DOMESTIC HOMICIDE REVIEW

REPORT INTO THE DEATH OF ADULT "S"

Date of death 29th April 2012

Report produced by Kathryn Shaw

ACKNOWLEDGEMENTS

Bradford Community Safety Partnership and the Domestic Homicide Review (DHR) Panel would like to acknowledge the enormous impact for family members; and the difficulties of professional involvement and formal proceedings at a time of personal grief and loss.

This Domestic Homicide Overview Report would not have been possible without the contribution from the family, and co-operation and information supplied to the DHR Panel by those invited to contribute through Individual Management Reviews.

This report reflects the contributions of the family and views of the DHR Panel who have invested their time, commitment and expertise throughout this process. The Panel and Overview Author also benefitted from the input and professional support provided by the Domestic Violence Manager: Safer Communities.

FAMILY STATEMENT

I am the mother of Samina who was taken from us on the 29 April 2012. Although Samina was taken in such a cruel and horrific way, I feel no bitterness towards the perpetrator. He took Samina but he can never take away all the memories that her family had with her. Samina's birthday was 30 October. Two of those have passed without her and although she has roses every week next to her picture and a candle to light her way, no-one will know what I would give to have one more minute with her or to just talk to her on the phone; her number is there on my phone. She left three beautiful girls and sisters and a brother, all with the memories of her. With this in mind, I do not forget and hope that Samina will not be forgotten. I hope in my heart that no other mother or family go through this. You find strength and the ability to carry on for your loved one. They have to have a voice as no-one else can speak for them; only the ones left behind; we are the ones that can speak for them. They must not be forgotten and all the services must learn from all the mistakes made and admit to the mistakes no matter how small; the answers mean so much to the loved one's left behind. This is not to apportion blame or point the finger at any one department or service. Just give the answers to the questions that we ask as life is precious and we need as much information as we can get. As the curriculum states; every young person should learn English and Maths. But, we should be teaching the latter to respect and to honour each other. Relationships should be taught from a young age both at home and in school. Let's make a difference. Now, and in the future.

Date of statement: March 2015

The involvement of Samina's Mum and through her the comments and questions raised by other family members have been invaluable in this process in helping to understand Samina, and also alerting the Panel to additional questions to be asked. The Overview Panel is very grateful for this contribution.

REPORT SUMMARY

This Report Summary provides an overview of the key points outlined in detail in the full Overview Report.

Bradford is a metropolitan borough of West Yorkshire and has the youngest and fastest growing population outside London; and has the fourth largest population in England after Birmingham, Sheffield and Leeds; with an estimated 526,000 people living in the area. Bradford Observatory hosts the 2011 Census data for Bradford City Council[1] and this reflects the ethnic diversity of the city with the ethnic minority population representing one-third of the total population of Bradford.

1. The Review Process

All names in this report have been anonymised for publication and dissemination. The family have chosen the names for their daughter and her children.

This summary outlines the process undertaken by Bradford Domestic Homicide Review (DHR) Overview Panel in reviewing the murder of *Samina* a resident of Bradford in West Yorkshire prior to her death on 29th April 2012.

The scope of the review will consider agency responses, contact and involvement with "*Samina*" and her partner "*Harsha*" from 1st January 2010 to 29th April 2012.

1.1. Decision to undertake a Domestic Homicide Review (DHR)

West Yorkshire Police notified Bradford Community Safety Partnership of the death of Samina, they considered the information available in this case and as the death meets the definition of a domestic homicide as set out in the Domestic Violence, Crime and Victims Act 2004 agreed that:

- a DHR would be undertaken

[1] https://bradobservatory.files.wordpress.com/2014/06/geographies-of-diversity-bfd-jun14.pdf

- the death did not require consideration of a Serious Case Review and there were no contra indications to undertaking a DHR

All relevant agencies were contacted in a request for initial information relating to contact with the deceased and her partner, and informed of the requirement to secure any records relating to the homicide against loss and interference. The Home Office was notified of the intention to hold a DHR on 16th May 2012.

1.2. Disclosure and criminal proceedings

The statutory guidance states that all material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the Police Senior Investigating Officer and disclosure officer to assess whether it is relevant to the criminal case (DHR Guidance 2013: 88.p23).

Inquests will in most cases remain adjourned whilst criminal proceedings are being considered, to ensure that any evidence heard cannot prejudice any future trial. The Coroner can resume an inquest following the conclusion of criminal proceedings if questions remain relating to the circumstances of the death which in his or her opinion need to be explored. In this case, the inquest opened on 24th July 2012 and has not been resumed. The partner of the deceased was arrested and charged with the murder of Samina on 17th October 2012. He was convicted of her murder at Bradford Crown Court, and sentenced to life imprisonment to serve a minimum of 20 years.

1.3. Agencies participating in this review

The initial scoping enquiry asked agencies to identify if there had been any contact with either Samina and her children, or Harsha from the 1st January 2010 to 29th April 2012 and if so in what capacity. The following agencies responded with information indicating some level of involvement and were asked to provide an Individual Management Review (IMR) and a detailed chronological account of their contact during the time period under review.

All IMR authors confirmed they were independent of the line management and delivery of identified services:

- City of Bradford Metropolitan District Council: Children's Social Care
- Bradford District NHS Care Trust (school nursing service)
- Bradford District Care Trust (NHS)
- City of Bradford Metropolitan District Council: Education and Learning (schools)

- City of Bradford Metropolitan District Council: Housing
- General Practitioner (GP)
- West Yorkshire Police

1.4. DHR Panel

The DHR Panel consisted of members who were senior managers nominated by their agency with no previous involvement in the case, and with enough authority to effect change in their own agency. The Panel and appointed Chair agreed the terms of reference and their responsibility to look openly and critically at individual and agency practice; to see whether this DHR indicates that changes could and should be made and if so, to identify how those changes will be brought about.

DHR Panel

Panel membership: some agencies have been reconfigured or renamed during the completion of this report. This information reflects the organisation as it is known at the date of this Overview report.

Role of agency representative	Agency represented
Independent Overview Author Safeguarding Consultant and Trainer	Self employed
Domestic Violence Manager	Bradford Metropolitan District Council: Safer Communities (from 2013)
Superintendant	West Yorkshire Police
Senior Housing Officer	Bradford Metropolitan District Council: Housing
Senior Probation Officer	West Yorkshire Probation Service (became National Probation Service from 1st June 2014)
Senior Service Manager	Bradford Children's Social Care
Board Manager	Bradford Safeguarding Children Board
Head of Equality and Diversity	Bradford District Care Trust (NHS) became NHS Foundation Trust in 2015
Designated Nurse Safeguarding Children	NHS Bradford Airedale (became Bradford City, Bradford Districts Airedale, Wharfedale and Craven CCGs)
Safeguarding Service Manager	Bradford District Care Trust (became Bradford District Care Foundation Trust)

The original Independent Chair and Overview Report Author was commissioned by Bradford Community Safety Partnership on 30th July 2012 but unfortunately had to resign due to ill

health in January 2013; a second Independent Chair and Overview Report Author was appointed later that month. A decision was made by the Community Safety Partnership to commission a new Overview Report in December 2014 due to unresolved differences between the appointed Chair and the Review Panel.

A third Independent Overview Report Author was commissioned to complete the Overview Report on 19th December 2014. The current author has had no involvement in this DHR process prior to December 2014; is not employed by any organisations involved in the DHR and has no responsibility for delivery of identified services in Bradford or management of any individual mentioned in the report.

2. Key themes and Conclusions arising from this Review

- Using evidence from DHR analysis, chronology of agency involvement and Individual agency Management Reviews

This review began on 16th May 2012 and was concluded in January 2016. The guidance indicates that reviews including the Overview Report should be completed where possible within six months of the commencement of the review. Bradford Community Safety Partnership is particularly mindful of the impact of any delays on family members. In this case the family expressed their view that they recognised the importance of taking the time required to complete an accurate and comprehensive report, and individual agencies have progressed their action plans. There have been a number of factors contributing to this delay which is discussed further in the report.

The Panel concluded that the death of Samina could not have been accurately predicted. There is no evidence that the action from any individual or agency failed to protect her, but the review does highlight areas where improvements to practice can and should be made. This is explored further in the terms of reference, and relevant learning has been detailed in agency reviews and the DHR analysis.

The Panel identified that the DHR provided a collective overview which was not available to single agencies involved with Samina at the time. The reflective process of the DHR has identified areas of improvement which individual agencies have progressed through their action plans; these are detailed in Panel Recommendations and Agency Recommendations, in section 7 of this report.

Relevant disclosures of domestic violence between Samina and Harsha were limited to one incident in November 2011 when Samina telephoned the police to report that Harsha had made threats to her and the children and caused criminal damage, she suspected Harsha had broken a window in the door. When a police officer arrived at the address after the call Samina had changed her mind and did not want to make a report, and felt this had been resolved as Harsha had apologised. Aspects of this police response were not compliant with expected standards of practice, and this has been addressed individually and in agency recommendations.

There were no other warning signs or indicators of risk identified in Samina's contact with other agencies. The absence of more in depth disclosures limited the opportunity for professionals coming in contact with the family to consider effective risk management, or to respond to potential personal impact of violence and abuse.

Agencies involved with the family generally knew there had been verbal confrontations with Samina and her ex partner over contact and residence of the children, but information was not enough to indicate that her current partner, Harsha, was an on-going risk to her or her children. The Panel agree that agency contact with Samina highlighted areas where service providers should and will learn lessons and improve practice; although there is the risk that this assessment is partially based on hindsight.

Following the police investigation, information became known at Court of historical violent behaviour from Harsha to Samina. There was no evidence that she shared this information with family members, friends or colleagues. However information was known to the Police about the alleged incident in November 2011 as described above (Para 1).

There is no evidence that Samina felt unable to report concerns or seek help from agencies, but the terms of reference explore where potential barriers may have been a contributing factor. What is known from Harsha's previous history is that he had the potential for violent and unpredictable behaviour; what is unclear is how far and to what extent this behaviour impacted on his relationship with Samina and her children, and how this contributed to events leading up to her death in April 2012.

The DHR provided the opportunity to reflect on current training provision and the skills practitioners need in order to develop and deliver effective services in Bradford. Agencies will be supported to ensure that practitioners are applying routine or targeted enquiry where appropriate, and know how and where to access relevant training and support.

Recommendations reflect the key learning points from this DHR to ensure that the impact and indicators for children and young people witnessing and living with domestic violence are fully addressed in training, and training also reflect the diversity of families in Bradford. This should include the specific issues for children of dual heritage/mixed parentage, and the role of services in addressing these needs.

There is no evidence in this DHR that agency policies, procedures or practitioner responses prevented Samina or her family receiving services as a result of their ethnic, cultural, linguistic and religious identity; or that any other relevant equality or diversity issues were identified as defined in the guidance for the Equality Act (2010). Bradford has been identified as an area with expertise and experience in delivering culturally sensitive services (Maps of Gaps 2, 2009). The DHR process has provided an opportunity to consider how this is collectively promoted and how standardised and consistent practice is delivered. There was little evidence from agency reviews to support specific stated intent and practice relating to meeting the individual needs of this family, and this has been addressed in the recommendations.

The safety, physical and emotional wellbeing of children is an essential consideration for all those making decisions in cases of domestic violence and abuse. There is a significant body of research which identifies the devastating effect of living with abuse, and the Adoption and Children Act (2002) extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic violence can have serious implications for children's development. There is no evidence that any of the children reported domestic abuse to any member of their family, or to any professional prior to the police investigation. No child protection or safeguarding concerns were identified as a result of this Domestic Homicide Review.

Potential missed opportunities to offer intervention were identified in agency IMRs and are detailed in the DHR; relevant practice recommendations have been implemented as a means to improve service delivery. The DHR identified potential areas where joined up working and sharing information could be improved; these are addressed in agency and Panel recommendations. Although there have been substantive changes in organisations and DHR systems since the events surrounding the death of Samina in 2012, Bradford Community Safety Partnership will fulfil the purpose of this DHR and act on identified lessons learned to improve service responses to domestic violence and abuse victims and their children.

BRADFORD DOMESTIC HOMICIDE REVIEW (DHR) PANEL

CONCLUDING REPORT

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1.0. INTRODUCTION

This section outlines a summary of the process undertaken by the Domestic Homicide Review (DHR) Panel.

1.1. Statutory Requirement for a Domestic Homicide Review (DHR)

All names in this report have been anonymised for publication and dissemination. The family have chosen the names for their daughter and her children.

This report of a Domestic Homicide Review (DHR) examines agency responses following the murder of "*Samina*" a resident of Bradford in West Yorkshire prior to her death on 29th April 2012.

The requirement for Bradford Community Safety Partnership to conduct a Domestic Homicide Review is detailed in current statutory guidance from the Home Office (2013) *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews.*[2]

This was issued as statutory guidance under section 9 (3) of the Domestic Violence, Crime and Victims Act (2004); and this provision came into force on 13th April 2011. The updated guidance document for the conduct of domestic homicide reviews was published on 26th June 2013 and has been used for the relevant points of reference in this Overview Report.

The key purpose for undertaking a Domestic Homicide Review (DHR), as identified in the statutory guidance, is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. DHRs are a vital source of information to inform national and local policy and practice. In Bradford all involved agencies have a responsibility to identify and disseminate common themes and trends, and act on any identified lessons to improve professional practice and our safeguarding responses. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

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[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.2. Decision to undertake a DHR

West Yorkshire Police notified Bradford Community Safety Partnership of the death of Samina who died on 29th April 2012. A decision was made that a DHR should be undertaken and the Home Office was notified on 16th May 2012. The grounds for doing so were based on the information available at the time, and that the following criteria for undertaking a Domestic Homicide Review (DHR) were met:

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

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

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

(Domestic Violence Crime and Victims Act 2004, s9:3)

All relevant agencies were contacted in a “scoping” request for initial information relating to contact with the deceased, her children and partner which asked agencies to identify if there had been any contact with either Samina or Harsha from 1st January 2010 to 29th April 2012 and if so in what capacity. Those agencies who responded with information indicating some level of involvement were asked to provide an Individual Management Review (IMR) and a detailed chronological account of their contact during the time period under review. All agencies were asked to confirm that their records were appropriately secured.

An Independent Chair/Overview Report Author was appointed to write the Overview Report and chair the Panel meetings; terms of reference were agreed collectively. This was only the second DHR undertaken in Bradford and the process has evolved and changed since this time. All DHRs conducted on behalf of the Bradford Community Safety Partnership include specific Terms of Reference relating to the children where appropriate, which have been agreed by the Bradford Safeguarding Children Board.

1.3. Timescales

- Reports

The Panel approved the proposed time period for IMR authors as requiring a detailed Chronology and IMR analysis from 1st January 2010 to 29th April 2012.

Authors were also asked to consider and include any other incidents of significance, history or background outside of this timescale, to inform understanding of the events leading to her death.

- Process

This review began on 16th May 2012 and was concluded in January 2016. The statutory guidance indicates that reviews including the Overview Report should be completed where possible within six months of the commencement of the review (DHR guidance 2013: 42). Bradford Community Safety Partnership is particularly mindful of the impact of any delays on family members. In this case the family also expressed their view that they recognised the importance of taking the time required to complete an accurate and comprehensive report. There have been various contributing factors, and a full timeline of relevant information has been compiled for the Home Office by Bradford Metropolitan District Council's Domestic Violence Manager.

To summarise the key points: the first Independent Chair and Overview Report Writer was commissioned by Bradford Community Safety Partnership on 30th July 2012 but unfortunately had to resign due to ill heath in January 2013; a second Independent Chair and Overview Report Writer was appointed later that month.

The Panel met in May 2013 to discuss issues raised by family members and as a result requests for further information were forwarded to IMR authors and responses collated by the Chair. In November 2013 Samina's family requested a meeting with West Yorkshire Police, and a meeting was arranged with the police, an advocate and the family in January 2014.

