Domestic Homicide Review - Amolita 2011

Independent Chair of Review Panel and author or report:
Davina James-Hanman, Against Violence and Abuse

1. Executive Summary
2. Overview Report
3. Action Plan
4. Home Office Quality Assurance response

1. Executive Summary

LB NEWHAM DOMESTIC HOMICIDE REVIEW PANEL
EXECUTIVE SUMMARY

Name	Age at the point of the murder	Relationship
Amolita	29	Victim
Duhsambada[1]	46	Husband / Perpetrator
Adult 2	37	Brother of perpetrator
Child 1	9	Daughter of victim and perpetrator
Child 2	7	Daughter of victim and perpetrator
Ms X	Unknown	Niece of victim

Address 1 is the home in LB Newham where Amolita lived with her daughters.

INTRODUCTION

This review report is an anthology of information and facts from nine agencies, all of which were potential support agencies for Amolita[2]. Seven agencies had records of contact with Amolita prior to her death. They are:

Aanchal Women's Aid
Amolita's solicitor
Cafcass
LB Newham Housing
Metropolitan Police Service
NHS North East London & the City
The school attended by Amolita's daughters

All but LB Newham Housing were aware of the domestic violence and had significant contact.

THE FACTS

Amolita and Duhsambada[3] were married in Bangladesh in November 2000. They moved to the UK in 2002. They had two daughters, one in 2001 and the other in 2003. In 2005, Amolita reported domestic violence to the police and went into a refuge, moving to permanent accommodation in LB Newham in 2006. Duhsambada petitioned for child contact and the case continued until June 2009. During this time, Amolita regularly reported instances of harassment and threats from Duhsambada to

[1] Not his real name
[2] Not her real name
[3] Not his real name

both herself and to members of her family in Bangladesh. Child contact was granted to Duhsambada and he thus remained regularly in Amolita's life.

In July 2011, the London Ambulance Service was called to Amolita's address where they found the dead body of Amolita. She had been strangled. Duhsambada was arrested on suspicion of murder.

After an initial appearance at Newham Magistrates Court, Duhsambada appeared at the Central Criminal Court in July 2011 where an application for bail was refused. A trial date was set for February 2012. Duhsambada pleaded 'Not Guilty' to the murder of Amolita but was found guilty in March 2012. He was jailed for life with a minimum tariff of 17 years.

ABOUT THE REVIEW

The Review considered agencies contact/involvement with Amolita and Duhsambada from when she moved to LB Newham in March 2006 until July 5 2011. This Review began on 23 September 2011 and was concluded on November 1 2012. Seven meetings of the DHR Panel took place.

The DHR Panel was chaired by Davina James-Hanman, the Director of AVA, an independent charity working on all forms of violence against women and girls.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder and to complete an IMR in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to make their services more accessible.

Seven IMRs and one background report were completed. In addition, interviews were undertaken with the following:

Aanchal caseworker
Amolita's solicitor
Two teachers at the children's school
A close friend and relative of Amolita (Ms X). This interview also afforded the opportunity for a brief conversation with the relative's mother.
The two children of Amolita and Duhsambada (Child 1 & 2)

ANALYSIS

Amolita was married to Duhsambada for eleven years, from 2000 until the point of her death. He was violent and abusive to her from their wedding night and continued his attempts to control her even after she left him in 2005.

Amolita did engage with agencies but failed to find what she seemed to be seeking. She wanted 'back up' for her stance in refusing to be an 'obedient wife' as defined by Duhsambada. Cafcass correctly focused on the children, her solicitor focused on making his client appear 'reasonable' to the court, housing focused on supplying her with a tenancy, the police focused on evidence, health professionals focused on the clinical issues, Aanchal was asked for an intervention that they could not provide (a

warning letter to Duhsambada) and some parts of the wider Bengali community muttered to her about family 'honour'.

Author's note: All of the above agency responses prioritised statutory duties, or agency and community agendas ahead of Amolita's needs, yet with the exception of the failures to refer to Children's Services, none can be fairly categorised as 'wrong'. The statutory remit of Cafcass is to focus on the children just as it is the statutory duty of the police to focus on investigating crimes. However, without close co-ordination between agencies, no-one has a complete picture and each agency is working in a silo, dealing with just one part of the picture. What it does demonstrate is the complexity of issues that require multi-agency responses: it is not simply a matter of agencies sharing information but also necessitates a refocusing of priorities if interventions are to be truly holistic and effective.

As a consequence of agencies not responding holistically, and strengthened by Duhsambada's threats to her family abroad, Amolita never found the kind of help she wanted. Even with the benefit of hindsight, it is hard to see how this might have been achieved although it is possible that had each of the statutory agencies probed a little more and made her feel less judged, Amolita may have felt supported enough to pursue courses of action (injunctions, police reports etc) that she had come to doubt in terms of their effectiveness.

CONCLUSION/LESSONS LEARNT

Risk identification: This case demonstrates, as many others before it, that leaving an abuser and having disputes over child contact are key risk factors for homicide. It also confirms research showing that the victim's assessment of the level of danger she faces is the most accurate[4]: Amolita reportedly told family members that Duhsambada would kill her and he did. A further issue which should have been recognised, but was not, was the longevity of the abuse. Seven years after leaving the relationship, Amolita was still being harassed by Duhsambada. This level of persistence should have been a warning sign.

Appropriate services: Amolita did not seem to trust state agencies but she had a long and mostly open relationship with Aanchal. This demonstrates the importance of specialist domestic violence services which are focused on providing a service to women from specific communities or ethnic groups; a type of provision that is rapidly disappearing as the public sector budgets shrink.

Child contact: The prolonged child contact proceedings undermined Amolita's confidence in statutory services ability and willingness to protect her and the children. From her perspective, the Family Court was on Duhsambada's side granting him everything he asked for. Amolita reported to both Aanchal and Ms X that she did not feel that Cafcass believed her version of events and seemed unconcerned at the ways in which Duhsambada was using child contact to exert control over her. Cafcass would like to make it

[4] Battered Women's Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Reassault D. Alex Heckert and Edward W. Gondolf (2004)

clear that whilst they accept this was Amolita's view, it does not accord with theirs.

Communication and clarity of roles and responsibilities between agencies: The Review found a few instances of poor communication and information sharing: whilst most of these are unlikely to have affected the course of events, of particular concern is the lack of referrals by any of the agencies in contact with Amolita to LB Newham Children's Services.

Community knowledge and views: Ms X and her mother provided much support to Amolita and her children but did not themselves know how to resolve the issues she faced. In addition, parts of the Bengali community shunned Amolita for being separated from her husband. Individual and collective notions of 'honour' impact on women's safety and decision-making and the existence and propagation of such concepts allows violence and abuse to continue with impunity.

RECOMMENDATIONS

1. Community Health Newham (East London Foundation Trust (ELFT) and GP practices need to agree a process which ensures that where children under five years of age register or deregister with a GP, the health visiting service is informed. In addition where the parent(s) are vulnerable, this information should be shared and the family discussed at practice meetings and a care plan agreed. This recommendation is a CQC/SCR requirement and is in the process of being implemented.

2. Ensure commissioning of school nursing services includes providers that have a policy in place which follows up those children not known to health services at school entry. This needs to include pro-active work with families where they do not respond to school entry health questionnaires as these will be the most vulnerable of children.

3. A rolling programme of domestic violence awareness be provided to the GP practices in Newham as part of their safeguarding training

4. Exploration with GPs as to the best way to flag women who are/have been subjected to domestic abuse on the practice IT system and also have it identified within the children's records. The new General Medical Council guidance for doctors highlights the need for family members to be linked. This is particularly important where the parents have different names and do not necessarily reside in the same house.

5. Each refuge in Newham to have a named health visitor who will be responsible for the health needs of all the families within that refuge.

6. All agencies to have basic domestic violence awareness training,

supplemented by multi-agency training for relevant staff that includes an awareness of risk factors.

7. Raise community awareness of domestic violence to:

    - Ensure that concerned friends and family members have an awareness of where to go for help
    - Challenge myths and stereotypes about domestic violence

8. All agencies to review their referral processes for children at risk of significant harm

9. The Panel originally wanted to recommend the following for Cafcass:

Where there are allegations of current domestic violence and disputes over child contact, the local Children's Services should be routinely notified.

However, Cafcass rejected this recommendation stating:

We did, in fact, do that as a matter of policy for a period of time but stopped. We receive over 45K private law applications per year. Domestic violence is a feature of about one half of these. Sending approximately 22K notifications to Children's Services per annum is not seen as good safeguarding practice by either us or Children's Services. Our child protection policy therefore directs staff to make child protection referrals to Children's Services where our information (including that derived from domestic violence) suggests that a child is suffering, or likely to suffer, significant harm (Children Act 1989).

Consequently the Panel, specifically supported by LB Newham Children's Services, would now like to recommend that the Government take up this issue nationally.

10. Government: Cafcass be made a statutory partner for DHRs, similar to their role in local safeguarding procedures.

11. Commissioners: Ensure that domestic violence provision in the locality is not solely focused on risk but also offers opportunities for early intervention and counselling / resettlement support. Commissioners should also take account of the specialist nature of this work which is not easily replicated in generic provision.

