sensitive interviews with an interpreter when necessary, and not with a family member as interpreter. Completion of this recommendation to be reported to the Community Safety Partnership by May 2015. The following link may also prove useful: *Glasgow Violence Against Women Partnership Good Practice Guidance - Interpreting for women who have experienced gender based violence:* http://www.ccrm.org.uk/images/docs/2.2bgood%20practice%20interpreting%20for%20women%202011.pdf

4.5 **Recommendation 3: All Sectors of Health**

That strategic leaders should ensure that domestic abuse training with reference to NICE Guidance[8] Recommendation 6 should be delivered to all sectors of Health which is tailored to their practice needs and which is of sufficient depth to develop the skills needed for assessment, and consultations. The training should enable practitioners to:

- understand relevant research evidence relating to domestic abuse and aspects of physical and mental ill-health
- identify signs of domestic abuse
- recognise high risk groups

[8] NICE public health guidance 50: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. Issued: February 2014. guidance.nice.org.uk/ph50. Recommendation 6: Ensure trained staff ask people about domestic violence and abuse.

- develop ways of asking sensitively about domestic abuse
- how to handle a disclosure of domestic abuse
- how to risk assess and refer to MARAC when appropriate
- know when and where to refer to a specialist agency both statutory and voluntary
- understand barriers to disclosure and/or reporting domestic abuse, including additional barriers experienced by those in the BME and LGBT communities and those with insecure immigration status

Organisations to respond to this recommendation training course should aim to be developed by April 2015, and dates for a programme of courses set and publicised by the end of May 2015.

4.6 **Recommendation 4: Barts Health & East London NHS Foundation Trust**

In line with NICE Guidance Recommendation 6[9]

a) Routine questioning for domestic abuse to take place by A&E as part of their history taking for all self- harm attendances.

b) All staff involved in routine questioning of patients about domestic abuse to have undergone training as outlined in Recommendation 3 and in line with NICE Guidance Recommendation 6, before embarking on this role.

c) To ensure that all recording sites (file, Rio, Datix) have prompts for asking service user about their experience of domestic abuse or violence

The enactment of this recommendation should aim to commence by May 2015 and progress reported to the Community Safety Partnership.

4.7 **Recommendation 5: East London NHS Foundation Trust**

To review the allocation of cases process to prompt the consideration as to whether circumstances in the service user's background require a particular gender of practitioner and whether an interpreter needs to be arranged. This process to be reviewed and amended as necessary by March 2015 and outcome reported to the Community Safety Partnership by June 2015.

4.8 **Recommendation 6: General Practitioners**

General Practitioners should have a clear care pathway for supporting patients who are identified as victims of domestic abuse. The pathway should be agreed with local partners to ensure safe and clear lines of communication and information sharing to enable victims to access support as soon as possible. The pathway should be developed and agreed by May 2015. The following link may be helpful in developing a pathway: http://www.caada.org.uk/dvservices/resources-for-general-practice-managers.html

[9] ibid