In February 2014 the Panel met to discuss a potential breach of confidentiality relating to the principle of Individual Management Reviews being shared with family members. Legal advice was sought by the Panel, and a letter sent to the Home Office for clarification in relation to the process. In March the Home Office were informed of a delay; and the first draft Overview report was received from the Chair in June 2014. A response was received from the Home Office in September 2014.

Due to unresolved differences between the appointed Chair and the Review Panel a decision was made by the Community Safety Partnership to commission a new Overview Report in December 2014. A third Independent Overview Report Author was commissioned to complete the Overview Report on 19th December 2014; with contracts and material to begin this process received in January 2015. A total of eleven Panel meetings were undertaken during the DHR process with the final meeting on 12th August 2015. Learning events which include an offer to family members will be co-ordinated once the report is published.

There has been the opportunity to improve and develop systems since this DHR started in 2012, and this has continued to be a focus for discussion at a strategic and operational level. This is discussed further in "learning lessons".

1.4. Confidentiality

In all cases the Overview Report and Executive Summary should be suitably anonymised and made publicly available.
(DHR guidance 2013: 74)

Bradford Community Safety Partnership is following the Home Office DHR guidance in publishing a Public/Executive Summary and Overview Report which are anonymised in order to protect the identity of the deceased and family members. All members of the family are referred to through fictitious names rather than initials; the family have chosen the names for their family members. The report has identified professionals and other individuals through job titles in order to comply with these principles of confidentiality and the Data Protection Act (1998).

The detailed findings of each individual management review (IMR) are confidential and will not be published, but relevant points are summarised in this report. Each IMR has been fully discussed with the DHR Panel; and identified issues have been shared within their own agency to form recommendations and action plans where appropriate. Identified action has been undertaken at the point of completing the IMR, and is not delayed by the publication of the Overview Report. The Overview Report may be subject to Home Office approved redaction[3] before publication.

[3] There may be editing or revisions made by the Home Office

- Dissemination

The findings of the review are regarded as 'Restricted' until the agreed date of publication. Any other appropriate sharing of information would be agreed by the DHR Panel.

The final Overview Report and summary document will be formally presented to the Bradford Community Partnership who will give final approval for the Overview Report. The family will be given a copy of the final full Overview Report, and the report will also be circulated to the agencies represented in the DHR. The DHR Overview Report will not be published or disseminated until directed to do so by the Home Office Quality Assurance Group; once agreed the Overview Report and Executive Summary will be published on the Bradford Metropolitan District Council website; www.bradford.gov.uk.

Subsequent learning from this DHR will be disseminated to the local MARAC, Domestic and Sexual Violence Strategic Board, Bradford Safeguarding Children Board, Bradford Safeguarding Adults Board and relevant commissioners of services (DHR Guidance 2013: 100). The learning will also be incorporated into local and regional training programmes; and the Bradford Community Safety Partnership will put in place a means of monitoring and auditing the actions against recommendations and intended outcomes via the Bradford Domestic and Sexual Violence Strategic Board.

1.5. Methodology to the Overview Report

The Overview Report is informed by systems methodology and the principles of forensic social work. This means looking at how the actions of professionals are influenced by the organisations and systems in which they are working; and the application of social work to questions and issues in the criminal and legal systems. In a DHR context this relates to understanding and responding to the implications of domestic abuse. Data triangulation has been used to increase the validity of the recommendations; this means through using different sources of information it has been possible to ensure that learning and findings are supported by the evidence from individual management reviews, relevant research, family interviews, DHR Panel and Overview Author analysis.

- Independent author

The DHR Overview Report author is an Independent Safeguarding Consultant and trainer; an experienced Children Services Manager and registered social worker qualified to Advanced level and MSc Advanced Professional Practice in Social Work. The author has

extensive experience in operational and strategic development and delivery of family centred services, including refuge provision and supporting families bereaved by murder or manslaughter. The author of the Overview Report has been commissioned by the Community Safety Partnership to produce an independent report and has had no involvement in the delivery of identified services, or line management for any service or individual mentioned in the report. The author and the DHR Panel will look openly and critically at individual and agency practice to see whether this Review indicates that changes could and should be made and if so, to identify how those changes will be brought about.

In order to achieve these aims documentary evidence was examined and analysed:

i. Scoping responses

Bradford Community Safety Partnership undertook an initial "scoping" of relevant agencies to identify which organisations had been involved with Samina and Harsha. Seven agencies were asked to complete an Independent Management Review.

ii. Merged inter-agency case chronology

A chronology of each agency involvement was completed covering the advised timeframe, and merged using systems approved in serious case reviews.

iii. IMRs from the following agencies:

- Bradford Children's Social Care
- Bradford District NHS Care Trust (school nursing service)
- Bradford District Care Trust (NHS)
- City of Bradford Metropolitan District Council: Education and Learning (schools)
- City of Bradford Metropolitan District Council: Housing (brief management report)
- General Practitioner (GP)
- West Yorkshire Police

- A report was not requested from Yorkshire Ambulance Service (YAS) as contact was limited to transporting Samina to hospital; however the Overview author made contact in January 2015 to clarify outstanding queries from the family, and this is included in 3.3 – agency involvement.
- The Panel agreed not to approach Leeds Social Care for a report for this DHR as the notification of verbal disputes related to Samina and the father of her children (not the perpetrator of the domestic homicide) in 2010. The incident was classed as parental

conflict, and the input from Bradford was limited to liaison with Leeds Children's Social Care to share information, and was not connected to Samina's relationship with Harsha.

- CAFCASS investigated allegations made by Samina in 2010 that the children's father had hit the children; this was found to be a historical allegation and nothing was found to suggest unlawful chastisement; and this was not connected to Samina's relationship with Harsha, the perpetrator of the domestic homicide. The CAFCASS report was examined and no new or relevant information was found, therefore the Panel agreed they would not be approached to provide a report for this DHR.

- Meetings and Interviews

The Overview Report and DHR process was also informed by meetings with the DHR Overview Panel, family members and interviews undertaken as a part of the Individual Management Reviews.

The DHR Overview Panel met eleven times during the process of the DHR to agree terms of reference, receive and analyse the evidence from IMRs and discuss the draft Overview Report. The Panel consisted of members who were senior managers nominated by their agency with no previous involvement in the case, and with enough authority to effect change in their own agency.

- Family Contact

The 2nd Chair met with the family in June 2013 and the West Yorkshire Police panel member and police IMR author met with the family in January 2014.

The author of this Overview report met Samina's mother and the family advocate for the first time on 20th March 2015 and their comments informed the content of the review and the author's first panel meeting in April. The family have provided the Panel with a statement for inclusion in the report (see 3.4). Further information provided by family discussions and their meetings with the previous Chair and the Police representative on the Panel has added value and relevance throughout the DHR process.

DHR Panel

Role of agency representative	Agency represented
Independent Overview Author	Self employed Safeguarding Consultant and Trainer
Domestic Violence Manager	Bradford Metropolitan District Council: Safer Communities (from 2013)
Superintendant	West Yorkshire Police
Senior Housing Officer	Bradford Metropolitan District Council: Housing
Senior Probation Officer	West Yorkshire Probation Service (became National Probation Service from 1st June 2014)
Senior Service Manager	Bradford Children's Social Care
Board Manager	Bradford Safeguarding Children Board
Head of Equality and Diversity	Bradford District Care Trust (NHS) became NHS Foundation Trust in 2015
Designated Nurse Safeguarding Children	NHS Bradford Airedale (became Bradford City, Bradford Districts Airedale, Wharfedale and Craven CCGs)
Safeguarding Service Manager	Bradford District Care Trust (became Bradford District Care Foundation Trust)

Some agencies have been reconfigured or renamed during this review; the Panel membership information reflects the organisation as it is known at the completion date of this Overview report.

The Panel considered equality and diversity issues throughout the process which informed how the review was conducted. The Overview Panel was made up of members with a wide range of specialist knowledge and experience including; Bradford Metropolitan District Council- Domestic Violence Manager, Head of Equality and Diversity in Health and the Safeguarding leads for adult and children across Bradford. It was identified that the membership had the skills and knowledge to address the complexities of this DHR, and relevant understanding of the impact of domestic abuse and the particular considerations for Samina required in this review.

2.0. TERMS OF REFERENCE

The DHR Panel and the original Chair agreed the following terms of reference to direct and support the Domestic Homicide Review into the death of Samina on 29th April 2012.

The overall purpose of the Domestic Homicide Review process is to:

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

In addition the purpose of this DHR is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Reduce the risk of domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.1. DHR Panel: focus and key lines of enquiry to address in this DHR

All IMRs will consider the events that occurred, the decisions and actions of their agency and include the areas defined in the terms of reference. The DHR Panel identified that the following areas would be addressed in the Individual Management Reviews and the Overview Report:

- This Domestic Homicide Review will cover the time period from 1st January 2010 to 29th April 2012 the date of Samina's death.

In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:

1. Samina had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which she died was a 'one off' or whether there were any warning signs and whether more could be done in Bradford to raise awareness of services available to victims of domestic violence.

2. Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

3. Whether there were any barriers experienced by Samina or her family/ friends/colleagues in reporting any abuse in Bradford or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

4. Whether Samina had experienced abuse in previous relationships in Bradford or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.

5. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

6. Whether the alleged perpetrator had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

7. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Samina, the perpetrator Harsha, or the dependent children that were missed.

8. While it is not the purpose of this review to consider the handling of child protection concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children who may be affected by domestic abuse. If this is the case these issues will be raised with the Bradford Safeguarding Children Board.

9. The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

10. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

3.0. FACTS

3.1. Family members (anonymised)

Samina	White British	Died 29th April 2012 aged 34 years
Harsha	Asian British Indian	Ex/partner of the deceased. Convicted of her murder on 17th October 2012.
Suhail	Asian British Pakistani	Ex partner and father of her three children
Child 1 born in 1999	Asian White British.	Samina's daughter with her ex partner Suhail
Child 2 born in 2001	Asian White British.	Samina's daughter with her ex partner Suhail
Child 3 born in 2004	Asian White British.	Samina's daughter with her ex partner Suhail

3.2. Brief summary

Samina was born in 1978; she is described as a white British English speaking woman who agencies have documented converted to Islam. Samina's Mum describes her daughter as not practicing any particular religion. She was resident in Bradford at the time of her death.

Samina worked as a night carer in a residential home. Samina's Mum described how her daughter was very clear about her career in caring; she had taken various qualifications and was progressing towards a managerial role. In her personal life however, she was restless, unsure exactly where and how she wanted to live or what kind of relationship she wanted.

Samina was a single mother of three children, and was separated from their father *Suhail* who is an Asian British Pakistani and a practicing Muslim. Two children were born in Bradford and one in Wakefield; they are of duel heritage, Asian White British. Samina was the tenant in a housing organisation property in Bradford from 23rd May 2011 to the date she died. The property was in a row of four and had properties on either side; access to Samina's garden was through her house, as the rear gardens are individually fenced and secure.

The perpetrator Harsha was born in 1969, and is described as a British Asian on the police record and self described as Asian Indian when he was taken into custody and he is a Sikh. He also lived in Bradford; records indicate he had a Bingley address from 2010 but at times

it appears that Harsha was living with Samina; for example the GP records indicate she was co-habiting at the time of her death. Samina's Mum states it was unlikely they were living together as he maintained his home at Bingey, but agrees he probably did stay at her address on occasion.

It is not very clear when the relationship with Harsha ended. The family think they separated in October 2011, Samina told her Mum in a phone call around this time they had split up and she was not talking to Harsha. However in her last appointment with the GP in December 2011 Samina told the GP she would be happy if she became pregnant.

There were indications of potentially controlling behaviour from Harsha; the family had gone out with Samina for a birthday meal and she didn't put this on Facebook, her sister asked her why but Samina did not say. The family thought this was because Harsha would not be pleased to know she had gone out. However the family had no suggestion from Samina that he was violent.

Samina's Mum reported that she heard information presented at court which suggested that Harsha had attacked Samina in April 2012 because she had taken her car for an MOT, and he suspected her of having a relationship with a man at the garage. Samina's Mum believes he had hit her before as the post mortem refers to a previous fracture, which ties in with further testimony from Samina's daughter who said she had previously seen Harsha hit her Mum.

Evidence identified during the police investigation indicates there had been violence from Harsha to Samina, but this was not known at the time. There is no evidence that any agency, family member or friend knew this information which became known through police looking at phone messages after Samina's death. Samina died on 29th April 2012 and Harsha was convicted of her murder on 17th October 2012.

The Panel have not lost sight of the enormous personal impact and loss for everyone who knew Samina. On behalf of the family, Mum wants to include the following in the report: *"A mother and daughter usually have a special relationship as did Samina and me. There was nothing in the IMRs that I did not already know. But, the IMRs highlighted context of some of the issues and this has given me great peace of mind. We'll never get over it. Samina will never see her girls bring their boyfriends home, walk down the aisle, make families of their own ... we'll never get over it."*

The Overview Panel had not approved the sharing of IMRs as part of the DHR process and this is explored further in Areas of Learning (6.5).

3.3. Agency Involvement

The Overview Report is based on information from chronologies of contact and seven Individual Management Reviews. The DHR Panel has received and considered the following Individual Management Reviews (IMRs):

- **BRADFORD METROPOLITAN DISTRICT COUNCIL: CHILDREN'S SOCIAL CARE**
  The IMR Author is a Service Manager and has had no direct line management responsibility for this case.

Service involvement

There were five notifications of domestic violence received from the police in April, May, June and December 2010, the children were reported to be present on two occasions. These all relate to verbal confrontations between Samina and her ex-partner Suhail who is the father of her children; and were connected to disputes over custody and contact. Samina and Suhail were separated at the time and not living together, both were in new relationships.

Bradford Children's Social Care had no record of any history of abusive behaviour by Harsha to Samina or to any other partner; and he was not subject to any domestic violence notifications received by Children's Social Care (CSC).

IMR Analysis and learning

The IMR author identifies areas where practice could be improved, and missed opportunities and responses from Children's Social Care which were unsatisfactory.

Suhail raised concerns to Social Care relating to Harsha, but this did not result in any investigation or contact. This would have provided an opportunity to undertake safeguarding checks on the children, and assess whether or not Harsha posed a risk to the children or to Samina. The Group Service Manager for Children's Specialist Services confirms that access to Children's Social Care was redesigned in January 2012, and these systems have now changed. In Bradford all contacts and referrals are received at one central point where they are screened, assessed and appropriate action taken; this is referred to as the Front Door. On occasion where the IMR identifies reports should have been redirected to Leeds, relevant information to other authorities would be now be forwarded.

This was a “child in need” case which involved domestic violence and concerns regarding incidents of alleged harm. The IMR author identifies contributing factors to decisions made which include a number of moves and changes of address during a relatively short period of time. Disputes relating to contact and residence between Samina and Suhail resulted in the children moving from one parent to another. The children were living in two different authorities and it was difficult to keep track of the children’s home addresses. The IMR author identifies that the children’s wellbeing was monitored by the school; this consistency of schooling could have provided a positive source of information and detail which was never considered by Children’s Social Care at the time.

The intervention of Bradford Children’s Social Care was informed by the involvement and oversight from other agencies. The case was in private law proceedings and the level of concerns raised was not considered to meet the threshold for intervention. Their father said he was going to speak directly to school to see if the children were showing any signs of distress, and in May 2010 the Court made a Contact and Residence Order in relation to the three children. The family had a CAFCASS worker who was allocated to the case given the private law proceedings, and Leeds Children’s Social Care had undertaken two initial assessments of the needs of the children and did not identify a need for further intervention.

There were inconsistencies in information between the records held by the Police, Education and Children’s Social Care. Although this could have influenced the response to the reports of domestic violence, the IMR author assesses this is unlikely to have made a difference to the decisions made at the time, and the need for accurate recording is addressed in the agency recommendations. If this case was referred now further checks would be made with school and health providers as part of the revision to Front Door services.