12. LB Newham Housing: When applicants are referred from another Borough, routine screening of domestic violence should be done.

13. Explore ways in which solicitors might be included within local partnerships

14. Police: When undertaking risk assessments, officers should ask for a

history of abuse.

15. LB Newham Adult Services to consider referral pathways / contract management of Floating Support Service to ensure vulnerable women like Amolita do not fall through the gaps in provision.

16. Schools to share domestic violence information with health. The school should have raised their knowledge of domestic violence history, especially when they knew Duhsambada was once again residing with Amolita.

17. The family wished to recommend some form of action or policy which could address the issue of perpetrators abusing extended family members living abroad. Whilst they accept that no country has resources enough to undertake extensive investigations overseas, they felt that agencies would have taken Amolita a lot more seriously had she felt able to report these 'overseas' incidents to them openly and that Duhsambada may not have progressed to murder if police / agencies had begun to question him about them and warn him against any further such actions.

2. Domestic Homicide Overview Report Amolita 2011

DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF AMOLITA[5]

Name	Age at the point of the murder	Relationship
Amolita	29	Victim
Duhsambada[6]	46	Husband / Perpetrator
Adult 2	37	Brother of perpetrator
Child 1	9	Daughter of victim and perpetrator
Child 2	7	Daughter of victim and perpetrator
Ms X	Unknown	Niece of victim

Address 1 is the home in LB Newham where Amolita lived with her daughters.

INTRODUCTION

This Domestic Homicide Review (DHR) report examines agency responses and support given to Amolita, a resident of LB Newham prior to the point of her murder death on 5 July 2011.

SUMMARY OF THE CASE

Amolita and Duhsambada were married in Bangladesh in November 2000. They moved to the UK in 2002. They had two daughters, one in 2001 and the other in 2003. In 2005, Amolita reported domestic violence to the police and went into a refuge, moving to permanent accommodation in LB Newham in 2006. Duhsambada petitioned for child contact and the case continued until June 2009. During this time, Amolita regularly reported instances of harassment and threats from Duhsambada to both herself and to members of her family in Bangladesh. There are conflicting accounts as to whether this was with Amolita's blessing.

On July 5 2011, the London Ambulance Service was called to Amolita's address where they found the dead body of Amolita. She had been strangled. Duhsambada was arrested on suspicion of murder.

POST MORTEM

[5] Not her real name
[6] Not his real name

On 6 July 2011 a Home Office Pathologist carried out a post mortem at East Ham Mortuary and gave the cause of death as *"1A, Asphyxia and 1B Compression of the neck"*. His conclusion was that the compression was by hand.

INQUEST

On 12 July 2011 at Walthamstow Coroners Court opened and adjourned the inquest pending police inquiries.

Duhsambada was convicted at the Central Criminal Court and sentenced by a High Court Judge. The Coroner decided to record that verdict and sentence as the result for his records and no further Coroners Hearings will take place.

COURT DATES

After an initial appearance at Newham Magistrates Court, Duhsambada appeared at the Central Criminal Court on July 2011 where an application for bail was refused. A trial date was set for February 2012. Duhsambada pleaded 'Not Guilty' to the murder of Amolita but was found guilty in March 2012. He was jailed for life with a minimum tariff of 17 years.

SCOPE OF THE REVIEW

Amolita moved to LB Newham in March 2006 having been previously resident in a refuge in North London. This seemed an appropriate point at which to set the start of the scope for participating agencies. It should be noted that information gathered from interviews also covered earlier years.

This means that the Review considered agencies contact/involvement with Amolita and Duhsambada from March 2006 until July 2011.

The IMR from the Metropolitan Police also helpfully included information about their involvement with both parties between June 2004 and December 2005 which provided further contextual information about the history of domestic violence.

NHS North East London & the City also provided information outside of the scope which helped to show the number of times that the family had moved to different addresses in London since their arrival in the UK.

TERMS OF REFERENCE

The terms of reference for the review were to:

1. Review the involvement of each individual agency, statutory and non- statutory, with Amolita and Duhsambada between March 2006 and 5 July 2011. In order to critically analyse the case, the terms of reference required specific analysis of the following:

    - Communication and co-operation between different agencies involved with either party

- Opportunities for agencies to identify and assess risk
- Agency responses to any identification of domestic violence issues
- The training available to the agencies involved on domestic violence issues

2. Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic violence.
3. Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
4. Involve Amolita's family in the review process
5. Commission a suitably experienced and independent person to produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.
6. Commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary.
7. Establish a clear action plan for individual agency implementation as a consequence of any recommendations from individual management reviews.
8. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.
9. Provide an executive summary.

CHRONOLOGY

A complete chronology of agency involvement is attached at appendix A. Below are edited highlights of the most significant events.

Amolita and Duhsambada were married in Bangladesh in November 2000. She remained in Bangladesh where their daughter, Child 1, was born on 22 November 2001 whilst he travelled between Bangladesh and the UK. In April 2002 the family moved to the UK, and lived with his mother in North West London. On 13 October 2003 their second daughter, Child 2, was born.

In July 2005 Amolita left Duhsambada and went into a refuge in South West London, telling police at the time that she and her children had experienced violence from Duhsambada.

On 13 October 2005 Amolita reported that her brother in Bangladesh told her that Duhsambada had threatened to kill him unless she returned to him. She said that Duhsambada had rung her brother in Bangladesh and said "If your sister comes back to me I'll leave you alone, otherwise I'll kill you".

On 1 December 2005, following a call at the refuge from a third party claiming that Duhsambada was making threats about harming her, Amolita and her daughters moved to another refuge in North London for safety reasons. Duhsambada was given a first warning under the Protection From Harassment Act.

In March 2006, Amolita moved to LB Newham to be closer to Ms X and her mother.

On 1 June 2006, Amolita petitioned for divorce and an injunction was issued at Bow County Court on 12 June 2006 citing violence and harassment. This injunction expired on 22 June 2008.

On 9 July 2008 Amolita attended a Police Station to report a threat made by Duhsambada from Bangladesh to her mobile phone.

On 18 February 2009, Amolita attended the offices of her solicitor and stopped divorce proceedings.

On 15 September 2009, Duhsambada reported a burglary at Amolita's home address that he discovered at 04.00am whilst preparing his breakfast indicating that he was now living there.

Author's note: Almost all agencies who knew that Amolita had stopped divorce proceedings and that Duhsambada had moved into Amolita's house, assumed that a reconciliation had taken place and, indeed, Amolita herself told Aanchal that she was trying to make it work for the sake of the children. However, information from Ms X indicates otherwise. Both she and her mother report that Child 1 had given Duhsambada a key and that he had simply taken up residence. These conflicting reports possibly reflect Amolita's own ambivalence.

Records from Aanchal and information from Ms X suggest that Amolita was under constant pressure from Duhsambada and the wider Bengali community to reconcile. Amolita seemed to make strenuous efforts to carve out a new and independent life for herself but was constantly undermined by this pressure as well as the inability of agencies to protect her family members in Bangladesh and lengthy court battles. It is easy to understand how she might have given Duhsambada a second chance since he claimed to have changed. As with many abusers, however, these new behaviours didn't last long and Amolita found herself trapped all over again.

Disputed incident

The facts of the following incident are disputed between the two agencies involved. Each version has been included in this report (see page 12 for Aanchal version).

Police version:

On 16 December 2010 at 10.40 a case worker from Aanchal Women's Aid Centre rang Forest Gate Police Station to report Amolita had attended the centre after her husband had acted aggressively towards her and thrown a tea cup at her. The two children were at school. Officers attended the home address but received no reply. On contacting Aanchal they told police that Amolita would not answer her door and arrangements had been made for Amolita to be seen by a caseworker on 23 December 2010 who would then contact the Police Community Safety Unit. A MERLIN (referral to children's services) should have been completed.

From 21 April 2011 until 25 June 2011 Duhsambada was in Bangladesh.

Ms X reports that two days before the murder, Amolita told them that Duhsambada was going to kill her but that she couldn't report it to the authorities as Duhsambada was in Bangladesh so no-one would believe her. In addition, she didn't know when he would do it and what agency could provide her with round the clock protection forever?

Two days later, Amolita was last seen taking child 2 to school at 8.50am. CCTV footage shows her dropping her daughter off and then walking back towards the house. An hour and a half later, Duhsambada is seen leaving the house and getting into his car.

At 12.41 the police received a call from the London Ambulance Service who had been called to address 1 regarding a serious assault. The police officers found paramedics attempting to resuscitate Amolita. They informed officers that she had been dead for some time and had been strangled. Also at the house at this time were Duhsambada and his brother.

With the brother acting as an interpreter, Duhsambada explained that he and Amolita had argued earlier that day and she had threatened him with a knife. He had then slapped her round the face, and both had then grabbed each other's throats. Amolita had then fallen to the floor and he left the house. Duhsambada then phoned his brother and together they returned to the house about one hour later and called for an ambulance. Amolita had a scarf wrapped tightly round her neck. Duhsambada denied murder, claiming he had taken hold of his wife to stop her self-harming and had strangled her by accident.

