# BE SAFE BOLTON STRATEGIC PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# MRS MOHAMMADI

# MRS AHMEDI

# OVERVIEW REPORT

11th July 2017

Independent Chair: David Hunter

Report Author: Paul Cheeseman

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## 1. INTRODUCTION

1.1 The principal people referred to in this report are:

| Referred to in report as: | Relationship | Ethnic Origin |
|---|---|---|
| Mrs Mohammadi | Victim [deceased] | Iranian |
| Mrs Ahmedi | Mother of Mrs Mohammadi [deceased] | Iranian |
| Mr Mohammadi | Husband of Mrs Mohammadi [deceased] | Iranian |
| Eldest son of Mr & Mrs Mohammadi | Son of Mrs Mohammadi and Mr Mohammadi | Iranian |
| The younger son of Mr & Mrs Mohammadi | Son of Mrs Mohammadi and Mr Mohammadi | Iranian |
| Mr Mahmoodi | Brother of Mrs Mohammadi/son of Mrs Ahmedi | Iranian |
| Mrs Yousefi | Friend of Mrs Mohammadi | N/K |
| Ms Smith | Work Colleague of Mrs Mohammadi | N/K |
| Ms Gilani | Friend of Mrs Mohammadi | N/K |
| Address 1 | Home of Mrs Mohammadi, Mrs Ahmedi & Mr Mohammadi | |

1.2 At 02.16 hours on 09.12.2013 a call was made to the fire service from neighbours living close to Address 1. They were awoken by a bang and could see smoke and fire coming from the address. The fire service attended, forced entry to the premises and brought the blaze under control. They located the bodies of Mrs Mohammadi and Mr Mohammadi in the kitchen and the body of Mrs Ahmedi within an upstairs bedroom.

1.3 The cause of death of Mrs Mohammadi was established as multiple stab wounds and of Mr Mohammadi as inhalation of the products of combustion and ischemic heart disease. The cause of death for Mrs Ahmedi was established as inhalation of the products of combustion.

1.4 A major enquiry was conducted by Greater Manchester Police supported by investigators from Greater Manchester Fire and Rescue Service and a forensic scientist. The conclusion of the scientist was that the fire at Address 1 was deliberately set by an occupant of the house. The use of petrol as an accelerant in the kitchen, in addition to the gas from the uncoupled supply was confirmed.

1.5 Evidence was found that petrol cans and petrol had been purchased using a credit card in the name of Mr Mohammadi a few days before the fire. It was apparent that the property was secure at the time of the fire. The front door and the external kitchen door were locked shut and the keys were still in the locks. A large kitchen window unit had been forced outward by an apparent over pressure in the area and had dropped onto the garden below. This had happened at a very early stage of the fire as the windows were clean.

1.6 A comprehensive file of evidence was prepared and submitted to HM Coroner Jennifer Leeming who held an inquest in March 2014. Greater Manchester Police are reported to have said they believed no-one else was involved. Friends of Mrs Mohammadi reportedly told the Coroner that she had told them she wanted a divorce and one said that her husband [Mr Mohammadi] had stated: *"If you leave me, I will kill you and myself."*

1.7 The eldest son of Mr & Mrs Mohammadi reportedly said evidence from a pathologist showed his father had severe undiagnosed heart disease. He told the court it was possible his father collapsed after seeing his wife stabbed to death and had then succumbed to the smoke. The coroner told the sons: *"I have been greatly impressed by the courage and dignity shown by yourselves and by the family."* She recorded an open verdict on Mr Mohammadi and unlawful killing verdicts on Mrs Mohammadi and Mrs Ahmedi. Greater Manchester Police have recorded the incident as two murders with Mr Mohammadi as the person responsible. This accords with National Crime Recording Standards.

## 2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

### 2.1 Decision Making

2.1.1 Formal notification of the deaths of Mrs Mohammadi and Mrs Ahmedi was made to Be Safe Bolton Strategic Partnership on 9th January 2014. The Chair of the CSP made the decision that the circumstances met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance) on 14th January.

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months.

### 2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. Four panel meetings were held and attendance was good with all members freely contributing to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The Panel comprised of:

| | |
|---|---|
| ➢ David Hunter | Independent Chair |
| ➢ Paul Cheeseman | Assistant to Chair |
| ➢ Amina Jeewa | Bolton Council, Domestic Abuse Coordinator. |
| ➢ Tony Kenyon | Bolton Council, Community Safety Services |
| ➢ Helen Bolton[1] | Bolton Clinical Commissioning Group (CCG), Safeguarding Specialist |
| ➢ Leah Simms | Probation Operations Manager |
| ➢ Carole Marsden | Paws for Kids/DAV Services |
| ➢ Nezahat Cihan | Director of Operations, Iranian and Kurdish Women's Rights, London |

[1] Replaced after the final meeting by Pam Jones, Associate Director, Safeguarding for the CCG.