Bradford Children’s Social Care had no record of any history of abusive behaviour by Harsha to Samina, and there were no other relevant notifications. CSC was only aware of notifications of verbal incidents of domestic abuse relating to Samina and Suhail, and there is no indication in any of these notifications that Samina was at risk of physical harm. The IMR author identifies that given that many domestic homicides happen as a result of child contact or disputes over custody there should have been consideration of this risk. Although there is no indication that Suhail was ever physically violent, and he was not responsible for Samina’s death, this DHR has provided the opportunity to reflect on current provision and relevant training has now been put in place for all CSC staff.

Although West Yorkshire Police were following national protocols around sharing information, the IMR author identified that in 2010 the volume of DV notifications which did

not meet the threshold received by CSC from the police were a concern. There was an anxiety that this may result in an incident whereby information could be lost, or a delay in receiving a response. A review of these arrangements was undertaken by CSC and the police; this could be one explanation why the inaccuracy of details was not picked up at that time.

In response to these difficulties a new protocol was introduced in February 2012 and Children's Social Care has now integrated a police officer into the assessment team; this role deals with all domestic violence notifications. Although the volume of referrals continues to be an issue, further work has been undertaken to streamline processes. This is a positive development and has improved the effectiveness of both the practice and communication between the two services.

IMR AUTHOR RECOMMENDATIONS
includes submission of a full agency action plan

- The protocol between the police and Children's Social Care to be subject to an ongoing review process. *Updated action plan: this has been reviewed and revised.*
- Communication needs to take place when children are moving between Local Authorities and this must be recorded effectively.
- Children's Social Care to ensure that the use of letters when domestic violence notifications are received is no longer practice. *Updated action plan: This has now ceased to be common practice.*
- Remind assessment teams of the importance of clarity where children and family members are living at the time of the contact and to accurately record the detail and any changes on the case file.

- **BRADFORD DISTRICT CARE TRUST (BDCT)**
  The IMR author is a Specialist Health practitioner – Safeguarding Children; and is independent of the line management structure of any individuals or processes in this case.

Service involvement

Bradford District Care Trust provides a range of community health services; the only service which had any involvement with the children was the school nursing service.
The IMR identifies there was limited contact with the family; this included a telephone call from Leeds Social Care to the School Nurse team in May 2010 requesting information from the health records. This was a general enquiry regarding allegations made by Samina's ex partner Suhail which were unsubstantiated. Further information was requested in January 2011, and BDCT were later informed that the outcome of an initial assessment had resulted in no further action.

The only direct contact from BDCT related to administering routine vaccinations to Samina's eldest daughter; there was no direct contact with Samina although she was offered the opportunity to attend a briefing session, or to call the school nurse if she had any questions about the vaccine.

IMR Analysis and learning

There had been no identified health or wellbeing concerns to address regarding the three children and the school nursing service only had direct contact with the eldest child. During the three contacts for the vaccination in school, no additional information was gathered regarding the family composition, any significant others or any link between Harsha and his contact with the children.

The potential for this type of information to be gathered could have been more appropriate for year seven pupils when the Health Needs Survey Questionnaire is completed. The completed questionnaire can facilitate a face to face selective health interview with the School Nurse should any identified health concerns be raised by the young person in the questionnaire. This was completed by Samina's eldest daughter in autumn 2010 when she did identify and express feeling angry and depressed, however she declined any support or help regarding her feelings or emotions. There was no indication on the questionnaire to determine any causal factors for these identified feelings and emotions; therefore no health interview was facilitated by the School Nursing service. Information was not shared with pastoral staff in school as she declined any help or support. This is in the timeline of the relationship with the perpetrator, and the IMR author identifies it was a missed opportunity which may have given an insight into family life.

Each school has a named nurse who visits regularly and meets with teachers, and a referral system for schools to refer any concerns into the service. There is no indication in the health record to indicate that the unexplained absences from school or reports of bullying and bruising in 2010 and 2011 had been shared with the school nurse by school staff.
Police and social care records indicate a series of domestic disputes relating to child contact in 2010. The school nurse was not aware of this, other than a phone call from Leeds Social Care that allegations made by the children's father were unsubstantiated. Since 2012 if an enquiry about concerns for a child came from Children's Social Care to BDCT then enquiries would be made by the school nurse and/or arrangements would be made to see the child in school. The Group Service Manager for Children's Specialist Services has also recently clarified that all information should be shared in line with the Children's Social Care information sharing protocol. The current inter-agency protocol was updated in August 2014, and was considered effective by partner agencies.

The IMR author identifies a historic under resourcing of school nurses which will have had an impact on service delivery. There is a national shortage of school nurses and there has been insufficient recruitment to vacant posts. The author predicts it will be some time before additional trained school nurses are in post and reducing this under resource.
There is evidence of a family history of frequent changes of residence and addresses; this appears to be within the local area of Bradford and the surrounding areas which cut across different health organisations and other local authorities. The IMR author notes this could prove to be difficult for health professionals to be aware of the whereabouts of the family, and this transitory existence could have placed a barrier for the children to be able to access appropriate services and support to meet their needs.

The IMR author identifies good practice and timely multi-agency communication and pertinent information sharing when school nurses were responding to enquiries from other professionals to safeguard children and the expected standards in the Safeguarding Children policy and procedures were met.

Following the completion of the IMR current BDCT service provision has also been reviewed to consider children with mixed parentage where domestic abuse may be present. Consideration and attention has been given to training and how the theme of equality and diversity is promoted, and to ensure the safeguarding newsletter and e-learning promotes awareness of the impact of domestic abuse on children and young people. A domestic abuse standard for practice has also been developed for Health Visitor and School Nurse services in consultation with the safeguarding team.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- In accordance with the School Nursing Standards (BDCT, 2012) the School Nursing Service to review the Health Needs Survey Questionnaire offered to all year 7 and year 10 pupils. Giving particular consideration to;
  - The questions, how they are asked?
  - Is the young person making an informed choice regarding the question in each section which asks ‘would you like any help or support about…?
  - What is the purpose of a young person identifying concerns about their health and wellbeing, if they are not aware of what type of help or support is available and from which health professional or service?
- All staff in School Nursing Team should adhere to the Record Keeping Guidance for Safeguarding Children, Appendix 5 of the Safeguarding Children’s Policy (BDCT, 2011) and the Record Keeping Guidance for Nurses and Midwives (NMC, 2009)
- The Safeguarding Children’s team to raise awareness and disseminate information regarding the addendum (appendix 9) of the Safeguarding Adults Policy (BDCT, 2012) Guide: Working with Domestic Abuse. This will increase awareness of the opportunities of how to encourage disclosure or implement routine enquiry when School Nursing teams are working with young people.
- The Safeguarding Children team to deliver training sessions for the School Nurses teams on the subject of encouraging disclosure of domestic abuse, routine enquiry and how to ask questions.

- **BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST (BTHFT)**
  The IMR author is an Implementation Manager- Violence Against Women and Girls strategy; and is independent of any operational involvement with the staff in this IMR.

<u>Service involvement</u>

Samina attended the Accident and Emergency Department twice in 2011, the information given and the nature of her injuries made it clear that neither of these attendances related to domestic abuse. There was nothing in her records to suggest any history or indicators of violence or abuse. There was no history of Samina attending hospital with relevant injuries

during the period under review; and relevant contact was limited to her attendance with life threatening injuries at A&E on 26th April 2012.

IMR Analysis and learning

The IMR author identifies good practice from the portering team leader when Harsha brought Samina to the hospital on 26th April 2012, although at the time it was not possible to identify either adult. The porter was told someone was having difficulty getting a woman out of the car so he got a wheelchair and went to help. He noted there was a woman slumped in the foot well of the car, with her face on the car seat. The member of staff was concerned about the behaviour of the man. When he drove off without bringing the woman who appeared to need help into hospital the porter took the car registration, and rang the police with a detailed physical description of an Asian man who was the driver. It was this action that led the police to later attend at Samina's home address.

The documented evidence describes appropriate emergency care from BTHFT; and the clinical and emotional care given to Samina and her family from 26th April 2012 was in line with good practice, and their policy and procedures. One of Samina's daughters spontaneously told nurses about injuries her mum had sustained on 26th April; she had come home from school and found her mum to have blood coming out of her mouth and pains in her side. The nurse reported this evidence to the police. A further example of good interagency working was evident when the paediatric liaison nurse contacted the school nurse after Samina's death to discuss the likely effects on the children. This was good practice and an opportunity to safeguard the welfare of the children at this time.
The IMR author identifies several areas where the Trust can improve practice:

- The DoH national guidance "Responding to domestic abuse: a handbook for health professionals" (2005) recommends that the trust should have a domestic abuse strategy in place which is supported by training. Although BTHFT did not have a policy in place for dealing with domestic abuse, there was an action plan which was developed by an internal working group. There was no formal post in place or designated time to progress these actions, and there were areas where little or no progress had been made.
- There were no agreed procedures in place for instigating routine enquiry within the hospital. If a domestic abuse strategy had been in place there would have been two opportunities with Samina to 'routinely enquire' about domestic abuse, on 26 May 2011 and again on 8 September 2011.

- There is no evidence that Samina displayed any 'signs' of abuse, or made any disclosure therefore it is understandable that BTHFT staff did not undertake any specific risk assessments. The Domestic Abuse Stalking and Harassment (DASH)[4] risk assessment was not in place within BTHFT at the time but is now used by BTHFT to refer to specialist domestic violence and abuse services, and make referrals to MARAC.[5]
- The actions of the porter on 26th April 2012 were commendable; however the Domestic Homicide Review panel questioned whether these actions would routinely take place. It is acknowledged that relevant staff needs to be briefed on what to do in circumstances like this and this has now been undertaken.
- The IMR author describes relevant shortfall in resources. A part time six month post was created to develop routine enquiry in Accident and Emergency Department, and was also representing the Trust on MARAC which impacted on the time available to develop routine enquiry. This has now improved and a post has been commissioned across all Bradford Health Services to support these developments. BTHFT now has two representatives on MARAC; one from the Safeguarding Adults Team and one from Maternity Services.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- Staff member in a permanent post in order that routine enquiry can be successfully embedded into BTHFT in Accident and Emergency, maternity services and other high usage areas where women are present.
- Develop a "Domestic and Sexual Violence" policy for BTHFT.
- Share learning from incident with key staff.

- **CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL: EDUCATION AND LEARNING**

The IMR author is Head of special educational needs-early intervention team and has no line management role or involvement with any staff identified in this report.

[4] www.dashriskchecklist.co.uk

[5] MARAC – Multi Agency Risk assessment Conference

- Revisions to the IMR and revised recommendations were received 4th August 2015.

Service involvement

The three children were identified as attending two schools in Bradford during the period under review.

IMR Analysis and learning

The IMR author identifies that schools were aware of the Children Missing in Education guidelines and the process for notifying Education Social Work (ESW) if a child is not in school. However, the children are recorded as absent for periods of their education for 6 months (September 2007 to March 2008) and three months from September to December 2008. This was not known to the ESW Service which identifies this process has not been consistently applied across the authority. Although outside the period under review, this has been addressed in the recommendations.

As the original IMR was three years old the current arrangements for Children Missing in Education (CME) were highlighted in a summary report to the DHR author (August 2015) identifying what has changed since 2012.

Since the period of this review the procedures have been refined over time and remain in line with relevant statutory duties for all Local Authorities. Education Social Workers and Education Welfare Officers in their regular day to day contact with schools support and advise schools regarding children missing education procedures; and Bradford Council is also part of the national network for children missing education. Details of the actions a school should take if the whereabouts of one of their pupils and their family are unknown are readily available to all schools through the web based Bradford Schools Online "Children Missing Education – Guidance for Schools' https://bso.bradford.gov.uk/Schools/CMSPage.aspx?mid=50

As key link staff in school change, the Education Social Worker attached to the school will ensure that new staff know about the process. All staff in schools is encouraged to inform the ESW Service of any concerns they may have through local intelligence about a family and or children, there is no need to wait until 20 school days are missed before beginning the CME procedure. The ESW Service now has direct access to the Council benefits system to try establish any new information and addresses for the family; and has also

introduced ‘sibling checks’ in order that all children in the family, including those who are below statutory school age, are included in the enquiry.

There were some instances where staff interviewed during this review indicated that practice would be different following the death of Samina. One member of staff said there was a heightened sense of staff awareness, and more concerns are followed up with Social Care. There were also examples of positive work with pupils in relation to bereavement following Samina’s death.

None of the schools interviewed had specific policy and practice guidance related to domestic violence but that this was seen as being intrinsic to the safeguarding and child protection policy and practice. There was evidence that child protection and safeguarding training is undertaken at all levels within school and staff were clear about whom to report concerns to, again however this did not include specific training on working with domestic violence or how this may present itself in relation to a child’s behaviour in school. This has been addressed in agency recommendations.

School were aware there were some issues with Samina and Suhail about contact and residency, but further intervention such as a referral for a CAF was not considered necessary as CAFCASS were involved. School were not fully aware of the current family home circumstances, what they did know was that Samina was in a new relationship but her partner wasn’t seen in school. It would appear that there were no specific warning signs related to domestic violence, for example the children being unhappy in school. In hindsight and with training about domestic violence and how this would manifest itself in a child’s behaviour, there were aspects of the child’s school information that could have been considered in this context. Child 1 reported being bullied and was at First Aid daily and there was a further report of bruising. This should have been considered more fully by the school, and information shared with other professionals to triangulate concerns; this has been addressed in agency recommendations.

It does not appear that either school had identified the transitory nature of the family’s home life, with multiple moves as being an indicator that there was anything of concern happening at home, other than a couple who had separated and were managing complicated access arrangements. This is included in agency recommendations.

When Suhail, the children’s father came to collect the children at school shortly after Samina died he was very distressed and said Samina had died following domestic violence from her

partner. Social Services were unable to confirm this information with the school. This lack of clarity caused a difficulty for staff that needed to know who had caused Samina's death, to ensure they were not inadvertently putting any of the children at risk. The Group Service Manager for Children's Specialist Services has recently clarified that all information should be shared in line with the Children's Social Care information sharing protocol which was updated in August 2014, and was considered to be effective by partner agencies. As a result of the revision to Front Door Services an Education Social Worker and police officer are part of the multi agency team; this would ensure that in similar circumstances the school would now definitely be informed.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- Safeguarding training for Head Teachers and school Child Protection leads should be reviewed and include explicit reference to domestic violence and how this may be reflected in a child's behaviour in school. As a result domestic violence and its impact on children should be reflected in school safeguarding/child protection policies and procedures.
- Head Teachers and school Child Protection leads need to ensure that their record keeping systems are robust and prompt consideration of the child in the context of the family , a "think families" approach, and the need to discuss concerns with other professionals, sharing information accordingly
- Head Teachers and school Child Protection leads should ensure that children's records include all relevant information when a child moves from one school to another; and where there are particular concerns these are raised with the relevant lead in school.
- Head Teachers and school Child Protection leads should understand their responsibilities in relation to standards and guidance regarding Children Missing Education (CME)
- Head Teachers and school Child Protection leads are given clear guidelines about who to contact in domestic homicide situations so that they do not inadvertently put children at risk of the suspected perpetrator.

  - *Revised action plans confirm all actions were completed by March 2013.*

- **CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL: HOUSING**
  The IMR author is a Principal Operations Manager for the Housing, Employment and Skills Service and is independent of the line management and delivery of the services in this IMR.

Service involvement

A brief report rather than an IMR was requested from the housing provider as contact was limited. One relevant point of contact was identified as the housing organisation and Registered Social Landlord (RSL) which owned and managed the address where Samina was registered as the tenant from 23rd May 2011 to the date she died.

IMR Analysis and learning

Samina applied for a property and disclosed she was fleeing domestic violence. The IMR author identifies that Samina's application for a tenancy was in line with the relevant policies which recognised this was a priority. Samina reported that the new tenancy would help to resolve her situation, and that no further intervention was required as she was receiving support from family services in Leeds

The RSL has an established Domestic Violence policy with clear guidance for staff should assistance be requested. The housing organisation have no records of any reported disturbances from neighbouring properties or any concerns or requests for further assistance relating to domestic violence from Samina during the period of the tenancy.