At the time of the murder, both children were at their school which is so close to address 1 that it can be seen from the school. Although outside the scope of the DHR, information was provided about the way that the school responded to these events (see page 23) which is included as an example of sensitive and thoughtful practice.

TIMESCALES

This review began on 23 September 2011 and was concluded on November 1 2012. Seven meetings of the DHR Panel took place.

Several factors influenced the length of this review. As a consequence of halting the DHR in order for criminal proceedings to conclude, the review panel ended up attempting to progress matters during the Olympic period. As the host Borough for the London 2012 Olympics and Paralympics, LB Newham introduced a shift system for staff some weeks prior to the games beginning to ensure services were available at weekends. The lack of co-terminosity in working patterns made it impossible for the DHR Panel to convene for several months.

In addition to this, information emerged of a long involvement with Cafcass who were then contacted to request an IMR. Whilst wholly co-operative with the process, this also delayed proceedings whilst permission was sought from the court to disclose confidential information.

Finally, the restructuring of the NHS made it extremely difficult to engage with various health staff and the IMR was delayed by several months. Nevertheless, this has not delayed the implementation of learning from the IMRs.

Running parallel to this DHR, LB Newham was also undertaking a wide ranging and multi-agency review of its domestic violence service provision. Emerging issues from this DHR have been incorporated into its three year strategy and there is a commitment to include any additional recommendations once the DHR process is complete.

PARALLEL INVESTIGATIONS

Other than the criminal case against Duhsambada, there were no other parallel investigations.

Newham LSCB did consider a separate Serious Case Review but agreed that the DHR was the most appropriate structure especially since both children were not known to LB Newham Childen's Services until after the murder. Children's issues were considered throughout the

DHR process and the LSCB has agreed to consider the report and its recommendations when it can be disseminated.

CONTRIBUTORS TO THE REVIEW

DHR panel members were as follows:

Aanchal Women's Aid, a specialist South Asian women's support and advocacy service. (NB: Aanchal does not provide refuge accommodation.)
LBN Community Safety Unit
LBN Adult Services
LBN Children's Services
LBN Housing
London Probation
Metropolitan Police Service
Newham Action Against Domestic Violence (providers of the local IDVA service)
NHS North East London & City (a cluster of five PCTs)

All of the above were represented by senior staff and were all independent of the case. The Panel contained a mixture of those who were IMR authors and those who were not.

In addition, interviews were undertaken with the following:

Aanchal caseworker
Amolita's solicitor
Two teachers at the children's school
A close friend and relative of Amolita (Ms X). This interview also afforded the opportunity for a brief conversation with the relative's mother.
The two children of Amolita and Duhsambada (Child 1 & 2)

DISSEMINATION

DHR Panel members, Ms X and her mother and LB Newham Legal Department have all received a copy of this report. A decision was made at one of the Panel meetings that verbal and age appropriate feedback would also be given to Child 1 & 2 by their allocated Social Worker.

The DHR Panel also agreed that a copy of the full report will be attached to the children's records in Social Services. The DHR Panel wanted to ensure that if, in later years, the children wished to see the report that they would have access to it. Although this report was commissioned by the Community Safety Partnership, it was felt that as Social Services will be retaining responsibility for the children's care until they reach adulthood as well as retaining records beyond that point, that it was most likely that if either child came looking for a copy, they would start with Social Services. This decision was also influenced by the children's ages, since by the time they reach adulthood, CSP's cannot be guaranteed to still exist.

The Chair also consulted with Larasi, Chief Executive of Imkaan and a national expert on BMR women and domestic violence regarding the wording in some paragraphs.

CONFIDENTIALITY

The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim and perpetrator have been allocated alternative Bengali names. Amolita means 'priceless' and was a choice approved by Ms X.

Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

INDEPENDENCE

This report was written on behalf of the DHR panel by the Independent Chair of the Review, Davina James-Hanman.

Davina James-Hanman is the Director of AVA (Against Violence & Abuse) which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK. From 2000-08, she had responsibility for developing and implementing the London Domestic Violence Strategy for the Mayor of London.
She has worked in the field of violence against women for almost 30 years in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and two book chapters and formerly acted as the Dept. of Health policy lead on domestic violence as well as being an Associate Tutor at the national police college. Davina has also authored a wide variety of resources for survivors.
She was also formerly a Lay Inspector for HMCPSI, acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence (2007/08) and Chairs the Accreditation Panel for Respect. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. In recent months, her focus has been on improving commissioning and increasing survivor involvement in service design and development. Davina is also a Trustee of Women in Prison.
This report was written in October 2012.

All bar one of the IMRs report writers had no contact with the victim or perpetrator and each IMR was signed off by a senior manager within the organisation. The exception was Aanchal, a specialist Asian women's organisation that provided both support to access services and also social / educational activities. Amolita had a relationship with them spanning several years, including with the Director. As such, the organisation did not have staff members who fit the criteria for IMR report writers. To ensure some measure of independence, the Chair interviewed the Aanchal caseworker separately from their IMR.

THE REVIEW PROCESS

The Newham Domestic Homicide Review Panel was initially convened in on 23 September 2011 with all agencies that potentially had contact with Amolita and Duhsambada prior to the murder.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder (see appendix A) and to complete an IMR in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to

make their services more accessible. The exception to this was LB Newham Adult Services who having searched their records and found no contact, were not asked to complete an IMR since Amolita's circumstances fell outside their criteria for a response even had she come to their attention.

Each agency's report covers the following:

A chronology of interaction with the victim and/or their family;
What was done or agreed
Whether internal procedures and policies were followed
Whether staff have received sufficient training to enact their roles
Analysis of the above
Lessons learned
Recommendations

Seven IMRs and one back ground report were completed.

Four agencies responded as having had significant contact with the victim and / or perpetrator:

- Aanchal Women's Aid
- Cafcass
- Metropolitan Police Service
- NHS North East London & the City

Three of these agencies produced an IMR.

In addition, a comprehensive background report was provided by Cafcass who declined to submit a full IMR on the grounds that 'Cafcass has no statutory functions in respect of the protection of adults and is not named in the Domestic Violence, Crime and Victims Act (2004) as a body that may be directed by the Secretary of State to participate in a DHR'.[7] As such, their report contains no analysis or recommendations.

Three agencies responded as having had no contact with either the victim or the suspect or with any children involved:

- LB Newham Children's Services
- London Probation
- Newham Action Against Domestic Violence (providers of the local IDVA service)

It should be noted that LB Newham Children's Services did a full IMR with recommendations relating to events after the murder and thus outside the scope of this Review. Nevertheless, these recommendations will be implemented.

One agency responded with information indicating some level of involvement with the victim although their contact was of no relevance to the events that led to the death of the victim:

- LB Newham Housing

EQUALITY AND DIVERSITY ISSUES

[7] Letter to Chair 14.06.12

All nine protected characteristic in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have relevance to this DHR. These were:

Age: Amolita was only 19 years old when she married Duhsambada who was 16 years older than her. Duhsambada seemed to treat his wife as a child and became infuriated whenever she showed signs of independence.

Disability: Whilst not strictly a disability, many of those who had contact with Amolita commented upon her voice as being very soft and high pitched. There was some speculation from two of the interviewees that this may have been as a consequence of repeated strangulation attempts. As one said:

'I do believe that he had attempted to strangle her. I'm not a doctor of course but her voice was absolutely unique. You could tell that there was something very strange about her voice; it was very squeaky, very high pitched, as if her vocal chords had been damaged in some way.'

Another commented:

'She had a very soft voice. It was almost like her voice was constricted all the time. You had to really strain to hear her'

Information from her family suggests that Amolita was very embarrassed about her voice, feeling that it sounded like a whine. As she reported to her family, this inhibited her from speaking up, in particular in her dealings with Cafcass.

Marital status: Amolita's actions were shaped by the strong disapproval of parts of the Bengali community towards separated and divorced women.

Pregnancy: Amolita reported being assaulted whilst pregnant to both agencies and family members. This instilled in her a fear that Duhsambada was very dangerous and clearly willing to step outside social norms

Ethnicity: Both victim and perpetrator were Bengali and the existence of an Asian women's organisation was important to Amolita in assisting her to establish independence after separating from her husband albeit ultimately unsuccessful.

Nationality: The case involved family members living outside of the UK (in Bangladesh) as powerful influences on Amolita's decision making and at critical points, Duhsambada was between the two countries. Duhsambada's ability to threaten crimes against Amolita's family members abroad with no consequences for him in the UK was a powerful control strategy.

Wealth disparity: Whilst not a protected characteristic, the disparity in income between Amolita's family and Duhsambada was another significant influence on her decision making and on Duhsambada's ability to continue to intimidate and control her, even post-separation.

INVOLVEMENT OF FAMILY AND FRIENDS

In most of Amolita's agency contacts, only one specific incident or part of her life was being addressed and this gave a somewhat distorted picture of who she was as a person. From the interviews with those who knew her (including some professionals such as the school staff), a picture emerged of an entirely different person.