## 2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- Bolton General Practitioner Services
- Guy's and St Thomas' NHS Foundation Trust
- Greater Manchester West NHS Trust Bolton Primary Care Psychological Therapy

2.3.2 The following agencies helpfully supplied relevant information when requested. When this material is used within the body of this report it is attributed accordingly.

- Greater Manchester Police
- University of Bolton
- Bolton Citizens' Advice Bureau

## 2.4 Notifications and Involvement of Families

2.4.1 David Hunter wrote to the eldest son of Mr & Mrs Mohammadi, the younger son of Mr & Mrs Mohammadi, and Mr Mahmoodi to explain the DHR process and determine whether they wanted to contribute. Mr Mahmoodi spoke to David Hunter on the telephone and agreed to take part in the review; his views are attributed where appropriate. The letters were accompanied by the Home Office leaflet on domestic homicides and a leaflet from AAFDA (Action After Fatal Domestic Abuse) Delivery was arranged through the police Family Liaison Officers.

2.4.2 A number of people known to Mrs Mohammadi as friends, colleagues and associates have been spoken to by other members of the panel and provided relevant information which is included in the body of the report and attributed where appropriate. David Hunter also wrote to HM Coroner Jennifer Leeming informing her of the DHR and offering a briefing if needed.

2.4.3 There is a history of significant contact with the two sons of Mr & Mrs Mohammadi which is contained in a separate document provided to the Home Office. In summary, they challenged the decision to hold a DHR believing the circumstances of the death did not meet the criteria in the guidance, because it was possible someone, other than their father, might have killed their mother and set the fire. Following consultation with the Home Office Quality Assurance Panel, and legal advice, the Be Safe Bolton Strategic Partnership determined that the original decision by the Chair of the Partnership and the Core Screening Panel to hold a DHR was correct.

2.4.4 The younger son of Mr & Mrs Mohammadi had a meeting with the DHR Chair and others in which he expressed views on the DHR but declined to have them included in the report. He said that he was also speaking on behalf of the eldest son of Mr & Mrs Mohammadi who held a similar position. The DHR Panel respected their positions and appreciated how difficult it was for them.

## 2.5 Terms of Reference

### 2.5.1 The purpose of a DHR 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;
- Prevent domestic violence, abuse, honour based violence and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

### 2.5.2 Timeframe under Review

The DHR covers the period 01.01.1978 to 09.12.2013.

### 2.5.3 Case Specific Terms

i. How did agencies identify and assess the domestic abuse risk indicators in this case?

ii. Were the risk levels agencies set appropriate and what did agencies do to keep them under review?

iii. Was the impact of mental health issues properly assessed or suitably recognised and what action did agencies take in identifying and responding to these issues?

iv. What focus was put on understanding Mr Mohammadi's behaviour towards Mrs Mohammadi and Mrs Ahmedi?

v. What services did agencies provide for Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

vi. How did agencies ascertain the wishes and feelings of Mrs Mohammadi and Mrs Ahmedi about their victimisation and were their views taken into account when providing services or support?

vii. How effective were agencies in gathering and sharing relevant information and did they meet any resistance?

viii. How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, including honour based violence, when completing assessments and providing services to Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi.

ix. Were single and multi-agency domestic abuse policies and procedures followed including the MARAC and MAPPA protocols? Are the procedures embedded in practice and were any gaps identified?

x. Do any agencies' policies / procedures / training require amending or new ones establishing as a result of this case?

xi. How effective was agency supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

xii. Were there any issues in relation to capacity or resources within agencies or the Partnership that affected their ability to provide services to the victim and perpetrator or to work with other agencies?

## 3. DEFINITIONS

3.1 The experiences of Mrs Mohammadi fall within the Government definition of domestic violence which can be found at Appendix A. The domestic abuse services and risk assessment model used within Be Safe Bolton Strategic Partnership are described at Appendix B.

## 4. BACKGROUND - Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi

Note: The information in this section is drawn from chronologies, IMRs, family members and friends.