Although the policy is clear where a case of domestic violence is identified during a tenancy, no specific reference is made in the policy for dealing with new tenants who have been granted a tenancy because they are fleeing domestic violence. Although it is understood that an individual's circumstances are reviewed with them at the point of application, it would be beneficial to broaden the Domestic Violence policy to include details of the process to offer support to these tenants once a tenancy has been established. This is addressed in agency recommendations.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- That the Council's Housing Domestic Violence Protocol be amended to make it clear that all Housing Options staff will signpost clients to appropriate support agencies when they are aware that they are fleeing or experiencing domestic abuse
- That the Registered Social Landlords be asked to review their Domestic Violence policy to ensure that it includes clear guidance on the process to offer support to new tenants who have been granted a tenancy because they are fleeing domestic violence.

The Principal Operations Manager confirms that these actions have now been implemented.

- **GENERAL PRACTITIONER (GP)**
  The IMR Author is a GP Trainer and Programme Director

At the time of the completion of this report the author was commissioned through NHS Airedale, Bradford and Leeds PCT which is now Bradford District, Bradford City, Airedale, Wharfedale and Craven CCGs

Service involvement

The original Chair did not access the records for Harsha; this has been a process learning point and now consideration is always given to accessing GP records for perpetrators when a DHR is undertaken.

Samina had less than average contact with GP services, and there is no evidence of any consultation which includes indicators or disclosures of domestic violence or abuse.
In April/May 2010 Samina reports stress with her ex-partner relating to custody disputes but says all is fine with her new partner. In August 2011 in another consultation Samina is worried her partner may be "messing about". The last contact with Samina was December 2011 on an unrelated medical matter, when she says she would be happy if she became pregnant.

IMR Analysis and learning

The IMR author identifies pertinent features which include the mobility of Samina and her children. The medical record does not accurately track the addresses and school changes for the family; this is addressed in the GP action plan; recognising that accuracy is also dependent on the information given by the patient. The infrequent attendance and high mobility result in an absence of continuity of care. The children were not seen often and only one professional saw Samina more than twice, and this was limited to a couple of times a year. It is likely that a deeper, trusting and confiding relationship would have been established had Samina been better known. It can only be speculated that a deeper relationship may have enabled Samina to confide in a healthcare professional if domestic violence was an issue.

The IMR author reflects that the view from Samina's perspective could have been one of "yet another doctor/nurse" "never seeing the same person twice". Many GP surgeries struggle to meet the demand for appointments. The author considers it is possible that Samina may have struggled to obtain an appointment for a minor problem, and each appointment would be highly focussed on the individual in question with little if any regard paid to the wider issues affecting that person and the family.

Recommendations relate to incorporating selective enquiry (questions to patients relating to domestic violence) and increasing awareness to address these potential concerns. SystmOne is a clinical computer system used by healthcare professionals and is one of the systems available to GPs and healthcare professionals. Safeguarding information, training and procedures which include West Yorkshire Consortium Procedures Manual are available through SystmOne and form part of the GP action plan.

The IMR author reports that there is no evidence of professionals being aware of relevant policies, and no evidence of professionals not being aware, or not following them. This is ambiguous and could have been answered with an interview or telephone consultation with a relevant member of staff at the practice. Although no GP had sustained contact with Samina and contact was very limited there may have been a missed opportunity for the IMR in terms of learning through undertaking a desk top review and not personal interviews. This has been addressed as a process learning point, and GPs have been interviewed for subsequent DHRs.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- Incorporation of appropriate screening questions relating to domestic violence in consultations such as those relating to contraception and mental health.
- Increased awareness of domestic abuse, and identification of at risk individuals
- Accurate recording of social and demographic information on patient records

- **WEST YORKSHIRE POLICE**
  The IMR authors are both Serious Case Review Officers and have no operational or line management responsibility within the organisation and are independent to the reviewing process.

Service involvement

Harsha: There was a history of police involvement with Harsha; the IMR author has noted 6 relevant convictions outside the period of the review from 1992 to 2009 for threatening behaviour, criminal damage and racially aggravated threatening behaviour. There are three incidents which are domestic related violence with previous partners and Harsha is recorded as the perpetrator. There are several other similar offences where reports were made but not concluded and information is unclear, or there was insufficient evidence to charge.

Samina: There were four relevant reports of domestic abuse in 2010 in April, May, June and again in December that relate to a series of verbal arguments between Samina and her ex partner Suhail. These are assessed as compliant with Force policy, and appropriate domestic violence notifications were made to Social Care.

There was a significant incident of domestic violence and abuse between Harsha and Samina on 8th November 2011 when Samina called the police and informed the control room operator that Harsha had threatened to harm both her and her children over the phone and by text. Samina reports two windows have been smashed, she suspects Harsha caused the damage. Samina stated to the call taker Harsha had been threatening on the phone and sending texts “she was scared” and her “stomach was in knots”. Further threats were made to her grandmother and the children as well as to Samina.

There was no other police involvement until an officer attended at Samina's home address at 6.45pm on 26th April 2012. This followed concerns raised half an hour previously at A&E from a hospital porter. He had been concerned that the driver had not brought a female passenger of the car into the hospital, and he had passed the vehicle registration to the police. The police officer went to the property where the vehicle was registered and Samina's car was in the driveway. A number of attempts were made to obtain a reply; there was no response and the house appeared to be unoccupied.

Later that evening the police received a call from the ambulance service reporting concern for a female later found to be Samina. The police attended and Harsha was subsequently arrested.

IMR Analysis and learning

The IMR author identifies that although there are no recorded incidents of domestic violence and abuse between Samina and Harsha, Samina had reported an incident to the police when Harsha had threatened to harm both her and her children over the phone and by text in November 2011. The control room operator identified this was a domestic related incident; however this was not recorded as a crime by the police officer. Subsequently the action taken was not compliant with the West Yorkshire Police Domestic Abuse Policy or Safeguarding Procedures in dealing with reports of domestic violence incidents.

The PC visited Samina the following day and also made house to house enquiries; although Samina thought Harsha had done the damage to the glass door, no evidence was found to prove this. Samina told the officer that Harsha had since contacted her, apologised for his behaviour and she felt the matter had now been resolved.

The police officer did not investigate the alleged threats made to Samina and her family by Harsha, nor was Harsha interviewed about the alleged criminal damage. This was not compliant with the expected standard of practice. This was also a potential missed opportunity to signpost Samina to partner agencies for further services or support; and to risk assess Harsha, and potentially manage his offending behaviour.

This was not a positive safeguarding response and also missed the opportunity to assess the potential risk to both Samina and her children as there was no notification to Children's Social Care.

The IMR author assesses this is a developmental point for the individual rather than an overall recommendation as appropriate systems are in place, but the action of the officer

was not compliant with Force policy. The developmental issues of the IMR were fully addressed with individual officers in February 2013.

It is a requirement of Force policy that a DASH[6] risk assessment is completed by the attending police officer at any incident of domestic violence. The purpose of using this checklist is to help identify those who are at a high risk of harm and who should be referred to a Multi-Agency Risk Assessment Conference (MARAC) meeting in order to manage the risk. From the information available to the officers at the time this would not have reached the threshold for a MARAC referral. If this DASH risk assessment had been completed, Samina would have been contacted by the Safeguarding Unit staff, the police domestic violence co-ordinator would have contacted her and this would have provided an opportunity to make further enquiries about domestic violence and abuse that may have been unreported.

All death or serious injury incidents with recent police contact are referred to the Independent Police Complaint Commission. The Professional Standards investigation has now been completed; and included the action taken by the police officer when he attended at the home address to conduct a welfare check on Samina during the evening of 26th April 2012. This investigation did not identify any misconduct or negligence issues relating to the actions of the officer that evening.

The IMR author identifies that when the officer went to the home address there was an opportunity to locate Samina. The author details a number of attempts made to make contact; the officer knocked several times on the front door, the house was in total darkness and there was no reply to repeated knocking. The property is in a row of four and has houses on either side; access to Samina's garden was through her house as the rear gardens are individually fenced and secure. The PC was unable to directly approach the rear door at the back of the property; however the officer went through the neighbour's house and climbed onto the neighbour's fence to gain a line of sight into the house. This confirmed that the rear of Samina's house was also in complete darkness. The officer continued ringing registered numbers for Samina and again knocked loudly at the front door before establishing it seemed reasonable to assume the house was unoccupied. During the murder trial the judge commented that in his view the police officer had made all reasonable enquiries at the time to locate Samina.

Based on the information from previous reported incidents there was no evidence that Samina was at current risk of harm from Harsha or her ex-partner. In November 2011

[6] www.dashriskchecklist.co.uk

Samina had described Harsha to the police as her ex partner, and Harsha was not identified as the man who brought her to hospital.

The information available to the police at the time did not indicate any current history of domestic abuse, or that Harsha was a potential physical risk to Samina as a current or ex-partner. This and the appearance of an empty house informed the conclusion that the grounds were not met to force entry to the premises.

The IMR author identifies areas where the police response could have been improved. The incident log does not indicate that consultation or advice was sought when the officer attended at the address. In cases where safeguarding or welfare concerns are reported to the police it is essential that communication and frontline supervision are made aware of the concern, and that they monitor and oversee the initial response and subsequent outcome. There was no update following attendance at the address which would have been appropriate in accurately recording any concerns, and facilitating a timely response in locating Samina. This has been addressed in agency recommendations.

Additional police personnel now sit alongside Children's Social Care to screen and risk assess all notifications of domestic violence and abuse, and this will have a positive impact on the current system.

IMR AUTHOR RECOMMENDATIONS
includes submission of full agency action plan

- West Yorkshire Police to ensure that when Safeguarding or Welfare concerns are reported to the Police, that supervision (communication and frontline) are made aware of the concern and that they monitor and oversee the initial response and subsequent outcome.

- **YORKSHIRE AMBULANCE SERVICE –NHS (YAS)**
  Named Professional for Safeguarding Children: Yorkshire Ambulance Service

An IMR was not requested from Yorkshire Ambulance Service (YAS) as contact was limited to transporting Samina to hospital; however the Overview author made contact in January 2015 to clarify outstanding queries from the family.

Clarification of times of attendance: 26th April 2012

- First call in to YAS was made at 22.56 by a female member of the public relating to a 33 year old unconscious female.
- The rapid response vehicle arrived at the scene 9 minutes later at 23.05, and the responder began medical intervention before handing over to the ambulance crew at 23.19
- Police were contacted at 23.40 just before the ambulance was leaving the scene to transport Samina to hospital; reporting that the ambulance service were concerned for a female at her home address who was unconscious with facial injuries
- The ambulance left the scene at 23.45 and arrived at Hospital 1 at 23.48

Medical intervention and the YAS response met all the required standards and protocols of Yorkshire Ambulance Service.

3.4. Family involvement

We acknowledge the difficulties of any formal proceedings and professional involvement at a time of personal grief and loss; but in any domestic homicide members of informal support networks such as family, friends and colleagues are often the best people to help professionals understand what happened. This also gives people their opportunity to ask questions, and suggest other people they think should contribute.

The Domestic Violence Manager made contact with Samina's Mum in October 2012 at Court and informed her that a DHR would be taking place, and mum confirmed she wanted to be contacted. Samina's mother later made contact with Advocacy After Fatal Domestic Abuse (AAFDA) and contact with the DHR Panel was established. The second Chair wrote to Samina's Mum in March 2013 and direct contact was maintained with the family and Chair including allowing her and her husband access to the IMRs, this is discussed further in the report. The family and advocate also subsequently met with the Police representative on the Panel, and the final overview report writer. Questions raised by the family have been incorporated into the process and family comments have been included in the Overview report.

A letter was also sent to the children's father Suhail, but no response was received. Contact was then made through the Family Liaison Officer who confirmed with him that he had received the letter and did not respond because he did not want to contribute to the review at

any time. Relevant sharing of information has therefore been restricted to incidents of agency contact that also involved Samina. Phone calls were made to Samina's work colleagues but no response was received.

The family identify there are particular areas where the DHR Panel could consider their experience as part of the overall learning process. Initial family contact after the incident should include independently confirming that all relevant family members have been contacted and informed that a DHR is to be undertaken, rather than solely relying on family networks. This information can be limited or affected by family estrangements, and agencies should not rely solely on the family to provide accurate information of relevant people to contact.

There needs to be individual consideration for family members who live outside the local area to ensure they are updated and included in ongoing information about the DHR. With the particular expertise of a panel experienced in working with the issues of domestic violence and abuse it is also important to consider the potential impact for people who may be separated as a result of threats of violence, and to ensure that contact is inclusive and sensitive to these risks and experiences.

The family also want to highlight the value of effective information sharing, and in their case the decision made by the Chair to share agency IMRs. This was described as very helpful to the family and enabled them to deal with many questions from other family members. On occasion Samina's sister rang her Mum and asked why a certain thing had happened, and she was able to turn to the relevant document and give her a response, even in the early hours of the morning when something distressing had come to mind. Samina's Mum described the trauma of not knowing and not having information about what had happened, and that at some point in the future this may provide much needed answers for Samina's children.

Samina's stepfather stated, "The more information you give, the more light you bring to otherwise grey areas in our minds. We didn't want to live with that dark in our minds. We needed information, the light, because it eases our minds."

The family have provided the Panel with a statement for inclusion and further information which is included throughout the Overview Report.

FAMILY STATEMENT

I am the mother of Samina who was taken from us on the 29 April 2012. Although Samina was taken in such a cruel and horrific way, I feel no bitterness towards the perpetrator.

He took Samina but he can never take away all the memories that her family had with her. Samina's birthday was 30 October. Two of those have passed without her and although she has roses every week next to her picture and a candle to light her way, no-one will know what I would give to have one more minute with her or to just talk to her on the phone; her number is there on my phone. She left three beautiful girls and sisters and a brother, all with the memories of her. With this in mind, I do not forget and hope that Samina will not be forgotten. I hope in my heart that no other mother or family go through this. You find strength and the ability to carry on for your loved one. They have to have a voice as no-one else can speak for them; only the ones left behind; we are the ones that can speak for them. They must not be forgotten and all the services must learn from all the mistakes made and admit to the mistakes no matter how small; the answers mean so much to the loved one's left behind. This is not to apportion blame or point the finger at any one department or service. Just give the answers to the questions that we ask as life is precious and we need as much information as we can get. As the curriculum states; every young person should learn English and Maths. But, we should be teaching the latter to respect and to honour each other. Relationships should be taught from a young age both at home and in school. Let's make a difference. Now, and in the future.

Date of statement: March 2015

4.0. ANALYSIS

This section focuses on analysis of the key lines of enquiry in the terms of reference, applying the findings from agency IMR's and family input as evidence for learning and recommendations.

Key lines of Enquiry

What was known by agencies?

- Bradford Children's Social Care knew there had been verbal confrontations with Samina and her ex partner over contact and residence of the children, but had no information to indicate that Harsha was a risk to her or the children. Concerns about Harsha were raised by Samina's ex partner in 2010, these were not investigated.
- There were no direct health or wellbeing concerns to address in the contact from the school nursing service. Bradford District Care Trust (BDCT) was aware that Leeds Social Care had undertaken an initial assessment and there had been no further action. Samina's eldest daughter had reported she felt angry and depressed in Year 7, but did not give any reasons for this, and she declined support.
- There was no relevant history of Samina attending hospital during the period under review; and relevant contact with Bradford Teaching Hospital was limited to her attendance at A&E with life threatening injuries on 26th April 2012.
- School knew that there had been disputes over custody between Samina and her ex-partner in 2010; but had no information or concerns relating to the relationship with Harsha.
- Samina was rehoused in May 2011 after she had reported she was fleeing domestic violence. This was believed to have related to previous disputes between Samina and her ex-partner over custody and access to the children. Samina said the new property would resolve her situation and there were no other concerns or requests for further support during the tenancy.
- The GP was aware there was stress relating to custody and disputes with her ex-partner, but Samina reported no concerns relating to the relationship with Harsha.
- West Yorkshire Police knew of the reported domestic incidents between Samina and her ex partner Suhail; they knew there had been one report of threats made by Harsha in 2011. They knew Harsha had an extensive history of violence to both males and females, and this included previous domestic abuse.