She was very clearly devoted to her children and played an active role at their school:

'She participated in all the family learning sessions that we run; family literacy, family numeracy, ESOL classes and she also participated in a triple P - it's a parenting programme - the power of positive parenting. And it wasn't as a result of any referral from any other agencies to support her parenting, it was a way of her actually meeting other parents, other people and getting to know what learning in schools in the UK was about'

For much of her life, Amolita put other people's needs first; her birth family, her children and her husband. She endured cruel treatment from Duhsambada from the day they were married and told family members about him drugging her, depriving her of sleep, raping her, beating her and denying her access to the outside world. There has been some suggestion that the marriage was a forced or at least a coerced one. Caught in notions of 'family honour' she struggled to be a good wife and endured his abuse but when he began also being violent towards her children, she fled with them to a refuge. From that point until her death, she tried to assert her independence and build a new life for herself. It was her most heartfelt wish that her children would go to University and be able to be independent so that they would not be compromised as she had been. She learned English, enrolled in a driving course, was studying at college and engaged in a range of activities at her children's school. But in the background, Duhsambada wasn't letting go. A three year battle over child contact wore her down and every time she made a renewed effort to break free from his control, he threatened her family members or used the children who, understandably, wanted to see him, to insinuate his way back into her life. During the interview, the children spoke of how their father wanted Amolita to stay home all of the time and did not like her engaging in activities that took her outside of the home.

There were some happier times: she watched lots of romantic films, especially big Indian blockbusters and she loved to bake. The children spoke about a happy holiday in Southend and how Amolita loved company. Asked to describe their mother they said she was kind, thoughtful and smiled at them a lot.

The children also talked about their mother asking for help from a relative who refused, about how she was forced into marriage with their father, how he swore at her, especially about going to college and how she never learned to drive because she ran out of money: 'Our Dad doesn't share his money'.

Ms X reported that Amolita always felt like the system in place was there to prove that she was lying, it was never there to prove that she was right and therefore should be protected.

Efforts were also made to meet with three other family members and a friend but all declined to participate in the Review.

METROPOLITAN POLICE (MPS)

Police records show that Duhsambada had one previous conviction for violence, when he assaulted someone at work.

Author's note: Information from the family revealed that it appeared that Duhsambada told Amolita that his conviction was for killing someone: a claim he made to frighten her into

believing that he was capable of murder and to show that he could get away with it again, as he had once before.

There are eleven police reports dealing with the victim and perpetrator. Six of these reports relate to domestic violence or threats by Duhsambada to Amolita. One relates to a report of a missing person, made by Duhsambada (shortly after she left him); one relates to a call to police by Duhsamabad's brother to report Duhsambada's distress at not being allowed to see his children, another relates to denial of access to his children and safety fears, one concerns a threat to Duhsambada made by an unknown male on his mobile phone and the last incident relates to a burglary at Address 1. There is nothing to suggest that these last two incidents are connected to the domestic violence issues.

There are three significant incidents that relate to physical domestic violence; 9 June 2004, 18 June 2005 and 16 December 2010. The other three domestic violence incidents relate to threats against either Amolita or members of her family. Amolita clearly tries to take action in dealing with her situation by calling police herself on occasions, attending advice centres for help and obtaining an injunction to prevent her husband contacting or assaulting her.

Overall, police action in relation to the reported incidents was in accordance with the policies and SOP's in force at the time with the exception of three incidents (18 July 2005, 1 March 2008 and 16 December 2010) when a CRIS report and in the latter incidents MERLIN reports should have been completed.

The MPS IMR states that it has made much progress in relation to domestic violence over the past decade. All gaps in responses have been identified and rectified prior to this DHR and the MPS are confident that practice is embedded and monitored so that in the event of similar circumstances arising, the matter would be dealt with differently, that is, to a higher standard. Efforts have also been made at a local level to improve communication between the police and Aanchaal and both parties now report a co-operative relationship with Aanchal including via the local MARAC.

The IMR contains no recommendations for the MPS.

Author's note: Separate reviews and accountability mechanisms for the MPS, such as the Greater London Assembly Police and Crime Committee and the work of the Mayor's Office of Policing and Crime (MOPAC) would suggest that their confidence in service improvements is mostly justified.

LB NEWHAM HOUSING

Records show that Amolita applied to London Borough of Newham for housing in March 2006. No risk was identified or stated in the Housing Application.

On 15 September 2009, Amolita reported a break-in into her property following the loss of her front and back door keys. Both door locks were replaced.

There were no concerns from the victim or neighbours recorded against the tenancy to suggest that Amolita may have been at risk. Housing was unaware of the history of domestic violence and in none of their subsequent contacts was there reason to suspect that this was an issue.

LB Newham Housing IMR contains no recommendations.

AANCHAL

Amolita was referred to Aanchal Women's Aid in 2006 for resettlement support. Following a stay in two refuges, Aanchal supported Amolita with welfare rights,

personal development and access to education. She was encouraged to attend events and activities such as health days and children's events.

During this time Amolita gained in confidence and was a frequent visitor at Aanchal. She began attending college three days a week and was learning to drive, having passed her theory test.

She was referred to a solicitor on April 11 2006 because she wanted an injunction for her own safety and her children's safety when in Bangladesh, as she had learned that her husband had travelled to Bangladesh after her separation, where he was harassing her family members. There were problems in obtaining the injunction as there were no grounds and there had been no recent direct contact.

Amolita continued receiving welfare rights support hereafter.

On 12 September 2006 Amolita first spoke about her concern with child contact issues. Amolita reported to Aanchal that the re-appearance of her husband in her life as a consequence of family court proceedings was a disturbance in her life again and she reported that her husband told many lies. It should be noted that Cafcass case records evidence no meetings involving both Amolita and her husband at the same time so Amolita's reports to Aanchal relate to his involvement in her life rather than his physical presence. She was angry that she was suffering again, having to make taxi journeys to transport her children to and fro in regard to supervised contact sessions. All appointments with Amolita in 2006 were regarding child contact.

Author's note: The reference above to Cafcass meetings with her husband most likely refers to observed contact sessions as ordered by the court.

On 4 August 2007 Amolita told Aanchal she was concerned that child 1 wanted her father back home. She felt she had moved forward so much and was now being drawn back because there was on-going contact with her husband.

On 17 September, Amolita was again distressed about child contact and discussed a change of solicitors and files not being transferred from the old solicitor. Throughout September there were discussions about Duhsambada taking the children back to his home, to his mother and brother, and she was very unhappy and distressed with this.

All of 2008 contact with Aanchall was regarding welfare benefits.

In February 2009, Amolita discussed with Aanchal the possibility of re-conciliation with her husband and asked what would be involved in this process. She disclosed that her husband's behaviour had improved a lot towards her and he came to collect children from home every weekend regarding contact. He was also granted overnight stay for child contact although he had not done so.

Author's note: In early December 2008 the court had ordered contact to build up gradually so that from July 2009 the children would have overnight staying contact. Handovers were to take place at the Discovery Centre and a review of the case was set down for 12 June 2009.

On 23 February her solicitors closed the case due to re-conciliation.

On 2 March 2009 Amolita told Aanchal that her husband was trying to control her and had been staying in her home. The key was given by child 1 to Duhsambada. Amolita was not happy as things were moving too fast and she could not make decisions. Aanchal suggested changing locks and making an appointment with the solicitor again. She was also advised to not allow her husband to stay overnight and to meet him only in public places.

On 3 March 2009, Aanchal spoke to the solicitors with whom Amolita was not happy. Aanchal discussed options and personal safety plans and confirmed they would step in as soon as she decided what she wanted to do. Amolita was also asked to contact Aanchal again within the next two days.

On the 5 March 2009, Amolita called into the Aanchal office and had a discussion around the dangers of allowing her husband back into the property as well as highlighting the dangers of the impact on the children and her benefits. Amolita became very angry and refused to speak about it.

There was then a gap of six months during which time Amolita did not have contact with Aanchal despite repeated efforts to contact her.

On 14 September 2009, Aanchal carried out a review with Amolita. She said that husband said he would be good and that he was not the same as before. The court was happy that they wanted to reconcile. She reported that the children were OK with him. Although Duhsambada wasn't working and did not contribute towards the house, Amolita reported that she was independent, going to college, learning English and doing all the shopping on her own, which he would not have allowed in the past. She agreed to keep in contact about benefits and any changes in the situation.

From April to September 2010 all appointments were regarding benefit checks, and small grants.

In November 2010, Amolita wanted a warning letter to be sent to her husband, to stop being aggressive towards her. She also disclosed that he was threatening to do something to her brother and mother in Bangladesh. She felt if her brother and mother were safe in Bangladesh, she would be better able to take action. She was uncertain about her husband again and said he was not happy that she was seeking educational opportunities.

She disclosed that her husband was going to Bangladesh in January 2011 and would use this time to decide what to do. Aanchal encouraged Amolita to report to police, regardless of whether she wants to take action or not.