### 4.1 Mrs Mohammadi

4.1.1 Mrs Mohammadi was born in Iran and was the daughter of Mrs Ahmedi. She moved to the UK in 1981 with her father and younger brother when her parents' marriage broke down, although she is reported to have spent periods living with both parents. She undertook a beauty therapy course in Brighton and met Mr Mohammadi in 1988/89 while living in London with her family. They married shortly after and had two sons who are referred to in this report as the eldest and younger son of Mr and Mrs Mohammadi.

4.1.2 At the time of her death she lived at Address 1 with her husband and her mother, Mrs Ahmedi. She had part time employment with a large retailer in Bolton and attended Bolton University where she was studying law. Her first language was Farsi but she spoke English well and acted as an interpreter for an agency.

### 4.2 Mrs Ahmedi

4.2.1 Mrs Ahmedi was born in Iran and was married with two children, Mrs Mohammadi and a younger brother [Mr Mahmoodi]. She separated from her husband in 1980 and moved to the UK in 1983. She did not speak English. She lived in Brighton and later moved to London where she had a sheltered housing flat. She was diagnosed with a serious condition and moved to Address 1 around 01.12.2013.

### 4.3 Mr Mohammadi

4.3.1 Mr Mohammadi was born in Iran and moved to the UK when he was a young boy where he was educated at a boarding school. His parents did not marry and were separated when he was very young. His father had two children from a subsequent marriage. Mr Mohammadi is described as being an architect although he is believed to have been made redundant about six years prior to the homicides. For a period of time he is believed to have owned a shop in Bolton.

### 4.4 Mrs and Mr Mohammadi's Relationship

4.4.1 Mrs and Mr Mohammadi lived at Address 1 with their sons for a number of years although both sons had left at different points in time to study at University. At the time of their deaths Mrs Mohammadi, Mrs Ahmedi, and Mr Mohammadi were the only known occupants and the property was for sale with a local firm of estate agents.

4.4.2 Mr Mohammadi's character is described as having changed since he encountered difficulties with an inheritance in Iran from his late father's estate which started around 2008. As a result of these issues he spent substantial periods of time in Iran leaving his eldest son to look after family and financial matters.

4.4.3 Since the death of his father in 2008, Mr Mohammadi is described as having had problems for some time and being aggressive with violent mood swings and this is believed to have impacted upon his relationship with his sons. Mr Mohammadi is said to have cried for days at a time and was believed to be at breaking point and

is described as using "mental torture" on Mrs Mohammadi by, for example, making unkind remarks about her relationship with her children. A few days before the fire it is known that Mrs Mohammadi told her eldest son that she was going to leave Mr Mohammadi as their relationship was 'going downhill' and she had been looking for places to rent; she had also suggested trial separation or counselling to him.

4.4.4 Family, friends, and other colleagues also provide important information as to the state of the relationship between the couple. The following paragraphs contain information drawn from conversations panel members had with friends or has been provided by Greater Manchester Police as part of their major incident enquiries.

4.4.5 Mrs Mohammadi had been an employee of a large national retail outlet where she worked with Ms Smith. Ms Smith initially provided information that she was the 'Sales Manager' at this outlet and had known Mrs Mohammadi for the previous six years. She was aware of Mr Mohammadi's visits to Iran and Mrs Mohammadi had explained to her that she did not love her husband, that 'he brought her down', and Ms Smith believed that Mr Mohammadi controlled Mrs Mohammadi's life. At some point Mrs Mohammadi disclosed to Ms Smith that Mr Mohammadi had struck her. It appears no other person in the company was aware of this disclosure, although it was known that Ms Smith had, on occasions, witnessed telephone conversations between Mrs Mohammadi and her husband during which she had heard Mr Mohammadi screaming and swearing at her. Another manager in the store was unaware of the fact that Mrs Mohammadi was having marital issues. However they noticed that she was upset. It is not clear what level of understanding supervisory staff had of Mrs Mohammdi's marital problems other than that within Ms Smith's personal knowledge. Ms Smith later became aware that Mrs Ahmedi had a serious illness and was coming to stay with Mrs Mohammadi, so she could receive treatment. Ms Smith was aware of Mrs Mohammadi coming into the store on 04.12.2013 when she spoke to another employee and was clearly upset over Mrs Ahmedi's prognosis. At this time Ms Smith was the Deputy Manager. Mrs Mohammadi was given a bunch of flowers which were intended for Mrs Ahmedi a couple of weeks prior to her death.