Responding to the Terms of Reference:

1. Samina had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which she died was a 'one off' or whether there were any warning signs and whether more could be done in Bradford to raise awareness of services available to victims of domestic violence.

Referrals were made by the police to HALT (Help Advice and Law Team) and Victim Support.

West Yorkshire Police had consent from Samina to refer her to Victim Support following the reports of domestic disputes with her ex-partner, Suhail. City and Holbeck Safeguarding emailed the Victim Care Unit (VCU) on 24th April 2010 and Victim Support attempted two contacts by phone but they were unable to reach her. A letter was sent the following day asking Samina to contact VCU if she still needed support; this followed the procedures in place at the time. There was no direct contact with Samina. Unfortunately HALT have been unable to clarify any information for this review as their Data Protection policy requires them to destroy client records four years after case closure or last contact. Samina is not on their system so it is not possible to clarify if previous Overview Authors requested any information from HALT. If the organisation had received a referral the paperwork and electronic information would have been destroyed around April 2014.

The police IMR identifies that the incident in which Samina died was not a 'one off' incident because a potential risk of violence in this relationship was indicated when Samina reported criminal damage in November 2011. There were no other warning signs or indicators indicated in Samina's contact with other agencies.

Information became known at Court that there had been violent behaviour from Harsha to Samina. During the police murder investigation one of the children reported she knew that Harsha had previously been violent to her mother. One of the investigating officers commented how despite her very young age, Samina's daughter was an excellent witness in Court. Her testimony was significant and contributed to the evidence for the successful charge of murder, as it confirmed this had not been a "one off" event.

Information retrieved from Samina's phone confirmed there had been prior incidents of violence, and the post mortem revealed a previous fracture, it is unknown if this was related to an injury caused by domestic abuse. There was no evidence that she shared this

information with family members, friends or colleagues or that this information was known by any of the agencies involved with the family.

Bradford has a comprehensive history of multi agency events and publicity to raise awareness of services available to victims of domestic violence and abuse, and strategic plans which profile and make appropriate links with adult safeguarding. It is evident that Samina had some understanding of how to access these services, she also knew of people who had experienced intimate partner violence and she had spoken out about these issues. It cannot be said with certainty that Samina was too frightened of the consequences to seek help, but practice experience and research tells us this is a significant consideration, and this is a potential factor for her which may have prevented disclosures of abuse. The Panel are also aware that it is rare for domestic violence incidents to occur in isolation, and typically emotional abuse and coercive control occur throughout the relationship.

It is the view of Samina's Mum that her daughter will not have told people if she was being abused because she was a private person and had a lot of personal pride and self respect; she described how "Samina always saw the best in people, she was also very forgiving." She saw herself as a person who looked after and protected others, and she supported family and friends in this regard, "she was always there for her sisters and her brother." It would have been difficult to be seen as needing help herself, "if she had a problem, she would never ask for help. She would just go quiet." Mum reflects that Samina may also have seen she could help Harsha get rid of his "demons."

2. Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

The process of contacting the family is detailed earlier in the report (3.4.). There was no indication or hint to family members that Samina was experiencing past or current violence from Harsha. She was happy in her new property and had spent time and money making a home for herself and her three daughters. Although Samina's Mum lived out of the area she had regular contact with her and other family members. There appear to be several opportunities for private discussions with people she trusted, but there has been no information to indicate Samina disclosed to anyone that she was experiencing abuse. During the police investigation witness statements were obtained from Samina's work colleagues. One statement records that Samina had stated "her chap (Harsha) wouldn't

think twice about hitting a woman". There is no evidence that Samina disclosed to colleagues she was experiencing violence and abuse, or that she was at risk or in fear of Harsha.

There were no indications prior to the homicide, such as changes in behaviour that raised any questions from family, friends or colleagues.

3. Whether there were any barriers experienced by Samina or her family/ friends/colleagues in reporting any abuse in Bradford or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

Barriers to reporting abuse can be present in any individual or community. Assumptions and expectations can lead to anxieties, particularly when people try to access mainstream services that present as powerful, formal and potentially disempowering; but it appears that Samina felt able at least on occasion to access relevant services, which included both police and housing providers.

The barriers of perceived and experienced racism can influence reports to the police and statutory services if there is a belief that the agency response will be disproportionate or negatively influenced by the race, ethnicity or religion of the complainant, or the alleged perpetrator (Wilson 2005). There is no evidence that Samina felt unable to report concerns, or that these barriers were experienced.

On occasion it was difficult for professionals to be clear about the whereabouts of the family; and there were several changes of address. This transitory existence could have placed a potential barrier for Samina and her children to be able to build ongoing supportive professional relationships and access appropriate services to meet their needs. Although this is a possibility, there is no clear evidence to indicate if this was a relevant factor for this family.

Research and practice experience tells us that women will often seek help at the time the risk of violence extends to her children (Rasool, 2015) or if there is an impact on them as a result of the relationship. Samina's Mum wanted the Panel to know that Samina lived for her kids and she always had them with her, she would never leave them with anybody and she always put them first. Samina was a protective and loving mother and she was trying to separate from Harsha, perhaps recognising the impact of his behaviour on her children.

Although there may have been periods where they were together, the evidence supports the view that she was also trying to end the relationship.

Little is known of the reasons behind Samina seeking help as direct disclosures of domestic violence are so limited. There is a report from Samina to the police in November 2011 of her windows being broken and she suspected Harsha, she also reports threatening calls and texts made by Harsha; Samina tells the call handler she is scared, “her stomach was in knots”. It appears that she contacted the police on the occasions when there was a confrontation with Suhail, and on the one occasion she reported concerns about Harsha. Her mother describes how Samina would see herself as capable, and would prefer not to approach others for help, and this may have contributed to her reluctance on occasion to report violence from Harsha.

One of the primary barriers to disclosing intimate partner violence is the understandable fear of consequences and possible repercussions (Wolf et al 2003). Most domestic homicides occur when it appears the partner is abandoning the perpetrator emotionally or physically, attempts to leave are also a key risk factor in the severity of escalating violence (Aldridge and Brown 2003, Richards 2004) and it is clear that Samina had ended or was trying to end the relationship. Harsha had a criminal history which included acts of violence to women and it is possible that Samina had some knowledge of this, though it is unclear to what extent. Chair 2 records her findings relating to the risk of violence:

Family members were aware that Samina had found out that Harsha had been violent to a previous partner. It is the family’s view that in all likelihood Samina would have confronted Harsha about this, and they wonder if this may have been the trigger on 26th April.

The Domestic Violence Disclosure Scheme came in to force in 2014 (Clare’s Law). This would now allow Samina to ask the police about Harsha’s previous history; a multi-agency panel would meet to examine information held and decide whether or not there were legal grounds for sharing the information with those asking to receive it.

4. Whether Samina had experienced abuse in previous relationships in Bradford or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.

There is evidence of domestic violence notifications between Samina and Suhail, and on one occasion Samina was named as the suspect following a verbal dispute. A number of allegations and counter allegations were made during this time which did not lead to specific charges, but serve to illustrate the complexities and difficulties when there is parental conflict over child contact, and how organisations have to assess information from a neutral perspective.

Samina made contact with housing services when she was rehoused in May 2011 after she reported she was fleeing domestic violence; Samina's Mum confirms this related to events with Suhail. Samina said the new property would resolve her situation, and there were no other concerns or requests for further support during the tenancy.

On the occasions Samina sought help from the police she did not want any further involvement with other agencies, and although the police made referrals to HALT and Victim Support Samina did not take up this support.

There is one report in November 2011 where Samina makes contact with the police in relation to a window being broken and threats made by Harsha to harm both her and her children, and she describes being scared. When contacted by the police Samina feels this has been resolved as Harsha has apologised. Samina's Mum recalls being told by her daughter that the attending police officer said "If I had a pound for every woman that said, it's alright it's been resolved. I won't take him back, I'd be a millionaire." Samina indicated to Mum that she thought the police officer had been condescending. We do not have any clear understanding of Samina's view on the police intervention or if she thought this was effective, but it is her Mums' opinion that overall she felt there was not much point in getting in touch.

There is no evidence that Samina felt unable to report concerns or seek help from agencies, but similarly the terms of reference also explore where potential barriers may have been a contributing factor.

5. Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse experienced by the victim that were missed.

Specific questions at the first point of contact asking all service users whether domestic violence is an issue that requires support is also known as “routine enquiry”. Selective or targeted enquiry involves asking women directly about their experiences where there are specific concerns or suspicions, rather than asking everyone even if there are no apparent indicators of abuse.

Samina contacted agencies and told them on occasion that domestic violence was an issue where she felt they had a role in helping her; for example the reports to the police and housing. She made one report of threats from Harsha, and it is possible to assume that there were previous or ongoing concerns which went unreported. One of the children disclosed during the murder investigation that Harsha had previously been violent to her mother, but no previous disclosures of this were made by the children or Samina.

If a domestic abuse policy had been in place at Bradford Teaching Hospital the IMR author highlights there would have been two opportunities with Samina to ‘routinely enquire’ about domestic abuse, on 26 May 2011 and again on 8 September 2011 when she attended hospital. If targeted enquiry had been in place the question is not likely to have been asked as the reasons for Samina attending on those two occasions were clearly not related to domestic violence or abuse. Routine enquiry, although harder to implement, would have provided an opportunity to ask the question and given Samina a choice about raising this. She would have also known this was an organisation that could support her and understood these issues if she chose to disclose in the future. The Trust is working on implementing routine enquiry in Accident and Emergency Departments and this is reflected in agency recommendations.

The current Bradford and District Domestic Violence and Sexual Violence Strategy[7] responds to the relevant NICE guidance[8] produced in February 2014. This makes a number of comprehensive recommendations to create the optimum environment for disclosing domestic violence and abuse. Research suggests that women may be more likely to disclose their experiences of being abused to health professionals than to other agencies

[7] Bradford and District Local Health Economy Strategy and NICE guidance; tackling Domestic and Sexual Violence 2015-2020

[8] NICE guidance – Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014)

(Davidson et al, 2001). In recognition of this, the Department of Health, in their (2005) 'Responding to Domestic Abuse: A Handbook for Health Professionals' recommend that health professionals should take a proactive approach by asking direct questions about violence and abuse.

If this had been available at the time of Samina's contact with relevant agencies it is possible these practice improvements could have had a positive impact. If there had been a more widespread use of routine enquiry, and this had been consistently applied in all the agency contacts, there is the potential that Samina would have felt able to disclose or report any concerns she may have had about violence in her current relationship. It remains open to speculation whether this would have led to any disclosure of abuse from Samina. As an adult with the mental capacity and the right to make her own decisions she may have remained reticent or in denial about her own experiences of abuse, and simply not wanted professionals involved in her personal life.

Routine enquiry is often embedded in healthcare settings and as the majority of the population have contact with their GP and other health related services this is an appropriate and positive source of support. It is often harder to integrate these principles across housing and social care settings, however Bradford has included "asking the question" and routine enquiry into the multi agency training delivered through the Workforce Development Unit. In 2014 there were 26 multi-agency sessions and 16 additional 'on demand' sessions delivered to local practitioners.

Health staff has access to all of the multi-agency training on domestic abuse, which includes work around asking questions. Further developments include a training needs analysis and audit, and continued work to embed routine enquiry into various health settings.

6. Whether the alleged perpetrator had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

In order to fully evaluate the responses of agencies it is helpful to have an understanding of Harsha's past behaviour. Evidence of a bad character can be defined as "evidence of or disposition towards misconduct" (section 99: Criminal Justice Act 2003). In this case, evidence for this is entirely related to contact with the police and previous convictions, as there was no other contact with agencies identified in this review.

Harsha has an extensive history from 1992 of violent and threatening behaviour.

Although outside the timescale and scope of the review these factors are relevant to the terms of reference in terms of determining attitudes, values and risk which contributed to his future behaviour. Dobash et al (2001 & 2002) conclude that perpetrator characteristics such as previous criminal record and substance misuse are associated with partner homicides. Evidence became available at Court that Harsha was drinking alcohol to excess on a daily basis. A number of seminal reviews point to a general history of violence to people outside the family as a risk marker for domestic violence (Riggs et al 2000, Kropp 2002) and that these men are more likely to sexually assault and be severely violent to their partners (Saunders 1993). Several further and more recent studies confirm these associations; adverse attitudes to women continue to be linked to sexual aggression and intimate partner violence.

The quality of information on earlier reports of possible historic domestic related incidents is limited by the police recording system in use at the time; this was replaced and upgraded in 2003 and in 2012. Harsha had a history of abusive and violent behaviour and this may have informed an attitude that he could behave with impunity. There are definitely three incidents which are domestic related violence with previous partners and Harsha is recorded as the perpetrator; none of these are connected with Samina. There are several other violent offences which are potentially domestic incidents where information is unclear; there was either insufficient evidence to assume Harsha was the perpetrator, or the complainant did not want the police to continue the investigation.

Potential risk factors were highlighted retrospectively during the police investigation following Samina's death, such as Harsha's previous history and his possessiveness and controlling behaviour prior to the relationship between Samina and Harsha commencing. However when police attended at Samina's home address on 26th April 2012 there was no evidence that Harsha had been the man who had taken her to hospital, or that he was still involved with Samina. Samina said he was her ex-partner and her family believed the relationship had ended in October, nearly six months prior to the homicide.

Samina's Mum didn't know much about Harsha, but had met him fleetingly several times but not to speak to, "he would not engage in conversation with you", and Samina was evasive when asked about him. It appeared that Harsha did not want to get involved with any of Samina's family and he walked out if Mum visited the house. She formed the impression that he had a lack of respect for women. When Samina's Mum telephoned the house, she says she could always tell when he was there, from the tone of Samina's voice and style of conversation which would be more subdued and more monosyllabic. She states that in the

months leading up to the death, when Samina was separated from Harsha, she seemed much happier.

What is known is that Harsha had the potential for violent and unpredictable behaviour; what is unclear is how far and to what extent this behaviour impacted on his relationship with Samina and her children, and how this contributed to events leading up to April 2012.

7. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Samina, the perpetrator Harsha, or the dependent children that were missed.

- Samina

The police IMR highlighted areas for practice improvements as a result of failing to record the contact made by Samina in 2011 as a domestic incident. It is likely that any offence would have been addressed as more serious if the children were present. The Code for Crown Prosecutors states that a prosecution will probably be required if the offence was committed in the presence of, or in close proximity to a child (5.9.) and would also take account of any threats made to harm children. It is not clear if the children were present when the phone calls were made or when the windows were broken, but Harsha did make threats which included the children. The Group Service Manager for Social Care identifies that since this DHR there has been further work to look at the interface between the police and Children's Social Care. Additional police personnel will be involved in the screening and risk assessment of all domestic abuse notifications, and this will have a positive impact on the current system.

A DASH risk assessment was not completed by the police; this precluded a referral being made to the police Safeguarding Unit. The Panel discussed whether or not there was a missed opportunity to make a referral to a MARAC meeting; the conclusion was that this particularly incident would not have met the threshold as a 'high risk' referral so would not have been referred to MARAC.

The failure to record the police contact with Samina correctly as domestic abuse was identified to be human error rather than a systemic failure, as there are relevant policies and procedures in place which should have been followed. The current West Yorkshire Police Force policy for domestic abuse identifies a "duty of positive action" and the learning in the review highlights the need for effective supervision and management oversight in all reports

of domestic abuse. Individual issues have been addressed with relevant officers to promote learning from this DHR.