On 25 November 2010 Amolita contacted Aanchal to discuss her situation again. She appeared frustrated and agitated because Duhsambada had started to become aggressive and suspicious of her attending college and applying for a lap top. She reported continuing threats by him towards her family and recounted a recent incident when he threw the laptop charger across the room. Amolita had asked him

to leave the property and give her his key but he had refused. Aanchal encouraged her to report to police but she did not want to because of her concerns for her family back home. On this occasion she disclosed being afraid of her husband. She again repeated that she knew he was going to Bangladesh in January 2011 which would give her time and space to think and make decisions about the future. A risk assessment was carried out.

Aanchal also suggested getting an injunction. She did not want to go back to any solicitors.

On 6 December 2010, Amolita reported an incident to Aanchal when her husband threw a cup of tea at her. It missed her and she walked out of the house. She now wanted him out of the property. Aanchal advised on contacting the police and also getting an injunction. She was unsure and asked if Aanchal could write him a warning letter or speak to him instead. Aanchal informed her that this wass something they could not do.

Amolita agreed to report to the police. Police said they would come down to Aanchal offices, which they did not do. Amolita waited till 12.30. At this point Aanchal staff took her to the local police station. They waited until 1.15pm when Amolita had to leave to collect the children from school. An officer advised that she could go to her local police station to report which Amolita agreed to do but only when the children were not with her. Aanchal wrote a statement for the client to hand to the police station on arrival.

On 21 December, the police contacted Aanchal chasing Amolita's statement and they arranged for her and a Bengali interperetor to attend Aanchal office on 23 December. Amolita was hesitant and unsure about this course of action now as matters were fine between her and husband but she still concerned that he would do something to her family.

On 23 December 2010, Aanchal called the police because they did not come as agreed. Aaanchal gave the CAD number which police did not recognise. Upon checking against Amolita's name, their system indicated that a statement had been done. Aanchal queried this as the police had been chasing Aanchal for a statement on the 21 Dec. The police called back later to say they had visited Amolita's home the previous day and taken a complete report.

Amolita called the Aanchal office on the 5th January, wanting to know how the police knew about the incident. All parties were confused. Amolita was not happy saying she wanted to make her own decisions and she had only wanted a warning letter. Amolita hung up.

Aanchal then made repeated efforts to contact Amolita with no success although she did attend six welfare rights appointments between March and June 2011.

On 14 June 2011, the Director of Aanchal spoke with Amolita when she called to make an appointment regarding tenancy issues. A short conversation took place, where Amolita was asked how things were generally for her now and how the

children were. She specifically said “Everything is good. Children are happy. Husband is OK. I am going to college and I am going to drive. Everything is OK.”

An appointment was attended on 23 June 2011 regarding threat of eviction and a follow up appointment was made for the 30 June. She did not attend.

She was last seen by an Aanchal worker a week before she was murdered, outside Newham College, where her husband was waiting for her.

Aanchal reports that all policies and procedures were correctly followed. As such there are no recommendations from Aanchal’s IMR.

Cafcass

Cafcass’ involvement in this case commenced in June 2006 and ended in December 2008. The proceedings were initiated by two applications:

- The father’s application for contact with his two daughters.
- The mother’s application for a non-molestation order.

Both parents were legally represented throughout the proceedings.

Cafcass prepared three welfare reports addressing the father’s application, the first in November 2006, the second in January 2007 and the third in November 2008.

Amolita’s statement in support of her application for a non-molestation order was provided to the court at the hearing on 12 June 2006; she made serious allegations of domestic abuse throughout the marriage starting on the wedding night. The statement provides a graphic and horrific account of abuse. The alleged abuse included beatings, strangling, occasions when she was prevented from leaving and from seeing her own mother; kicking in the stomach two months after a Caesarean Section causing her stitches to open up. She stated that she received medical attention for this in Bangladesh. She alleges that the father threatened that if she dared to tell anyone the cause of this he would not hesitate to kill her or her family. She also alleges that the father punched one of the daughters when she was crying, refusing to allow mother to breast feed her. Many of the events occurred in Bangladesh. However, many were committed following her arrival in the UK.

The statement refers to a number of occasions when the police were contacted in the UK. Around July 2005, with the help of the police she went to a refuge with the children. She then moved to another refuge, she says, on the advice of the police as they believed she was at risk of being traced by the father. Eventually the council provided her with council property which remained secret from the father.

She says that in April 2006 the police advised her that she should stay cautious as the father had returned to this country from Bangladesh. According to her statement the police were of the view that father was a dangerous character, capable of tracing the mother and of assaulting her again.

She explained that her lack of English made it difficult to communicate with professionals such as the police.

In line with guidance to courts, the court initially ordered a Finding of Fact hearing which should have taken place on 22 & 23 October 2006 and asked Cafcass to report on the

question of contact. Had the Finding of Fact hearing taken place and found Amolita's allegations to be with foundation, the court and the Family Court Adviser (FCA) would have taken these into account and different decisions about contact may have been made.

The Finding of Fact did not, however, take place. The reason for this hearing being initially vacated is not apparent but at some point a hearing was set down for 16, 17 & 18 April 2007. This hearing was also subsequently (on 3 April 2007) vacated and there is no evidence on the file that the court gave consideration to a further date for another 13 months. In the absence of the court addressing this point it would have been for the parents' legal representatives to seek directions from the court on this.

The guidance to courts provides, however, for interim contact, pending the court making Findings of Fact. Following interviews with the parents and observations of the children with their father, Cafcass' first report to the court in November 2006 advised that the children could cope with contact in a contact centre. The FCA had observed the girls to relax and engage happily with their father after their initial distress, and that the father responded appropriately and affectionately towards them. At the hearing in November 2006 the court ordered contact to take place at a contact centre which provided a high level of supervision. The court did not ask Cafcass to undertake any further work at this point.

In September 2007, the court ordered Cafcass to prepare a further report to advise the court on whether the girls should stay overnight with their father. At some time prior to this, it appears that the court had decided that that contact should be unsupervised. The girls' mother brought them to a public place (the local library) for the handover to their father.

The allocated FCA interviewed each parent individually, spoke privately to child 1 & 2 and observed a contact visit between them and their father. Amolita alleged that the father had continued to abuse and intimidate her and that the children returned from contact tired and distressed. The father denied any violence and insisted that the mother was influencing the children. The children told the FCA that they were scared of their father but could not say why.

The FCA assessed Amolita as being a vulnerable and frightened young woman who appeared intimidated by the father. Nevertheless, the FCA concluded that contact should return to the contact centre and advised the court accordingly in her report filed in November 2007. The FCA also advised that Duhsambada should attend an anger management programme[8]. Cafcass notes that in cases where domestic violence is an issue, anger management is not regarded by experts in this field as being an appropriate programme as it does not address the fundamental underlying features of such violence, i.e. that of power and control. In any event, Duhsambada's denial of violence would preclude acceptance on a domestic violence perpetrator programme. Additionally, at this time the Family Court did not have the power to compel parents to attend any programmes.

The court followed the advice of the FCA and on 25 January 2008 ordered contact to take place at the contact centre previously used and that the FCA was to observe two of these sessions. There appears to have been no consideration at this point that the Finding of Fact had not taken place.

In Amolita's further statement to the court, she opposed contact taking place. She feared that Duhsambada would discover her whereabouts. She alleged that she had been ill-served

[8] Duhsambada did enrol for a two day anger management course. According to the Tutor he did not participate and asked to be given a completion certificate at the start of day 2 which he said he needed for his solicitor. On being told that he would have to wait until the course had, in fact completed, he left and did not return.

by her solicitor and had therefore changed to a new solicitor. She also alleged that Duhsambada had obtained her landline and had called and threatened her on numerous occasions. She further alleged that the father continued to telephone and on occasion visited her family in Bangladesh, threatening them and causing them stress.

In the event the contact visits did not take place. At the next court hearing on 13 May 2008, however, although she did not withdraw her allegations of domestic abuse, Amolita agreed that she would not pursue seeking a finding of fact. The court noted that she understood that as a consequence the court may not take her allegations into account. The reasons for the Amolita's decision are not recorded.

The court ordered a further series of contact visits to take place. Again the FCA was to observe these and report to the court. Again, however, they did not take place. Amolita reported that the children were too distressed and the father's solicitor reported that he had gone to Bangladesh.

On 8 September 2008 the court again ordered a series of contact visits and ordered that the FCA should observe two of these. She observed three out of the four sessions. While the children were in the first session initially upset, clinging to their mother, with encouragement they went to their father. In subsequent sessions the children clearly enjoyed their time with their father and told the FCA that they wanted to continue doing so. They were, however, wary of having overnight contact with him. In none of the sessions was there any evidence of Duhsambada abusing or intimidating Amolita.

In the final report to the court the FCA advised that contact should gradually be extended so that by the following July the children would have overnight contact at weekends with their father. The court made an order in line with the FCA's advice and also set down a review of the case for 12 June 2009. The court did not require Cafcass to undertake any further report for this hearing.