4.4.6 Mrs Mohammadi also disclosed to Ms Smith that she had kept a diary in which she recorded everything about her life, her mother, and home life, and that Mr Mohammadi had discovered the diary. Mrs Mohammadi had said repeatedly, "I need to leave him" and spoke of acquiring a small bedsit, so she could look after her mother. Mrs Mohammadi told Ms Smith that she and Mr Mohammadi had been sleeping in separate beds and said she intended to speak to Mr Mohammadi about leaving.

4.4.7 The panel decided to engage with the company so as to consider whether there was anything to learn with regard to their policies and response to Mrs Mohammadi as a victim of domestic abuse. The Independent Chair wrote to the company inviting them to take part in the review and they provided a formal written response. In it they stated they did not have a specific policy on domestic abuse. In the absence of a specific policy on domestic abuse the company said employees were able to obtain independent advice and support on any issues, whether personal or work related, through an expert third party provider the company has in place as part of an employee support package. The expert third party provider provides telephone and face to face contact on a range of issues including debt advice, counselling, hardship grants, career development, retirement housing and

relationships, including specifically issues relating to domestic abuse. The third party provider is promoted to employees through printed material and on the company website. When asked if this was the only response to significant personal problems such as Domestic Abuse the company said that a referral to Occupational Health would apply if the employee was absent, or had high levels of absences. Mrs Mohammadi did not have any significant absence from her work.

4.4.8 The company confirmed that Mrs Mohammadi's manager was aware there was a poster advertising the arrangements for the expert third party provider that was displayed in the staff room. Ms Smith did not feel the circumstances were serious enough to advise Mrs Mohammadi that she could use the service although there was nothing preventing Mrs Mohammadi from accessing that service independently. The company was asked whether it provided any training for managers and staff which included domestic abuse awareness and how disclosures should be dealt with. The company stated they provided training on how to advise employees to use the expert third party provider in confidence. The company believes it is better to provide access to experts in matters such as Domestic Abuse rather than expect its managers to attempt to provide detailed support in such a difficult area.

4.4.9 The company have in place procedures for monitoring the attendance and performance of employees, issues which can be an indicator of welfare needs. In respect of Mrs Mohammadi the company observed no absence or performance related issues, it was noted that she had not applied for leave for domestic reasons and the company did not hold any concerns about her welfare. It is not clear how Ms Smith responded to disclosures made to her by Mrs Mohammadi, however, in any case it appears local managers, who were aware of the incidents in the workplace, may not have recognised that these may have been indicators of Domestic Abuse.

4.4.10 the panel is satisfied there was some information known to managers in the company about Mrs Mohammadi's treatment by Mr Mohammadi. At the very least shouting and swearing down the telephone at Mrs Mohammadi was witnessed within the work place and the Panel recognises that this behaviour witnessed would fall within the definition of Domestic Abuse (Appendix A). The employee support package provided by the company is to be applauded but the benefits of this approach would be enhanced if there was further support in referring/sign-posting employees to use it.

4.4.11 Mrs Yousefi spoke to members of the DHR panel and told them she had known Mrs Mohammadi very well for a number of years. She only became aware of problems in her relationship with Mr Mohammadi about 2-3 years ago. In September 2013 Mrs Mohammadi told Mrs Yousefi that Mr Mohammadi was physically abusing her and she told her that he had hit her with a pan and grabbed her by the throat and that she had bruises, marks on her neck, and a bump on her head. Mrs Mohammadi disclosed to Mrs Yousefi that there was a lot of tension over the issue of Mr Mohammadi's father's inheritance and this caused him to take out his frustration on her.

4.4.12 Mrs Mohammadi also disclosed to Mrs Yousefi that she did not sleep well, believing that something would happen to her while she was sleeping. About a week before her death, Mrs Mohammadi told Mrs Yousefi that she had woken up during the night to find Mr Mohammadi standing over her in the bedroom. Mrs Mohammadi

told Mrs Yousefi in a telephone conversation that her husband had begged his mother-in-law to make Mrs Mohammadi stay, and he had said to Mrs Mohammadi, "If I can't have you no one can".

4.4.13 A few days before she died Mrs Mohammadi told Mrs Yousefi that she was going to leave her husband. The last time Mrs Yousefi spoke to Mrs Mohammadi was the day before the fire when she told her that she was going into Manchester the following day to look for accommodation. When asked by the panel members about the support she was able to provide to Mrs Mohammadi, Mrs Yousefi said she had advised her to leave Mr Mohammadi on a number of occasions but she would not do so because she felt there was no point as he would find her. Mrs Yousefi encouraged her to go to a solicitor and again Mrs Mohammadi said there was little point in doing this. The Panel did not find any evidence that Mrs Mohammadi consulted a solicitor; it seems she took her queries to the Citizens Advice.