The call handler response and the police attendance at the home address on 26th April is of critical importance to family members; questioning if the police officer had received more information and broken the door down to gain entry to the house would this intervention have saved Samina's life?

The family identify that as Samina was slumped in the footwell of the car when she arrived at the hospital car park with her head on the seat this indicated she was likely to have injuries or be unconscious. They highlight that with more information the officer subsequently attending at the property may have decided on a different response. In addition, if the call handler had identified that Samina could potentially be injured this could have been a critical factor to take into account. The family maintain their perspective that this was a significant omission, and that pertinent questions were not asked at this initial point of contact which could have led to a different outcome. They agree with the comments from Chair 2 that the questions asked appear perpetrator and not victim focussed.

Responding to family comments the evidence was reviewed again and the police maintained that in this area no opportunities were missed. In response to further concerns raised by the family, the author of this report then arranged to listen to the tape recording of the call.

The police view is that the call was appropriately graded in response to the information available from the witness, who stated that he did not have a clear view of Samina and did not want to move closer to the car. The porter stated he was not sure if he had witnessed a crime or not but a member of the public said someone had fallen in the car park and he had gone to see if he could offer any help. When he got to the car park a male told him "she's fine now" and slammed the door of the car and drove away. The porter repeated he wasn't sure if it was a crime or a problem but "it didn't look right". The registration number and description of the car was given, although the caller was uncertain that he was correct about the type of vehicle as he had only had a quick glance, and explained he was trying to "look without looking".
In response to questions from the call handler the porter was able to give a description of an Asian male in a high visibility jacket, short hair and an earring and unshaven. He stated he didn't see the female much as she was already in the car (in the foot well) and was head down with her face into the seat. In response to questions about her physical description he said he didn't have a good look. He was unable to confirm her ethnicity but said he

assumed she was a white woman based on the colour of her hair. He repeated "it may be nothing" but the call handler reassured him that he had a concern for the woman's safety and she had logged the call as a priority to stop the vehicle.

Based on the information given by the caller it is clear that he stated several times that he only had the opportunity for a quick glance before the vehicle left the car park. The porter stated he was trying to look without it being obvious, and in these circumstances it is commendable that he had managed to accurately record the car registration in the time available. His view of the woman in the car we now know to be Samina was limited to a brief view of the back of her head.

From the information already received from the caller, the call handler was in a position to decide that further questions relating to the passenger were not required, as the porter had stated the limits of what he could see. Given that the porter later confirmed in a written statement that he had not seen any injures, further questioning by the call handler about seeing any injuries could have lead the porter to state that he had not seen any injuries, which in turn could have led the call handler to downgrade the response.

Despite the limited information, the call handler despatched an officer as a priority; this would also be the expected response if injuries had been seen so the outcome would have been the same. A police officer located the car from the information received and attended the property as a priority; and a PCSO viewed the CCTV at the hospital.

The panel concludes that that all necessary and appropriate action was taken, and the outcome of the call was to respond immediately to the concerns for the safety of the female passenger. The panel are in agreement that further questioning from the call handler of the witness relating to injury would not have been necessary, as he had already stated that he could not see her. The written statement included no further detail than was given to the call handler. The police attendance complied with Force requirements and the call taker dispatched a PCSO to the hospital within minutes to view the CCTC and speak to the security officer. The details of the car were immediately broadcasted to all officers, and an officer attended the home of the registered keeper, which was Samina.

There is evidence described in the police IMR that sustained efforts were made to check if the house was occupied. The house was in complete darkness, and despite going through a neighbour's house to observe the rear of Samina's property the officer confirmed there was no sign of activity. The neighbour confirmed there had been no sound of a disturbance, and there was no reply to continued banging and knocking at the front door. The police officer

checked with the control room to enquire if the female he was looking for had any injuries; he was informed she had not.

The hospital porter had contacted the police to report he was not sure if he had witnessed a crime or not, but he was concerned for the welfare of the woman in the car park. It was not established or recorded by the call taker if the female later identified as Samina had any visible injuries, which the family view as an omission. The written statement from the hospital porter later confirms he could not see the face of the person in the car and did not see any injuries, he did not know if the passenger in the car was conscious or not. The police identify that after reviewing the tape recording of the call no matter what questions could have been asked by the call handler no more information of any value was available.

There was an unexplained delay when Harsha's sisters arrived at Samina's address with her children and when the 999 call was made to emergency services. Despite investigation this delay remains unaccounted for. A rapid response vehicle arrived at the property 9 minutes after the first 999 call and medical intervention, patient assessment and response met all the relevant protocols for Yorkshire Ambulance Service.

The police officer was confident when he arrived at Samina's property and made all the necessary checks that the house was empty. This informs why he made no attempt to force entry as the police have no power to enter premises in this case. However it is understandable that this forms a central theme to family concerns, and any opportunity to identify action that could have changed the outcome must be fully explored.

The issue of the call handling remains as a point of difference between the family and the view of the panel members, and the family has requested that the following be inserted into this report:

> We disagree with the panel's findings that there is not significant learning to be gained from the call handling. We are not blaming anyone here but simply trying to make sure that the relevant learning is extracted:
>
> The panel concludes that *"Based on the information already received from the caller we agreed the call handler was in a position to decide that further questions relating to his view of the passenger were not required, as he had stated the limits of what he could see"*
>
> We find this conclusion a little disconcerting because despite knowing the limits of what the porter could see the call handler does go on to ask other questions about the lady he saw, including about her hair and skin colour. Given that the porter had described her unusual

position, including her being in the foot well and her face being where a backside normally is in a car, we feel that the most relevant questions should have been "Did you see any injuries, or blood or did it seem that she was in distress?"

The panel has concluded that: *"Despite the limited information the call handler despatched an officer as a priority; this would also be the expected response if injuries had been seen so the outcome was the same."*

This conclusion is of concern. The family considers that another possible outcome, without using hindsight, is that questions about injuries elicits information about injuries and this extra information is then supplied to the attending officer. The latter, faced with the judgement call about forcing entry, may decide that evidence of injuries is a sufficient reason to force entry. We are not saying that these questions would have elicited information about injuries in this case but that such questions may elicit such pertinent information in other cases and this is the significant learning.

Recommendations for this Domestic Homicide Review are based on the facts as they present themselves to the Overview Panel. In this instance, the hospital porter did not see any injuries and so no further information about injuries would have been available to the attending police officer, therefore recommendations suggested by the family would not be appropriate for this review.

The attending officer requested a further welfare visit to be conducted at the address later that evening, which was not carried out. This has led to relevant learning and is addressed in agency recommendations. Force policy stipulates that supervision within the control room must “proactively and intrusively manage incidents logs and the ongoing prioritisation of incidents”. The incident remained open waiting for an officer to be dispatched, but there is no indication that any further action was considered in relation to the reported welfare concerns. It is not possible to provide a explanation for the apparent lack of management after the attending officer left the scene, the supervisor for the incident cannot be interviewed as they are no longer serving within the Force.

- Harsha

Suhail raised concerns to Bradford Children’s Social Care relating to Harsha, but this did not result in any investigation. This would have provided an opportunity to undertake safeguarding checks on the children, and assess whether or not Harsha posed a risk to the children or to Samina. The police notifications to Social Care indicated that Samina was the

suspect on one occasion; it is possible that this notification could also have been seen in the context and pattern of allegations made by each parent about the other and their new partners. There was no statutory child protection plans in place at the time and the level of concerns raised did not meet the threshold for intervention. The case was in private proceedings and the children's interests, wishes and feelings would have been the primary consideration of the Court, and represented by the appointed Children's Guardian.

Samina told her family there was Social Care involvement in the south of England relating to Harsha and his son; her Mum questions whether this should been considered by Leeds or Bradford Social Care. Leeds Children's Social Care had undertaken two initial assessments of the needs of the children and these did not identify a need for further intervention. If any significant risks had been identified in any local authority area this would have also formed part of the assessment undertaken during the court case in Bradford by the Children's Guardian, and notifications would have been made to the relevant authorities such as the police and Social Care.

The police IMR indicate that failing to record the report to the police of threats to Samina as a domestic related incident was a missed opportunity to assess the potential risk posed by Harsha, and potentially manage his offending behaviour. The developmental issues of the IMR were fully addressed with individual officers in February 2013.

During the police investigation following Samina's death one of the children described that Harsha had been violent to her mother in the past. There is no evidence that any of the children had previously sought help from the police, or attempted to report domestic abuse to other professionals such as teachers or the school nurse.

- Dependent children

The Panel is mindful of the many potential barriers for adults and young people which get in the way of involving professionals. Children may find it particularly difficult to tell anyone about what is happening at home and can go to great lengths to hide it. Possible reasons include wanting to protect the victim from further abuse, not wanting to share family secrets with outsiders, or fear of exposing the family to shame and dishonour (Mullender et al, 2002). It is noted that Chair 2 records that Samina told her children that they should keep family matters private saying "what happens in this house, stays in this house".

Bradford District Care Trust identified a missed opportunity to follow up the disclosure from Child 1 that she felt angry and depressed on occasion. This is in the timeline of the relationship with the perpetrator, and further enquiry may have given an insight into family life. The IMR author highlights how health workers who gain a greater awareness and a comprehensive understanding of the cultural and religious beliefs of families can be instrumental in supporting children to seek help and support (Izzidien, 2008[9]). Similarly, identifying the additional pressures that children and young people of mixed parentage may face when experiencing domestic violence and abuse within their home gives services the opportunity to consider appropriate support and interventions. This has been addressed in the BDCT recommendations and action plan.

Bradford Children's Social Care missed an opportunity to work more closely with the children's school, however the IMR identifies this would not have changed the decisions made at the time. The Education IMR reports Child 1 attending First Aid daily and reports of bullying and bruising. Hindsight and the opportunity to look at a number of agency reports alongside each other offer indicators that relate to Child 1 witnessing an abusive relationship, as she later discloses during the police investigation.

The Panel member for Children's Social Care indicates that systems are much more effective now; in the Integrated Assessment Team there is a permanent Education Social Worker and health practitioners who bring this information together. Schools are more aware of domestic violence and abuse through working with MARAC. There are plans being developed for schools to be notified of all domestic violence incidents reported to the police where there are children in the household. This would provide opportunities for schools to provide early intervention and support.

Failing to record the threats from Harsha to Samina as a domestic related incident is identified in the police IMR as a missed opportunity to assess the potential risk to both Samina and her children as there was no notification to Social Care. As the report from Samina stated the incident was verbal and assumed not be witnessed by the children it is possible that the level of risk may not have led to any intervention, therefore it is debatable whether it was a missed opportunity. Recent changes to the Front Door services, and Police and Social Care working together to screen notifications of domestic abuse will provide an improved response to similar reports for the future.

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[9] Izzidien, S (2008) *I can't tell people what is happening at home*. Online – www.nspcc.org.uk/inform

8. While it is not the purpose of this review to consider the handling of child protection concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children who may be affected by domestic abuse. If this is the case these issues will be raised with the Bradford Safeguarding Children Board.

The safety, physical and emotional wellbeing of children is an essential consideration for all those making decisions in cases of domestic violence and abuse. There is a significant body of research which identifies the devastating effect of living with abuse, and the Adoption and Children Act (2002) extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic violence can have serious implications for children's development.

It is apparent that at least one of the children was aware of previous violence in the relationship between her mother and Harsha; it is likely based on our understanding and experience of domestic violence and abuse that all three children have potentially seen or heard similar events. There is no evidence that any of the children reported this to any member of their family, or to any professional.

The potential missed opportunities were identified in agency IMRs, and practice recommendations have been implemented as a means to improve service delivery. No child protection or safeguarding concerns were identified as a result of this Domestic Homicide Review.

9. The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

Aspects of the IMRs identify the value of practitioners working with children and young people accessing training to respond to the potential indicators of domestic violence and abuse. In response to DHR enquiries the Workforce Development Officer for Domestic Abuse has outlined a package of comprehensive multi-agency training available to Bradford practitioners. Only one e-learning basic awareness course describes how it addresses the impact on children and young people. Although other local training courses include this

aspect of safeguarding, this highlights there is a potential gap in specific training focussed on the issues for children who experience and witness domestic violence and abuse.

The Panel discussions reflected a need to evaluate the current training available for professionals in Bradford, highlighting the shared safeguarding responsibility of all agencies and practitioners to respond to domestic abuse. The content of existing training will also be reviewed to ensure this specifically addresses the individual needs of families from all ethnicities, including the specific issues for children and young people of dual heritage/mixed race, ethnicity and faith families, (Caballero, 2007; Caballero et al, 2008).

10. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

There is no evidence in this DHR that agency policies, procedures or practitioner responses prevented Samina or her family receiving services as a result of their ethnic, cultural, linguistic and religious identity; or that any other relevant equality or diversity issues were identified as defined in the guidance for the Equality Act (2010).

In 2009 Bradford was commended by the Equality and Human Rights Commission for the level of service provision in the district for women experiencing violence. This acknowledged the diversity of services available in the district, including specific services for BME women and their children. At the time of Samina's death, Bradford had two refuges specifically for BME women, or women with dual heritage children. In 2013 a new outreach service for BME women experiencing domestic violence but who did not want to go in to refuge was established in the district.

Some information is missing in the individual agency reviews, such as how services meet the specific needs of Samina and her children in terms of their cultural identity. In addition several IMRs had no details of the family ethnicity or religion; it may be these were recorded by the organisation, but the author did not include this information. This has relevance in terms of considering effective referral and recording systems.
Services need to ensure they are providing an inclusive and accessible service; considering the potential barriers for families and individuals like Samina and the adaptations they may need to provide. IMR authors should be encouraged to provide this evidence as part of the review, particularly when this is specifically included in the terms of reference.

Samina was a white British woman who agencies have documented had converted to Islam. Although Samina's Mum says that Samina chose not to practice any religion, for a time this was a significant aspect of her cultural identity. Samina's Mum says that family life reflected a balance of both backgrounds and was not particularly restrictive. The family celebrated Eid and wore traditional dress for family events, but Samina made many choices based on her own principles and family history. Her three children are dual heritage; Suhail is a practicing Muslim and family life will have reflected this. For families where religion plays an important role in their lives it will also be a vital part of their cultural traditions and beliefs, as faith very often underpins culture. A family who do not practice a religion, or only follow aspects of a faith may still have a particular view about the spiritual upbringing and welfare of their children which should be accounted for in any service involvement.

Samina's family highlights where people from different cultures can have an allegiance through the same faith, and where cultural identity based on ethnicity is not necessarily exclusive. People may identify themselves as British in some circumstances and as part of a particular culture in other circumstances; but they may also identify with more than one culture. These issues of difference, culture, family, community support and identity were not fully considered in depth in the agency reviews.

This situation has to be considered in the context of a relative lack of knowledge, especially in the UK, about dual heritage and ethnicity generally (Phoenix and Husain, 2007). It can also be acknowledged that mixed relationships can raise negative assumptions, discrimination and stereotypes and this contributes to how adults and children can be subject to racism and prejudice in wider society. This could have been a potential barrier to help seeking by Samina or her children, but this factor is not identified or confirmed in any of the individual agency reviews, or by family members.

There was little evidence that any separate consideration had been given to what cultural and ethnicity needs Harsha may have, how this might impact on him, or how the service might need to adapt their responses to work with him; but Harsha had very little contact with services as part of this review.
Harsha came from a Sikh family and Samina's Mum recalls Samina saying his family were prominent members of the local community and Sikh Temple. It is not known to what extent his faith was relevant to Harsha, and there is little information in any of the IMRs relating to Harsha due to the limited contact he had with relevant services. Harsha was informed in

writing that a DHR was being undertaken but he has not responded to the opportunity to be involved.

5.0. EFFECTIVE PRACTICE

Identifying effective practice in Bradford and multi-agency collaboration

- Integrated Assessment Team

The Integrated Assessment Team (IAT) is a multi agency service with seconded partners from Health, Police and Education who work together to offer consultation to any professional who has a safeguarding concern for a child. This was previously known as the "Front Door". The referrals are taken by qualified professionals who assess the referral, with much more inquiry and tease out the concerns. This results in better signposting, improved information sharing and communication and informed and timely decision making.