The Cafcass report also notes that several changes in legislation and practice have been introduced in the intervening years. If the same set of circumstances arose now, they would be dealt with very differently.

As reported above, Cafcass did not submit an IMR and thus did not include any analysis or recommendations.

Nevertheless, there remain some issues of concern. Most importantly, that no referral was ever made to LB Newham Children's Services who were unaware of the domestic violence until after the murder despite the fact that Amolita moved to LB Newham at the start of Cafcass being involved with her case. The recommendation of anger management is also of concern since its contraindication in cases of domestic violence was known for some years prior to the recommendation made by the FCA. Finally, there appears to be a systemic problem with regards to the lack of questions as to why Amolita ceased to make representations for a finding of fact. It is very clearly not within the remit of the FCA to ask such questions and it is unclear whose responsibility it should be. Nevertheless, the fact remains that these representations had been made for over two years and in the Panel's view, the sudden termination should have resulted in questions being asked before the case proceeded further.
Subsequent events suggest that Amolita's experience of Cafcass undermined her trust in state agencies to help her and was probably a contributory factor to her feeling unable to continue to resist Duhsambada's efforts to insinuate his way back into her life.

NHS North East London & the City

Health provided a full chronology of their involvement with involvement with the family as detailed in the comprehensive chronology at appendix A. Key events were:

On 24 May 2006 Amolita registered herself and the children with a new GP in Newham. At the new patient interview, she reported domestic violence and asked that her information be kept confidential. She was seen again on the 9 June. She reported a history of domestic violence and that her husband was living in Camden Town. She had got married in Bangladesh in 2000 and 'since then she has been tortured physically and emotionally. She has seen doctors in Bangladesh'. Child 1 at that time had a BMI of 13.87. She weighed 12kgs (ideal weight 19kgs). Health education regarding her diet was given.

On 24 September 2007, Amolita changed GP (still within Newham).

On 17 October 2007 Amolita was prescribed amitriptyline for three weeks for stress relating to divorce proceedings. She reported that her husband had contact rights over the children. A medical certificate was provided in October 2007 as Amolita was unable to attend court due to illness.

On 20th January 2009 Amolita was prescribed oral contraception by the GP. The GP records note that she reported she was 'back with [her] husband for the sake of the children'.

In December 2009 both children were taken to the GP by their father. Dietary advice was given regarding Child 1 who was reported to be a fussy eater. Her parents were worried she was losing weight, BMI 13.7, weight 13.7kgs (ideal weight 21kgs), they were advised to bring her red book to the surgery to plot her growth and she was referred to the dietician.

On the 23 March 2010, Duhsambada attended the GP surgery, mild depression was noted using an accredited depression score.

On 19 April 2010, Child 1 failed to attend the dietician appointment. The GP was informed.

On 11 May 2010 Duhsambada registered with a new GP practice (the same one as the rest of the family) and gave his address as address 1. He saw the GP on the 7 June presenting with low mood, reporting that he had been on medication for six years, although medication (SSRI[9]) had been reduced from 30mg to 10mg. He reported that he had tried counselling in the past but that had been no help, that the depression had started due to family problems which were now settled.

Due to the mobility of the family they were invisible to health services apart from the GP.

In addition there was no liaison between GP and health visiting services following registration with any of the GPs involved. At interview, the last GP surgery the family were registered with reported that they did have a process in place for routinely informing the health visiting service of under-fives newly registering with the practice. The system does not

[9] SSRIs boost levels of a substance called serotonin in the brain. When serotonin is released it helps lift mood. Citalopram is one of the SSRIs commonly used to treat depression

appear to have worked on this occasion and this vulnerable family were not picked up by the health visiting service and therefore no support offered.

Child 1 attended the surgery with poor weight gain in June 2006 which was well below that which a child of her age would be expected to be. The GP did not consider domestic abuse as this was not flagged on her notes and therefore its impact was not considered when considering the cause of that failure to gain weight. Child 1 did appear to have a lot of minor ailments which may have contributed to poor weight gain. Failing to thrive without a medical cause can be a symptom of a child who is experiencing emotional problems and an opportunity was lost to explore the impact of the domestic violence suffered by Amolita on child 1.

It is not clear when Duhsambada re-joined the family on a permanent basis as he had an address with the HPU in Camden at the same time as Amolita reported that they were reunited. Following Duhsambada returning to the family home Amolita was not asked by the GP practice whether the domestic violence had stopped or was continuing on any of her attendances there. At interview the GPs were not aware they were the only agency involved with the family. They had also not realised that in all probability the domestic violence would be continuing or the significance of the impact of the domestic abuse on the children. One of the GPs said that at the time he had thought it was good that the parents were together and that it would be good for the children. The practice also reported that they had no clear flagging system in place for domestic violence and would be looking at how they could put one in place so that whoever the family saw would be aware.

Child 1 was taken to the doctor again with poor weight gain in November 2009 and December 2009. Psycho-social factors were discussed by the GP with Duhsambada in November 2009, but the continuation of domestic violence does not appear to have been considered. The GP reported that he was unaware of the domestic abuse at the time of the consultation.

A referral was made to the dietician following the December appointment. Neglect was not considered by the GP following the failure to attend the dietician, despite her being seen by him shortly afterwards and child 1's weight being well below the 2nd centile. She had only gained a 1.7kg in three and a half years.

Once the children stared school the school nurses followed procedures but did not consider the vulnerability of the children. This was a family new to Newham community health service and previous records were requested. However, the school nurse did not follow up or re-request records when they did not arrive. The school nurse did discuss Child 1 with the SENCO, but there is no evidence of the SENCO feeding back to the school nurse. This was a failed opportunity to pick up both the weight issues and to identify child 1 as a child who had a family history of domestic abuse which might require additional support.

Once Duhsambada returned back to the family home, domestic violence was never raised with Amolita again as the GPs were either unaware of it or thought that the abuse would have reduced or disappeared. In fact Duhsambada rang the surgery for prescriptions for Amolita reducing her access to the GP surgery and any possible intervention. Good practice would suggest that the GPs should have been pro-active in checking whether the abuse was continuing or not and whether domestic abuse was the underlying cause for some of her and the children's attendances. The introduction of a flagging system would have alerted the GPs to Amolita's history and she may well then have been asked whether the abuse was still occurring. This would also have enabled the GPs to identify surgery attendances which may have been related to domestic abuse. They would have also been less likely to correspond with her through her husband.

There was no risk assessment recorded in the GP records in relation to further violence or the impact on the children on Duhsambada's return to the family home. At interview the GPs had not realised that the family were no longer known to social services.

Children often get lost to health services when they enter refuges and it would appear this was the case in this family. Where there is a dedicated health visiting service to refuges this is less likely to happen.

Although there are clear lessons to be learnt for health staff in relation to sharing of information and risk assessment, it is unlikely that even had there been better communication between GP and health visitor, or school nurse intervention that Amolita's death could have been predicted.

Recommendations for NHS North East London & the City

The NHS North East London & the City IMR contains five recommendations:

1. Community Health Newham (East London Foundation Trust (ELFT) and GP practices need to agree a process which ensures that where children under five years of age register or deregister with a GP, the health visiting service is informed. In addition where the parent(s) are vulnerable, this information should be shared and the family discussed at practice meetings and a care plan agreed. This recommendation is a CQC/SCR requirement and is in the process of being implemented.

2. Ensure commissioning of school nursing services includes providers that have a policy in place which follows up those children not known to health services at school entry. This needs to include pro-active work with families where they do not respond to school entry health questionnaires as these will be the most vulnerable of children.

3. A rolling programme of domestic violence awareness be provided to the GP practices in Newham as part of their safeguarding training

4. Exploration with GPs as to the best way to flag women who are/have been subjected to domestic abuse on the practice IT system and also have it identified within the children's records. The new General Medical Council guidance for doctors highlights the need for family members to be linked. This is particularly important where the parents have different names and do not necessarily reside in the same house.

5. Each refuge in Newham to have a named health visitor who will be responsible for the health needs of all the families within that refuge.

2. KEY FINDINGS OF THE DHR PANEL

Amolita was married to Duhsambada for eleven years, from 2000 until the point of her death. He was violent and abusive to her from their wedding night and continued his attempts to control her even after she left him in 2005.

Amolita did engage with agencies but failed to find what she seemed to be seeking. She wanted 'back up' for her stance in refusing to be an 'obedient wife' as defined by Duhsambada. Cafcass correctly focused on the children, her solicitor focused on making his client appear 'reasonable' to the court, housing focused on supplying her with a tenancy, the police focused on evidence, health professionals focused on the clinical issues, Aanchal was

asked for an intervention that they could not provide (a warning letter to Duhsambada) and some parts of the wider Bengali community muttered to her about family 'honour'.

Author's note: All of the above agency responses prioritised statutory duties, or agency and community agendas ahead of Amolita's needs, yet with the exception of the failures to refer to Children's Services, none can be fairly categorised as 'wrong'. The statutory remit of Cafcass is to focus on the children just as it is the statutory duty of the police to focus on investigating crimes. However, without close co-ordination between agencies, no-one has a complete picture and each agency is working in silos, dealing with just one part of the picture. What it does demonstrate is the complexity of issues that require multi-agency responses: it is not simply a matter of agencies sharing information but also necessitates a refocusing of priorities if interventions are to be truly holistic and effective.