4.4.14 Mrs Yousefi says that some years ago Mrs Mohammadi reported an incident to the police as a result of which Mr Mohammadi was arrested but was released the following day. Consequently Mrs Mohammadi felt that reporting incidents to the police was a pointless exercise. Greater Manchester Police have no record that such a report was made or that Mr Mohammadi was arrested.

4.4.15 Mrs Yousefi expressed the view that services could provide more support for 'Asian people' in relation to domestic abuse and that awareness could be raised through methods such as printing leaflets and group work sessions to improve empowerment and help build confidence.

4.4.16 Ms Gilani said in a statement she provided to Greater Manchester Police that she became friends with Mrs Mohammadi over the last few months of her life. Mrs Mohammadi told Ms Gilani that Mr Mohammadi was controlling with mood swings; being angry then apologising. Ms Gilani persuaded Mrs Mohammadi to dress down at college from Iranian style dress to Western dress. Mrs Mohammadi would do this then she would change back into Iranian dress before her meeting Mr Mohammadi again. The fact Mrs Mohammadi felt that she had to change back into Iranian dress to meet her husband might be because she feared what he would say to her and if this was the case it could be an example of controlling behaviour by Mr Mohammadi. Mrs Mohammadi had discussed on a number of occasions threats made by Mr Mohammadi to kill her as well as himself. When she had talked to her husband about leaving, Mrs Mohammadi told Ms Gilani that he said, *"you leave me, I will kill you and kill myself ".*

4.4.17 The panel have discussed how services might be improved for friends such as Ms Gilani and Mrs Yousefi. The panel believe the experiences of Mrs Yousefi in particular illustrate the need for good, impartial advice to be available to friends and family members who receive disclosures of domestic abuse or have suspicions that it is occurring. The panel are aware of a very useful document that provides such advice produced by the Mayor of London's Office and believe consideration should be given to producing a local document based upon it. (www.london.gov.uk)

4.4.18 Mr and Mrs Mohammadi's wedding anniversary was due around the time of the homicides. Mrs Mohammadi's told other colleagues at work that Mr Mohammadi wanted to go on holiday to celebrate but she did not, and instead stayed at home to look after her mother, Mrs Ahmedi. She spoke of Mr Mohammadi not wanting Mrs Ahmedi to move in with them. Mrs Mohammadi had said that she did not love

Mr Mohammadi and could not stand him near her; they ate separately and she needed to leave him and find a place of her own. Another person, who knew Mr Mohammadi well, described him as controlling, dominant, and a person whose word was meant to be obeyed.

4.4.19 During their investigation into the deaths of Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi Greater Manchester Police recovered a diary kept by Mrs Mohammadi [referred to in para 4.4.6], a transcript of which was prepared and considered by the DHR panel. Sections of the diary appear to date from December 2010. It is written in the first person in English and appears to be a commentary by Mrs Mohammadi on the state of her marriage and relationship with Mr Mohammadi. While it does not contain any information to indicate that Mrs Mohammadi feared for her safety at that time, it does indicate that there were problems in their relationship which seem to be centred on Mr Mohammadi's travels to Iran and it supports the views expressed by other witnesses.

## 5. THE FACTS BY AGENCY

### 5.1 Introduction

5.1.1 Three agencies submitted IMRs and these are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. Three agencies provided short reports or information when requested (see paragraph 2.3.2). The main analysis of events appears in Section 6.

**Bolton Citizens Advice Bureau (CITIZENS ADVICE BUREAU)**

5.1.2 Between 2006 and 2013, Mrs Mohammadi consulted the Citizens Advice Bureau on ten different occasions. These related to; benefits advice November 2006 and March 2010; Disability Living Allowance appeal (now called Personal Independence Payment) June 2010; and a student loan June 2010. The first reference to Mr Mohammadi was when she consulted the Citizens Advice Bureau in July 2010 in relation to her '*husband in Iran transferring property in clients name'* and again in August 2010 in relation to *'debt..husband in Iran…advice re transferring property into clients name'.* In October 2010, she contacted the Citizens Advice Bureau concerning separation and was signposted to a family law-drop in operated by a firm of solicitors. In April 2011, she consulted them regarding employment advice and the final consultation was in July 2013; recorded as *'debt advice-clients husband living abroad and struggling financially as a result'.*

5.1.3 The Citizens Advice Bureau reports that the majority of the times Mrs Mohammadi accessed their services she advised them that she was a single person and that her husband had moved abroad. The case notes do not disclose that domestic violence was a consideration as she presented as separated. The Citizens Advice Bureau conclude that there did not appear to be any grounds to involve or include another agency in her case.