As part of the Integrated Assessment Team, a Domestic Violence Hub has been developed with a qualified experienced social worker and a police officer. Domestic violence referrals are screened daily by both the social worker and police officer and action is agreed. This may include contact only or no further action, or the case may be progressed to a referral for service and an assessment where there are safeguarding issues, or repeated domestic abuse referrals. This is recorded on Children's Social Care records. The referrals are graded to respond to the level of risk or concern, every referral has a review completed for historical information from both Police, and Children's Social Care.

- Cross Health Tackling Domestic and Sexual Violence Strategy

This updated strategy will be launched in November 2015[10]. The overall aim of the strategy is to promote a coordinated response to these issues by all the different health agencies that make up the whole of the health service within Bradford District. This will be achieved through the provision of the right support, intervention and information to ensure that individuals experiencing abuse can make informed choices

Clinical Commissioning Groups (CCGs) are statutory NHS bodies with a range of duties, including safeguarding children. They are essentially membership organisations that bring together GP's and general practices to commission health services in their area. The three local CCGs in Bradford have now permanently and jointly funded the post of Domestic Violence Manager (Health); the successful post holder will take up this role on 14th September 2015. This practitioner leads on the implementation of the strategy, with support from a steering group, which includes representatives from both acute Trusts, the Care Trust, the CCGs, public health and local authority.

[10] *Tackling Domestic and Sexual Violence 2015-2020; Bradford and district local health economy and NICE guidance – a strategic response to ending violence against women and girls (VAWG) and interpersonal violence against men*

- Multi agency information sharing and risk assessment

Multi Agency Risk Assessment Conferences (MARACs) bring together representatives from agencies to share information on those victims of domestic violence who are at the highest risk of serious harm. The Bradford MARAC meets fortnightly and is coordinated by Bradford Metropolitan District Council's domestic violence team.

The BMDC Domestic Violence Team is co-located with West Yorkshire Police, Bradford high risk domestic violence team within a local police station; and consists of a Domestic Violence Manager, Domestic Violence Coordinator, MARAC Coordinator and an Administration Officer.

This co-location will develop and enhance joined up services. West Yorkshire Police and the two Bradford Independent Domestic Violence Advocate services meet each morning (via video link) to discuss high risk cases that have come to the attention of the Police or MARAC team within the previous 24 hours. The Daily Risk Assessment Meetings (DRAM) ensures that immediate safety planning is carried out, preferably while the suspect is in police custody.

These pro-active responses help to safeguard service users and their dependents, and often include supporting them to access and navigate through the Criminal Justice System. The priority of this coordinated response is to increase safety providing appropriate intervention, aiming to reduce the risk of further domestic abuse and respond to the effects it may have.

6.0. CONCLUSIONS and AREAS OF LEARNING:

This section includes areas of learning from the analysis of agency IMRs, family contact and Panel analysis; responding to the terms of reference, the individual circumstances of Samina and making links to relevant research findings.

The Panel concluded that the death of Samina could not have been accurately predicted. There is no evidence that the action from any individual or agency failed to protect her, but the review does highlight areas where improvements to practice can and should be made. This is explored further in the terms of reference, and relevant learning has been detailed in agency reviews and the throughout the DHR analysis.

6.1. Working Together

There were potential missed opportunities identified in the DHR and areas where joined up working and information could be improved, these are addressed in agency and Panel recommendations. It has been a challenge for the Panel and Overview Author to fully explore the issues as they occurred in April 2012 when systems, resources and services are very different at the time of completing the DHR.

There have been particular difficulties in reviewing the role of Education as there have been substantive changes in the provider, service management and delivery which have impacted on personnel, policies and protocols. The focus of this aspect of the DHR is limited to those schools under the jurisdiction of Bradford Metropolitan District Council: Education and Learning. The Panel recognised it would be difficult to achieve global recommendations for all schools in Bradford such as voluntary-aided/voluntary controlled or trust schools, academies, independent and private schools.

The post of Lead Education Officer for Child protection has recently been vacated and this leaves a potential gap in terms of co-ordinating training, and supporting safeguarding leads in schools to address DHR recommendations. It would be helpful develop anonymised case studies relevant to schools to highlight potential missed opportunities from this and other DHRs, and profile this at relevant learning events.

<u>Informing Recommendations</u>

- Bradford Safer Communities will ensure that a specific representative for Education is included on DHR Panels where the family includes school age children

- The Panel representation will be evaluated to ensure that any relevant issues for pre-school children can be addressed by the proposed membership, or additional representation will be sought
- Education Strategic Director to evaluate support, resources and information available to teaching and non-teaching staff and access to multi agency training on domestic violence and abuse
- Education and Health – safeguarding lead in school to be supported to work closely with the named school nurse

6.2. Working with diversity

Although the principle purpose of any DHR is to focus on domestic violence and abuse and the relevant issues for the adult at risk of harm this cannot be seen in isolation where children are to be considered as part of the family dynamic. For Samina, her children were a central and constant consideration. Often the impact of domestic abuse on the child is one of the critical factors in women deciding to leave a violent relationship; and where there have been little or no disclosures of abuse, as in this particular DHR, the contact with children can be the only potential indicators available to professionals.

"Knowledge and understanding of culture and faith is critical to effective assessments of harm through neglect and/or abuse." (Munro, 2011).

Although the Munro Review focuses on the safeguarding of children, this principle is equally relevant in adult safeguarding, and in risk assessments related to domestic violence and abuse. These issues of difference, culture, family and community support were not fully considered in depth in the agency reviews.

Services need to ensure they are providing an inclusive and accessible service; considering the potential barriers for families and individuals like Samina, and the adaptations they may need to provide. Some IMRs do not refer to ethnicity or religion at all, others identify it has been reviewed and is not seen to be a relevant factor. Although Bradford has a range of specialist services and has been identified as an area with expertise and good practice, there was little evidence from agency reviews to support specific stated intent and practice relating to meeting the individual needs of this family.

The latest population figures produced by the Office for National Statistics (ONS) on 25 June 2015 show that an estimated 528,200 people live in Bradford District, which is the fourth largest metropolitan district (in terms of population) in England, after Birmingham, Sheffield

and Leeds; nearly one quarter of the population is aged under 16. Bradford Observatory hosts the 2011 Census data for Bradford City Council[11] and this reflects the ethnic diversity of the city, with the ethnic minority population representing one-third of the total population of Bradford. The professionals working to safeguard adults and children in Bradford face many challenges, but this also provides opportunities to develop a comprehensive range of skills and experience.

Bradford has expertise and experience in delivering culturally sensitive services, which could benefit and inform other areas. The DHR process has provided an opportunity to consider how this is collectively promoted and how standardised and consistent practice is delivered.

Informing Recommendations

- It would be helpful for future IMRs to demonstrate an understanding of the role of race and ethnicity in domestic violence and abuse; and how this relates to the potential barriers the people identified in the review face in accessing statutory and voluntary organisations. IMR authors should be encouraged to provide this evidence as part of the review, particularly when this is a specific terms of reference.

- West Yorkshire Consortium Procedures Manual for safeguarding children identifies that specific attention should be given to the children of mixed parentage (1.4.25) and relevant IMRs should have reflected this perspective.

- The Learning and Development subgroup of Bradford Safeguarding Children's Board will write to all training representatives in commissioned services to recommend that current safeguarding training for practitioners is reviewed and evaluated;
- to ensure that training reflects the key learning points from this DHR
- that the impact and indicators for children and young people witnessing and living with domestic violence are fully addressed
- that training reflects the diversity of families in Bradford, including the specific issues for children of mixed parentage and the role of services in addressing these needs

[11] https://bradobservatory.files.wordpress.com/2014/06/geographies-of-diversity-bfd-jun14.pdf

In addition the Bradford Domestic and Sexual Violence Strategic Board will review and evaluate the domestic violence and abuse training available to directly commissioned services; and ensure that referral information and sources of support are widely available to members of the public and service providers.

6.3. Routine, selective and targeted enquiry

There were limited disclosures of domestic violence and abuse from Samina in any of her contacts with professionals and agencies, and the use of routine enquiry may have given her the opportunity to disclose any issues of concern.

There is a wide range of evidence to support the use of routine, selective or targeted enquiry in terms of identifying and supporting women experiencing domestic violence (Mezey et al 2003; Bacchus et al 2005; Baird et al 2013). It is ineffective unless it is introduced with training on how to ask, and is carried out alongside a referral and care pathway with the resources and skills to address the domestic violence.

This DHR has provided the opportunity to discuss the current provision of training for routine, selective and targeted enquiry and recommendations have been made to ensure this is evaluated and developed as necessary to meet current and projected need.

Informing Recommendations

- The Learning and Development subgroup of Bradford Safeguarding Children's Board and Bradford Domestic and Sexual Violence Strategic Board will assist agencies to be assured that practitioners are applying routine or targeted enquiry where appropriate, and know how and where to access relevant training and support

6.4. Responding to delays in DHR process and improving quality of IMRs

The DHR process has not met agreed deadlines; and there has been a number of contributing factors which have been outlined in the report and have been fully detailed for the Home Office. These delays have not prevented individual agencies progressing the learning from their IMR and implementing in-house recommendations.

A significant change in practice as a result of this DHR is to suspend the sharing of information until after the trial rather than suspending the whole process. IMR authors are instructed to produce IMRs so that the DHR can continue at the earliest opportunity.

Additional staff is now allocated to the DHR process and these changes have had a positive impact on timescales.

Individual management reviews highlighted gaps in procedures or where protocols had not been successfully implemented and this has been addressed in agency recommendations. Implications for training and improving the knowledge and confidence of practitioners are also addressed in individual agency reports and action plans.

Informing Recommendations

- The Panel highlighted gaps in information which impacted on the accuracy of some of the IMRs and revisions had contributed to further delays. It was identified that all IMR authors who undertake a review for West Yorkshire Police should contact the Senior Investigating Officer to gain the fullest understanding of the case and family background, and it is good practice for the Independent Chair to also make contact.

- Guidance for the Crown Prosecution Service outlines the relevant factors to consider in relation to DHR process.[12] This might be expanded as a result of this DHR through reflecting on the learning available from the serious case review process which has developed over a longer period of time, and the guide currently in use for the police, Crown Prosecution Service and Local Safeguarding Children Boards gives the opportunity to evaluate the quality and timing of reports. http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

  Whilst a DHR may influence a national perspective over a longer period of time, it would be possible for Bradford to evaluate this guidance and adopt any relevant standards for a local protocol or practice improvements.

6.5. Family contact

The current Home Office guidance for the conduct of Domestic Homicide Reviews[13] states that the Community Safety Partnership should inform family members at the same time as informing the Home Office of the decision that a DHR will be commissioned (3:23). In this case Samina's mother was contacted at court in October 2012, and the DV Manager informed her that a DHR was being commissioned. A letter was not sent to the family,

[12] http://www.cps.gov.uk/legal/d_to_g/domestic_homicide_review/
[13] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

although the guidance also refers to initial contact being made in person (6:50d) this has been a process learning point for the CSP. It is acknowledged that this DHR began in the very early stages of developing processes and systems and was the second review undertaken in Bradford. Learning has grown and practice has changed with time and experience.

The family identify there are particular areas from their experience to include as part of the overall learning process.

- Before making initial contact ensure all family relationships are confirmed; identify where family members are separated therefore at more risk of being excluded
- Ensure there is particular consideration given to people who may have moved out of the area
- Ensure contact is inclusive and sensitive to the potential impact of separation as a result of domestic violence and abuse

There has also been a differing expectation relating to the sharing of IMRs with family members. Samina's Mum has been very clear this was helpful to her and other family members, but Panel members had concerns that the Chair at the time undertook this sharing of information without consultation and reference to them. Panel concerns about sharing draft IMRs and Overview reports were primarily that these have not been checked for accuracy and relevance, and could have a negative impact on the family and DHR process. There was an impact on timescales in resolving this issue, and whilst acknowledging the benefits to the family in this case this also has to balance with the responsibility to implement timely recommendations.

This matter was formally raised to the Home Office in September 2014 and the response indicated that in some circumstances it might be appropriate, and can build confidence in the DHR process for the family of the victim. The Home Office go on to say "in such circumstances we would expect an IMR to be redacted and that a DHR Chair discusses their intention to share an IMR with the senior investigation officer." This raised the principles of the ownership of IMRs and the importance of staff contributions being clearly agreed and following the principles of the Data Protection Act, this would mirror the systems in place for serious case reviews.

<u>Informing Recommendations</u>

- The Panel fully endorse the need for open transparency; however it highlights the potential to clarify the working relationship between an independent Chair and the

DHR Panel. The Home Office Government Security Classifications April 2014[14] may provide an appropriate classification system and operates within the framework of domestic law, including Data Protection Act 1998 and Freedom of Information Act (2000).

It is likely that Bradford Metropolitan Council already have all the relevant measures in place, however having the system formally referenced on DHR documents for externally commissioned work would ensure there is a formality relating to distribution and information sharing that would have precluded IMRs being given to family members without the knowledge of the Overview Panel. Alternatively an information sharing agreement could be added to any contract with externally appointed DHR Chairs, which defines the expectations of those commissioning the review.

RELEVANT EXTERNAL REVIEWS

1. HMIC (2014)

The Overview author has included consideration of the recent HM Inspectorate of Constabulary (HMIC)[15] inspection of police handling of domestic violence and abuse. It is important to note the HMIC report and recommendations were completed sometime after this tragic incident.

HMIC (2014) identified good practice for attending officers in West Yorkshire such as implementing the current force policy to take 'positive action' to minimise the risk to domestic abuse victims. The Force also works well with partner agencies who deliver local services for victims of domestic abuse and they also share information, which can ensure that the level of risk is initially reviewed so that the appropriate service to be delivered to the victim.
As a result of this inspection, HMIC has developed 7 force-specific recommendations for West Yorkshire Police, designed to tackle any risks identified in the service to victims of domestic abuse; and these should be considered in conjunction with recommendations to all forces set out in HMIC's national report on domestic abuse. There are a number of areas which are relevant to the DHR process:

[14] https://www.gov.uk/government/publications/government-security-classifications

[15] www.hmic.gov.uk

- In West Yorkshire HMIC found that there has been a lack of training for staff in dealing with domestic abuse. Most frontline staff identified they could not recall much, if any, training about domestic abuse beyond an initial input delivered when they first joined the force.
- There was little evidence that the control room supervisor routinely supervises domestic abuse incidents
- There is no systematic consistent process in place to ensure that the lessons learned from domestic homicides are fed back to all staff, and processes and practices improved as a consequence.
- ACPO should consider collating findings from domestic homicide reviews to encourage learning across forces.
- Following HMIC's inspection, there should be a further multi-agency inspection; this should consider how local services provide advice, assistance and support to victims of domestic abuse. The inspection should not only consider how individual services contribute to keeping victims safe, but also the quality of the partnerships and the ways in which joint working is scrutinised.

Local Response to HMIC review

The West Yorkshire Police and Crime Commissioner established a West Yorkshire wide sub-group to examine implementation of Domestic Homicide Reviews across the region. The sub-group has reported back to the Police Crime Commissioner lessons learned from the process of implementation in order to share good practice. The group have also agreed to establish a process of disseminating lessons learned from individual DHRs across West Yorkshire and to the wider Yorkshire and the Humber regions. This includes combining lessons learned from several DHRs in order to protect confidentiality.

The HMIC made a recommendation to ensure front counter staff, call handlers and frontline staff should receive training appropriate to their role. The Domestic Abuse and safeguarding training in Bradford District includes modules covering honour based violence, risk assessment of domestic abuse incidents, harassment, stalking and violence as well as safeguarding adults at risk, missing from home investigations, and safeguarding young people. This subject was for all staff in the Bradford District, attendance was between 80 – 95%. Further training is planned for October to December 2015 which will focus on domestic abuse and child safeguarding. The police IMR author also addresses the issue of management oversight as an area of learning and in the agency recommendation.