As a consequence of agencies not responding holistically, and strengthened by Duhsambada's threats to her family abroad, Amolita never found the kind of help she wanted. Even with the benefit of hindsight, it is hard to see how this might have been achieved although it is possible that had each of the statutory agencies probed a little more and made her feel less judged, which is what she reported to her family, Amolita may have felt supported enough to pursue courses of action (injunctions, police reports etc) that she had came to doubt in terms of their effectiveness.

3. CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

There no words more poignant than those written by Ms X:

Blackmailed into marriage (he was rich, she was poor; he had friends in high places, her widower mother had no one and a large family to support), she was married in Bangladesh, brought to England, and abused from the day of her wedding. Enduring daily beatings, rape and broken ribs, it was only when her husband raised his hands against her daughters that she found the willpower to ignore the sometimes suffocating burden of 'family honour' and finally escape. From the day she entered the police station with her three words of English to the moment she breathed her last, she tried everything she could to secure three things: a divorce, sole custody of her children and acceptance in her community.

She died unable to accomplish even one of these goals. For to divorce a man who wants to 'keep' you, and is rich enough to secure the best lawyers, one needs money (and legal aid, now demolished, is rarely enough). Nor did she have deep enough scars to convince the social workers or the judge in her custody trial of the dangers posed by the father towards her children. On top of all this, [Amolita] had to further ignore the sneers of distant family members or strangers in her community who felt they had every right to judge her for daring to 'leave' her husband.

LESSONS LEARNED

Risk identification

This case demonstrates, as many others before it, that leaving an abuser and having disputes over child contact are key risk factors for homicide. It also confirms research showing that the victim's assessment of the level of danger she faces is the most accurate[10]:

[10] Battered Women's Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Reassault D. Alex Heckert and Edward W. Gondolf (2004)

Amolita reportedly told family members that Duhsambada would kill her and he did. A further issue which should have been recognised, but was not, was the longevity of the abuse. Seven years after leaving the relationship, Amolita was still being harassed by Duhsambada. This level of persistence should have been a warning sign.

Appropriate services

Amolita did not seem to trust state agencies but she had a long and mostly open relationship with Aanchal. This demonstrates the importance of specialist domestic violence services which are focused on providing a service to women from specific communities or ethnic groups; a type of provision that is rapidly disappearing as the public sector budgets shrink. Already Aanchal reports that their service design has been influenced by funders so that they can now only provide advice and advocacy support that is no longer supplemented by recreational and community activities. This provision used to help women to form new social networks, rebuild their lives and resist community stigma.

It is possible, based on knowledge of community norms and some of the threats made by him, that Duhsambada feared losing his standing within the Bengali community if he appeared as a man who could not control his wife. Initiatives to challenge such beliefs – which extend far beyond parts of the Bengali community – are much needed.

Child contact

More than any other issue, this is the one where there was the most variety of opinions.

For example:

Amolita's solicitor: 'I realised she was starting to lose credibility with the court because instead of bringing up things that *mattered, s*he was for some reason which I can never quite work out, focused on things that were trivial like the point for the hand-over of the children. She wanted it to be near her home and he lived some distance away and wanted it to be near his home and it was little things like that which tended to reduce her credibility with the court.

Amolita's caseworker: 'Child contact was holding her back. She knew his personality and at one point she did say that he sits at the Cafcass meeting and he tells *lies* and no one believes me but in the end she felt compromised and in a situation where she, no matter what happened, had to allow child contact. So she was distressed for nearly a year around those issues but there was no way out. She came, I think, she just came to a point of acceptance because she felt 'I can't fight'.

Ms X: 'My mum accompanied my aunt to the courts so many times and I remember one case my mum came home crying and I said what's wrong and she goes the judge has actually called Amolita a stupid woman for her fears of being killed. She actually warned the judge 'if you let him see the kids then that will be the end of me' and the judge said to her 'don't be a silly woman'.'

Cafcass: 'The contact centre supervising the father's contact provided detailed reports on each of the seven sessions that took place. These were provided to Cafcass. Some aspects of the father's attitudes and behaviour (e.g. asking the girls if they wanted to go to his house and who loved them more; requesting to take the girls outside of the centre contrary to the court order) may have been evidence of a manipulative personality. His unwillingness to share the cost of the mother's transport could also have been a sign of attempts to control the mother. Otherwise, the centre reported no evidence that the father attempted to intimidate or harass the mother.'

Amolita reported to both Aanchal and Ms X that she did not feel that Cafcass believed her version of events and seemed unconcerned at the ways in which Duhsambada was using child contact to exert control over her. Cafcass would like to make it clear that whilst they accept this was Amolita's view, it does not accord with theirs.

Communication and clarity of roles and responsibilities between agencies

As detailed above, the events of December 2010 are disputed between the police and Aanchal. Whilst it is unlikely that the confusion affected the course of events in this case, it does highlight how clear communication between agencies is essential to prevent clients losing faith or 'falling through the net'. Communication could also be improved both internally to NHS North East London & the City and there is clearly a need for more GP education about the dynamics of abuse.

Of particular concern is the lack of referrals by any agency to LB Newham Children's Services. When interviewed after the murder, Child 1 described the way that her father treated her mother as 'torture'; a shocking word for a nine year old to use. Four agencies in contact with Amolita failed to notify LB Newham Children's Services that the children were at risk of significant harm.

Community knowledge and views

Ms X and her mother provided much support to Amolita and her children but did not themselves know how to resolve the issues she faced. In addition, parts of the Bengali community shunned Amolita for being separated from her husband. Individual and collective notions of 'honour' impact on women's safety and decision-making and the existence and propagation of such concepts allows violence and abuse to continue with impunity. Work is thus needed at a community level to challenge these ideas, although it should be noted that they are not exclusive to the Bengali community or indeed views held by all Bengalis.

In the UK there has been much emphasis on improving agency responses which is, of course, essential. Much less attention has been paid to improving the awareness and understanding of the general public, or in ensuring that supportive friends and family members have the knowledge about where to find appropriate help.

GOOD PRACTICE

During the interview with the school attended by child 1 & 2, two areas of good practice emerged that deserve highlighting although one falls outside the scope of the review.

The first example is that during the registering of any new child at the school, the parent is asked for details of all adults who are permitted to have contact with the child and also if there are any adults who are not permitted to have contact. They make it clear that in situations of domestic violence, the school will do everything they can to protect the children and refuse permission for all adults to remove a child if it is someone no staff member recognises. When Amolita registered her children, this created 'permission' for her to disclose that she had moved to LB Newham as she was escaping domestic violence.

The second example concerns the school's response after the murder. The teachers pro-actively made contact with the parents of the friends of child 1 & 2 to let them know that that their child was supporting child 1 or 2. Flexibility was permitted with regard to the timetable to allow child 1 & 2 to spend additional time with their friends. This created a sense of safety and support for child 1 & 2 and this thoughtful practice is to be commended.

RECOMMENDATIONS

In addition to those proposed by individual agencies, the panel agreed the following:

1. All agencies to have basic domestic violence awareness training, supplemented by multi-agency training for relevant staff that includes an awareness of risk factors.

2. Raise community awareness of domestic violence to:

    - Ensure that concerned friends and family members have an awareness of where to go for help
    - Challenge myths and stereotypes about domestic violence

3. All agencies to review their referral processes for children at risk of significant harm

4. The Panel originally wanted to recommend the following for Cafcass:

Where there are allegations of current domestic violence and disputes over child contact, the local Children's Services should be routinely notified.

However, Cafcass rejected this recommendation stating:

We did, in fact, do that as a matter of policy for a period of time but stopped. We receive over 45K private law applications per year. Domestic violence is a feature of about one half of these. Sending approximately 22K notifications to Children's Services per annum is not seen as good safeguarding practice by either us or Children's Services. Our child protection policy therefore directs staff to make child protection referrals to Children's Services where our information (including that derived from domestic violence) suggests that a child is suffering, or likely to suffer, significant harm (Children Act 1989).

Consequently the Panel, specifically supported by LB Newham Children's Services, would now like to recommend that the Government take up this issue nationally.

5. Government: Cafcass be made a statutory partner for DHRs, similar to their role in local safeguarding procedures.

6. Commissioners: Ensure that domestic violence provision in the locality is not solely focused on risk but also offers opportunities for early intervention and counselling / resettlement support. Commissioners should also take account of the specialist nature of this work which is not easily replicated in generic provision.

7. LB Newham Housing: When applicants are referred from another Borough, routine screening of domestic violence should be done.

8. Explore ways in which solicitors might be included within local partnerships

9. Police: When undertaking risk assessments, officers should ask for a history of abuse.

10. LB Newham Adult Services to consider referral pathways / contract management of Floating Support Service to ensure vulnerable women like Amolita do not fall through the gaps in provision.