7.0. RECOMMENDATIONS

7.1. Overview Report: Panel Recommendations

Reflecting IMR reviews, family input, research findings and analysis throughout the DHR process

<u>Recommendation 1:</u> Training and learning opportunities

The DHR provided the opportunity to reflect on current training provision and the skills practitioners need in order to develop and deliver effective services in Bradford. Domestic abuse training should reflect key learning points from this DHR to ensure that the impact and indicators for children and young people witnessing and living with domestic violence are fully addressed, and also reflect the diversity of families in Bradford. This should include the specific issues for children of dual heritage/mixed parentage, and the role of services in addressing these needs.

- The Learning and Development subgroup of Bradford Safeguarding Children's Board will write to all training representatives in commissioned services to recommend that current safeguarding training for practitioners is reviewed and evaluated in respect of the above

- In addition the Bradford Domestic and Sexual Violence Strategic Board will review and evaluate the domestic violence and abuse training available to directly commissioned services; and also ensure that referral information for sources of support are widely available to members of the public and service providers.

- The Bradford Domestic and Sexual Violence Strategic Board will assist agencies to be assured that practitioners are applying routine or targeted enquiry where appropriate, and know how and where to access relevant training and support

<u>Recommendation 2:</u> Working Together

Bradford Domestic and Sexual Violence Strategic Board to continue to support opportunities for collaborative working and multi agency training; in addition the DHR identifies the following areas:

- Education Strategic Director to evaluate support, resources and information available to teaching and non-teaching staff and access to multi agency training on domestic violence and abuse. In addition to ensure that the safeguarding lead in school is supported to work closely with the designated school nurse.

Recommendation 3: Process and systems

Bradford Community Safety Partnership should evaluate the current process for DHRs to ensure that previous improvements and current practice reflects the learning identified in this review; identifying if there are any areas where practice and processes can be improved.

As discussed in areas of learning, this includes:

- specific representation for Education on DHR Panels where the family includes school age children
- to ensure that any relevant issues for pre-school children can be addressed by the proposed Panel membership, or seeking additional representation
- ensure IMR authors demonstrate an understanding of the role of race and ethnicity in domestic violence and abuse; and how this relates to the potential barriers and particular needs for the people identified in the review
- Police IMR authors should liaise closely with the HMET Senior Investigating Officer
- To evaluate the DHR guidance for the Crown Prosecution Service to identify any relevant areas for practice improvements
- Define the systems and principles for information sharing IMRs

7.2. Agency Recommendations from IMR Authors in their Individual Management Reviews.

This includes submission of a full agency action plan which is approved and signed off by their senior managers. Individual agency action plans will also be monitored by Bradford Domestic and Sexual Violence Strategic Board.

Agency recommendations have been formulated and agreed as a result of the combined learning from this and other Domestic Homicide Reviews, Serious Case Reviews in Bradford and ongoing evaluation and service improvements.

Bradford Children's Social Care

- The protocol between the police and Children's Social Care to be subject to an ongoing review process.
- Communication needs to take place when children are moving between Local Authorities and this must be recorded effectively.
- Children's Social Care to ensure that the use of letters when domestic violence notifications are received is no longer practice.
- Remind assessment teams of the importance of clarity where children and family members are living at the time of the contact and to accurately record the detail and any changes on the case file.

Bradford District NHS Care Trust (school nursing service)

- In accordance with the School Nursing Standards (BDCT, 2012) the School Nursing Service to review the Health Needs Survey Questionnaire offered to all year 7 and year 10 pupils. Giving particular consideration to;
  - The questions, how they are asked?
  - Is the young person making an informed choice regarding the question in each section which asks 'would you like any help or support about…?
  - What is the purpose of a young person identifying concerns about their health and wellbeing, if they are not aware of what type of help or support is available and from which health professional or service?
- All staff in School Nursing Team should adhere to the Record Keeping Guidance for Safeguarding Children, Appendix 5 of the Safeguarding Children's Policy (BDCT, 2011) and the Record Keeping Guidance for Nurses and Midwives (NMC, 2009)

- The Safeguarding Children's team to raise awareness and disseminate information regarding the addendum (appendix 9) of the Safeguarding Adults Policy (BDCT, 2012) Guide: Working with Domestic Abuse. This will increase awareness of the opportunities of how to encourage disclosure or implement routine enquiry when School Nursing teams are working with young people.
  The Safeguarding Children team to deliver training sessions for the School Nurses teams on the subject of encouraging disclosure of domestic abuse, routine enquiry and how to ask questions.

Bradford District Care Trust (NHS)

- Staff member in a permanent post in order that routine enquiry can be successfully embedded into BTHFT in Accident and Emergency, maternity services and other high usage areas where women are present.
- Develop a "Violence Against Women and Girls" (VAWG) policy for BTHFT.
- Share learning from incident with key staff.

City of Bradford Metropolitan District Council: Education and Learning (schools)

- Safeguarding training for Head Teachers and school Child Protection leads should be reviewed and include explicit reference to domestic violence and how this may be reflected in a child's behaviour in school. As a result domestic violence and its impact on children should be reflected in school safeguarding/child protection policies and procedures.
- Head Teachers and school Child Protection leads need to ensure that their record keeping systems are robust and prompt consideration of the child in the context of the family , a "think families" approach, and the need to discuss concerns with other professionals, sharing information accordingly
- Head Teachers and school Child Protection leads should ensure that children's records include all relevant information when a child moves from one school to another; and where there are particular concerns these are raised with the relevant lead in school.
- Head Teachers and school Child Protection leads should understand their responsibilities in relation to standards and guidance regarding Children Missing Education (CME)

- Head Teachers and school Child Protection leads are given clear guidelines about who to contact in domestic homicide situations so that they do not inadvertently put children at risk of the suspected perpetrator.

City of Bradford Metropolitan District Council: Housing

- That the Council's Domestic Violence Protocol be amended to make it clear that all Housing Options staff will signpost clients to appropriate support agencies when they are aware that they are fleeing or experiencing domestic abuse.
- That the Registered Social Landlords be asked to review their Domestic Violence policy to ensure that it includes clear guidance on the process to offer support to new tenants who have been granted a tenancy because they are fleeing domestic violence.

General Practitioner (GP)

- Incorporation of appropriate screening questions relating to domestic violence in consultations such as those relating to contraception and mental health.
- Increased awareness of domestic abuse, and identification of at risk individuals
- Accurate recording of social and demographic information on patient records

West Yorkshire Police

- West Yorkshire Police to ensure that when safeguarding or welfare concerns are reported to the Police, that supervision (communication and frontline) are made aware of the concern and that they monitor and oversee the initial response and subsequent outcome.

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APPENDIX

1. Appendix One: DHR Action Plan

   - Up to date action plans for each of the agencies contributing to the DHR can also be provided by Bradford Safer Communities.

Appendix 1: Overview Report Action Plan

DHR ACTION PLAN: PANEL RECOMMENDATIONS

The scope of each recommendation is local unless otherwise stated.

Please note: *At time of publication (2018) these actions contained within this report are dated. Practice in the areas decribed has been reviewed and improved, and learning from this and other DHRs has been incorporated into these improvements.DHR processes within the Bradford Community Partnership also now adhere to more recent Home Office guidelines.*

1. Training and learning opportunities

Action to take	**Lead agency**	**Target date**	**Date completed**
Write to all training representatives in commissioned services to recommend that current safeguarding training for practitioners is reviewed and evaluated - to ensure that training reflects the key learning points from this DHR - that the impact and indicators for children and young people witnessing and living with domestic violence are fully addressed - that training reflects the diversity of families in Bradford, including the specific issues for children of mixed parentage and the role of services in addressing these needs	Learning and Development subgroup - BSCB		Bradford Council's Learning & Development team offer a range of tailored courses internally and externally (including to schools) relating to all aspects of Domestic & Sexual Abuse, as well as Forced Marriage, Honour Based Abuse and Routine Enquiry. Internal and external training needs are regularly reviewed and provision is adjusted accordingly.
Review and evaluate the domestic violence and abuse training available to directly commissioned services; and also ensure that referral information for sources of support are widely available to members of the public and service providers.	Bradford Domestic and Sexual Violence Strategic Board		
To be assured that systems and resources are in place to evaluate	Bradford Domestic and Sexual Violence Strategic		

that practitioners are applying routine or targeted enquiry where appropriate, and know how and where to access relevant training and support	Board		

Training and learning opportunities

	Date of review	Evaluation of outcome
1.a)		
1.b)		
1.c)		

2. Working Together

Action to take	Lead agency	Target date	Date completed
Evaluate support, resources and information available to teaching and non-teaching staff, and access to multi agency training on domestic violence and abuse. In addition to ensure that the safeguarding lead in school is supported to work closely with the named school nurse.	Bradford Metropolitan District Council: Education and Learning		Bradford Council's Learning & Development team offer a range of tailored courses internally and externally (including to schools) relating to all aspects of Domestic & Sexual Abuse, as well as Forced Marriage, Honour Based Abuse and Routine Enquiry. Internal and external training needs are regularly reviewed and provision is adjusted accordingly.

Working Together

	Date of review	Evaluation of outcome
2.a)		
2.b)		

3. Process and systems

Action to take	Lead agency	Target date	Date completed
Evaluate the current process for DHRs; to ensure that previous changes and improvements and current practice reflect the learning identified in this review. Identify if there are any areas where practice and processes can be improved. In addition to ensure that family contact responds to the learning points identified in this DHR.	Bradford Community Safety Partnership		New Statutory Guidance on DHRs being adhered to, robust governance and continuous review in place.

Process and Systems

	Date of review	Evaluation of outcome
3.a)		
3.b)		

Appendix two: Process Chronology

29/04/2012	Female victim died
30/04/2012	Police notified the Community Safety Partnership (CSP)
01/05/2012	Community Safety Partnership (CSP) Chairs Group discussed the case. This group is made up of the Chairs of the sub-groups and includes West Yorkshire Police, CBMDC, Health and Probation.
01/05/2012 (M1)	Bradford Domestic Homicide Review Panel convened
02/05/2012	Organisations scoped for information and asked to secure files
15/05/2012	Decision to implement DHR made by the two chairs of the CSP
16/05/2012 (within one month of homicide)	Home Office notified of the intention to hold a DHR
30/07/2012	Initial Independent Chair appointed *(The first of three)*
11/09/2012, 12/09/2012 and 29/11/2012	Training sessions for Independent Management Report Authors and Overview Panel members
	DHR suspended until after trial Subsequent DHRs have only suspended the sharing of information until after trial – IMR authors are requested to complete IMRs and Action Plans during the period between the homicide and the end of the trial to reduce the delay caused by the suspension.
08/10/2012	Trial begins
10/10/2012	Family members informed of DHR process
17/10/2012	Perpetrator convicted of murder (minimum 20 years imprisonment)
08/11/2012 (within one month of conviction) (M2)	Initial meeting of Overview Panel to agree Terms of Reference
04/12/2012	IMR authors instructed to proceed with IMRs
11/12/2012	CAFCASS asked if they had any involvement with the deceased and perpetrator (the information was reviewed and not considered relevant to the DHR)
31/12/2012	Deadline for initial chronologies
07/01/2013	Initial Independent Chair resigned due to ill health
15/01/2013	2nd Independent Chair appointed

01/03/2013 (M3)	Overview Panel meeting to discuss initial IMR chronologies (IMR authors invited)
28/03/2013 (within 5 months of conviction)	Overview Panel meeting to discuss IMRs (IMR authors invited) *Minutes of the Overview Panel dated* ***Thursday 28th March 2013 indicate*** *DJH had spoken with the mother of SW who wass keen to engage and would be having a further meeting w/c 8th April 2013.*
01/05/2013 (within 7 months of conviction)	A meeting to discuss 1st draft report was scheduled but **cancelled** to allow for corrections to be made to IMRs and for the Overview Report to be written
06/2013	2nd Chair meets with Family
16/05/2013 (M5)	Overview Panel meeting to discuss issues raised by the family
11/2013	Family request meeting with representative from West Yorkshire Police
01/2014	Meeting takes place between West Yorkshire Police, the family and their Independent Advocate.
02/2014	DHR Panel met to discuss a potential breach of confidentiality relating to the principle of Individual Management Reviews being shared with family members. Legal advice was sought by the Panel, and a letter sent to the Home Office for clarification in relation to the process. In March the Home Office were informed of a delay.
06/2014	First draft Overview Report was received from the Chair
09/2014	A response to first draft was received from the Home Office.
12/2014	A decision was made by the Community Safety Partnership (CSP) to commission a new Overview Report in December 2014 due to unresolved differences between the appointed Chair and the Review Panel.
19/12/2014	A **third Independent Overview Report** Author was commissioned to complete the Overview Report on 19th December 2014. The current author has had no involvement in this DHR process prior to December 2014.
20/03/2015	3rd Chair/Author meets with Family and Independent Advocate to inform first Panel meeting. Statement for inclusion in final report provided by the family.
12/08/2015	A total of eleven DHR Panel meetings were undertaken during this DHR process with the final meeting on 12th August 2015
12/2015	Lead Officer for Domestic Abuse and DHRs taken suddenly ill – long-term.
06/2016	Review ‘concluded’ by Author/Chair
10/10/2016	Final Report submitted to Home Office Quality Assurance (QA) Panel.
31/03/2017	Response to Report Submission received from Home Office Quality Assurance Panel. Some recommendations for future practice made. Panel states that is *“does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report”.*

07/2017	Development Officers recruited to Domestic Abuse Team with CSP following sustained period of short-staffing. This DHR is allocated to new staff member – familiarisation with case & DHR processes follows.
25/07/2017	New Development Officer provides update to family and advocate. Explains that Home Office QA panel points are being looked into, including request for a response from Housing Options (CBMDC).
19/09/2017	CSP letter to QA Panel giving assurances around the recommendations made in their letter dates 31st March 2017.
19/09/2017	Copy of response to QA Panel sent to family via advocate alongside offer from Development Officer to meet with the victim's mother and her advocate in Bradford or at her home.
09/10/2017	Telephone conversation between Development Officer and family's advocate to agree approach, discuss case and how best to communicate and engage with family. Decision to visit the family at their home made and dates discussed via email.
02/11/2017	Response from QA Panel to CSP letter of 19/09/17 received. It states that *"the Panel is satisfied that all matters have now been addressed and would like to thank you and your colleagues for your participation in the process and for the considerable work that you have put into the report in this case".*
21/11/2017	Development Officer (CBMDC) undertakes two day visit to meet with the victim's mother and her independent advocate. Family and advocate request that a number of points about DHR processes, and a small number of minor amendments, be brought back to the CSP and DHR Standing Panel for consideration in advance of publication of the final DHR Overview Report.
21/11/2017	Target date for publication agreed with family and advocate - by 31st January 2018 – following development of an appropriate web page to host DHR reports and guidance. This will be the first DHR review published in Bradford.
29/11/2017	Development Officer's notes from family meeting shared with advocate.
13/12/2017	Amended notes/comments returned by advocate.
13/12/2017	Family/Advocate suggested report amendments are shared with Chair of DHR Standing Panel and Chief Superintendent of West Yorkshire Police (WYP). WYP Superintendent and their *Central Safeguarding Governance Unit* to consider amendments and respond .
17/01/2018	WYP confirm that they find the family's suggested amendments to be reasonable. Other suggestions on DHRs and processes from family noted. Amendments to final draft made. New bespoke web page drafted to host publication of this and other DHRs in Bradford District. New target publication date agreed with Family and advocate of end February 2018.
02/2018	Final DHR Overview Report, and content of Quality Assurance Panel's letters, published on newly developed Bradford Council *Domestic and Sexual Abuse* web pages. URL shared with the family, advocate and Home Office Quality Assurance Panel.