11. Schools to share domestic violence information with health. The school should have raised their knowledge of domestic violence history, especially when they knew Duhsambada was once again residing with Amolita.

12. The family wished to recommend some form of action or policy which could address the issue of perpetrators abusing extended family members living abroad. Whilst they accept that no country has resources enough to undertake extensive investigations overseas, they felt that agencies would have taken Amolita a lot more seriously had she felt able to report these 'overseas' incidents to them openly and that Duhsambada may not have progressed to murder if police / agencies had begun to question him about them and warn him against any further such actions.

This is clearly beyond the authority of Newham CSP but the Panel would thus recommend that Government explore this at a national level to explore the possibilities that may exist to move towards this outcome.

An action plan for taking forward these recommendations can be found at appendix B.

WAS THIS HOMICIDE PREVENTABLE?

There is no immediately obvious point at which the homicide could have been clearly prevented in that there was no agency which did not fulfil its remit or follow its policy with the exception of referrals to LB Newham Children's Services as described in this report.

Nevertheless, it is easy to see how the protracted battle over child contact wore Amolita down and undermined her trust in the 'system' to protect her and her children, potentially deterring her from seeking further help.

It is also possible that had Children's Social Services been notified by either health professionals, Cafcass, Police or Aanchal, that Amolita and her children may have received the support she needed.

The Panel also concluded that the focus on high risk in recent years has inhibited the development of multi-agency work for 'lower' risk victims. It is hoped that the nascent Domestic Violence Champions project will provide more opportunities for professionals to informally create opportunities for intervention with victims not currently attracting a high risk rating.

This case highlights the unacceptable pressures placed on Amolita by some members of the community linked to individual and collective notions of 'honour' which then impacts on women's decision-making and places women's lives at greater risk. The circumstances of this death highlight the critical need to carry out work on a community level to challenge attitudes that allow violence to persist with impunity. In the desire to uphold notions of family 'honour', a woman is dead, a man jailed for life and two children will now grow up without either parent as part of their lives.

The Panel wishes to express its condolences to the children, family members and friends of Amolita. May she rest in peace.

3. Domestic Homicide Action Plan

Recommendation	Action	By when	Lead Officer
ELFT CHN / GP practices agree and implement the sharing of information in relation to newly registered/deregistered children under 5 years of age	ELFT/NELC continue their current work to agree a process and implement across Newham	December 2012	Head Children, Young People and Women's services/ NHS NELC
ELFT CHN Put in place an action plan to ensure that children who transfer in to Newham are visited and previous records requested within 5 days of being notified, if family is of concern. Universal pathway transfer in visit to be completed within 28 days of notification. This latter timescale to be reviewed once health visiting numbers increase.	Recirculate "Transfer in Pathway – Health Visiting (August 2011)" and "Procedure for action with regards to no access visits, failed contact and refusal of services (Health Visiting and School Nursing) –March 2011)	31st October 2012	General Manager & Lead Nurse, Services for Children & Young People
School nurses have a policy in place which follows up those children not known to health services at school entry. This needs to include pro-active work with families where they do not respond to school entry health questionnaires as these will be the most vulnerable of children.	Complete draft for consultation in respect of reviewing 4year questionnaire and school entry assessments at 5 to 5½ years protocols including section on failure to respond within 2 weeks with liaison with school and GP and SW if child has a CP or CIN plan. Implement agreed procedure.	30th November 2012 May 2013	General Manager & Lead Nurse, Services for Children & Young People
Exploration with GPs as to the best way to flag women who are/have been subjected to domestic abuse on the practice IT system and also have it identified within the children's records. The new GMC guidance for doctors	The lead GP for safeguarding children identifies the best way to flag families affected by DV within GP surgeries and implements this across Newham	April 2013	GP clinical lead

highlights the need for family members to be linked. This is particularly important where the parents have different names and do not necessarily reside in the same house.			
A rolling programme of DV awareness be provided to the GP practices in Newham as part of their safeguarding training	GPs receive training about domestic abuse and the impact on children as part of their child protection training	April 2013	GP clinical lead
Each refuge in Newham to have a named health visitor who will be responsible for the health needs of all the families within that refuge.	Produce a list of which refuge is covered by which health visiting team and identify named health visitors for the refuge to contact	30th November 2012	General Manager & Lead Nurse, Services for Children & Young People
All agencies to have basic domestic violence awareness training, supplemented by multi-agency training for relevant staff that includes an awareness of risk factors.	Develop and implement training programme	December 2013	LB Newham Domestic & Sexual Violence Strategic Board
Raise community awareness of domestic violence to: • Ensure that concerned friends and family members have an awareness of where to go for help • Challenge myths and stereotypes about domestic violence	Develop and implement community awareness programme building on the work already undertaken by NAADV	December 2013	LB Newham Domestic & Sexual Violence Strategic Board
All agencies to review their referral processes for children at risk of significant harm	Agree and implement a review process	July 2013	LB Newham Domestic & Sexual Violence Strategic Board

Ensure that domestic violence provision in the locality is not solely focused on risk but also offers opportunities for early intervention and counselling / resettlement support.	To be included as part of the new DV/SV strategy for LB Newham	November 2012	LB Newham Domestic & Sexual Violence Strategic Board
To lobby Government for: • Inclusion of Cafcass as an agency with a duty to participate in a DHR • A change in national policy to require referral of cases involving domestic violence to the local Children's Services • An exploration of how to better respond to abusers that threaten and / or assault family members living abroad as a way to control their victim in the UK	To formally write to the Home Office raising these issues as part of the DHR guidance Review	February 2013	LB Newham Domestic & Sexual Violence Strategic Board
When applicants are referred from another Borough, routine screening of domestic violence should be done.	Develop and implement new procedure	April 2013	LB Newham Housing
Explore ways in which solicitors might be included within local partnerships	Incorporated into the work plan of the new LB Newham DV / SV strategy	July 2013	LB Newham Domestic & Sexual Violence Strategic Board
Officers should ask for a history of abuse when undertaking risk assessments.	Implement new procedure	February 2013	Metropolitan Police

Consider referral pathways / contract management of Floating Support Service to ensure vulnerable women like Amolita do not fall through the gaps in provision.	To be incorporated into next commissioning process	April 2013	LB Newham Adult Services
Schools to share domestic violence information with health.	Develop information sharing protocol for schools	April 2013	Head Children, Young People and Women's services/ NHS NELC

4. Quality Assurance from the Home Office

Home Office

Violent Crime Unit
2 Marsham Street
London
SW1P 4DF

T 020 7035 4848
F 020 7035 4745
www.homeoffice.gov.uk

Ms Kelly Simmons
Domestic Violence Co-ordinator (Safer Newham Partnerships)
Enforcement and Safety Division
London Borough of Newham
Newham Dockside
1000 Dockside Road
London
E16 2QU

30 July 2013

Dear Ms Simmons,

Thank you for submitting the Domestic Homicide Review (DHR) report from Newham to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in July.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report, executive summary and the Action Plan. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on the clear efforts made to engage the family and to bring out the victim's perspective in this report. The Panel also welcomed the care and consideration shown towards the children through your decision to attach a copy of the DHR report to the Children's Social Care records, so they may access it in later years if they wish to do so.

There were some issues that the Panel felt might benefit from more detail and/or analysis, and which you may wish to consider before you publish the final report:

- proof reading the report again for factual errors such as the different dates of birth for the children in the table in the overview report and the executive summary, and the summary of the case and chronology. It may help to reduce the risk of identification by stating ages rather than dates of birth;

- more analysis regarding the missed opportunities for multi-agency working, as the report noted that there had been silo working, and that there was a lack of close co-ordination between the agencies. For example, was there any occasion when a referral should have been made to MARAC?;
- including some text to address the fact that no relevant agency in this case, appeared to have identified or taken action on the "Honour" – based violence aspect to this case and to consider including a relevant recommendation; and,
- further information on the contribution made by the BME expert.

The QA Panel noted the national recommendation to make CAFCASS a statutory partner for DHRs and will consider this further with the Department for Education.

The QA Panel also noted the recommendation relating to work to address perpetrators abusing family members overseas. This issue will be raised with the Vulnerable Groups Working Group and the Foreign & Commonwealth Office.

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Thank you.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel
Head of the Violent Crime Unit

Home Office

Violent Crime Unit
2 Marsham Street
London
SW1P 4DF

T 020 7035 4848
F 020 7035 4745
www.homeoffice.gov.uk

Ms Kelly Simmons
Domestic Violence Co-ordinator (Safer Newham Partnerships)
Enforcement and Safety Division
London Borough of Newham
Newham Dockside
1000 Dockside Road
London
E16 2QU

04 September 2013

Dear Ms Simmons,

On 30 July I wrote to you to confirm that the Home Office Quality Assurance (QA) Panel had assessed your report as adequate and that it could be published.

I asked that you consider some issues before publication. Thank you for confirming that there was not an "honour" – based violence aspect to this case.

Please could you include this letter as an appendix to the report when it is published.

Thank you.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel
Head of the Violent Crime Unit