**University of Bolton**

5.1.4 The University record Mrs Mohammadi as studying part time for an LLB[2] having started a course there in September 2013. Mrs Mohammadi declared a disability on enrolment and was seen by the University Disability Services Manager on 19.09.2013.

5.1.5 Mrs Mohammadi was assessed on 22.10.2013 by specialists used by the University. Mrs Mohammadi reported severe problems with short and long term memory which were evident throughout the test. The assessor was concerned she had no memory of her childhood or of what the assessor had said to her during the assessment; her profile was described as *'complex'.* It was suggested she visit her GP for referral to an Occupational Therapist and that she speak to the University Counsellor to discuss some of her early personal circumstances. She did not take up the suggestion of speaking with the Counsellor.

5.1.6 Mrs Mohammadi later called the University to say she was unhappy with the assessment and wished to be re-assessed. She held a meeting on 25.11.2013 with a disability advisor, the outcome of which was that Mrs Mohammadi would speak with the assessor for clarification and consult her GP about referrals. At the meeting

[2] The Bachelor of Laws (LL.B) is an undergraduate degree in law.

with the advisor Mrs Mohammadi told them that her mother (Mrs Ahmedi) had recently been diagnosed with a serious illness and she was offered support from the University but did not to take it up.

5.1.7 Mrs Mohammadi was described by University tutors as a good attender, a satisfactory performer, and as socialising well with other students. The University were not aware of any problems Mrs Mohammadi was experiencing at home and these only came to light from fellow students following her death. None of the students who were aware of the difficulties Mrs Mohammadi was experiencing at home sought help from University staff.

## 5.2 Guy's and St Thomas' NHS Foundation Trust

5.2.1 Mrs Mohammadi was known to Guy's and St Thomas' NHS Foundation Trust since she had cardiac surgery in the 1980's. She subsequently had intermittent outpatient follow up appointments with a specialist Consultant Cardiologist over two separate periods; 1987-1997 and 2006 until the time of her death in 2013.

5.2.2 The IMR author has reviewed all documentation on the numerous visits Mrs Mohammadi made to the outpatients at Guy's and St Thomas' NHS Foundation Trust. There are no concerns or indicators of any potential abuse prior to a visit she made on 24.10.2012. On this occasion she was seen by a Cardiac Consultant who had seen her regularly since May 2008. The notes of the consultation indicate that Mrs Mohammadi was presenting with physiological symptoms (e.g. palpitations) for which a cardiac cause was ruled out. She was asked some direct questions regarding possible stressors in her life at which point Mrs Mohammadi mentioned stress within her marriage. She did not, however, talk about domestic abuse and the consultant did not explore the issues further.

5.2.3 When spoken to by the IMR author the consultant involved stated that he did not have any concerns regarding Mrs Mohammadi being the victim of possible domestic abuse and that the issue did not require any further response from Guy's and St Thomas' NHS Foundation Trust other than to share this information with her GP. A letter was therefore sent on 29.10.2012 from Guy's and St Thomas' NHS Foundation Trust to Mrs Mohammadi's GP practice in Bolton that included a comment that she had mentioned *'significant marital problems at home…'*

5.2.4 Finally, the records held by Guy's and St Thomas' NHS Foundation Trust indicate they had no information regarding Mr Mohammadi and no information or knowledge regarding any mental health issues in relation to Mrs Mohammadi or her wider family or social network.

## 5.3 Greater Manchester West NHS Trust - Bolton Primary Care Psychological Therapy Service

5.3.1 Bolton Primary Care Psychological Therapy Service had contact with both Mr Mohammadi and Mrs Mohammadi during the period of this review. Mr Mohammadi was referred by his GP on 03.07.2007 for '*anxiety/anger'* and an appointment made for him to attend. However, it appears that Mr Mohammadi never attended any appointment with the agency because he worked between 0700hrs and 21.00hrs each day whereas the Bolton Primary Care Psychological Therapy Service was only operational between 09.00hrs and 17.00hrs. It appears from the records that it was

Mrs Mohammadi who made all the contact with Bolton Primary Care Psychological Therapy Service on behalf of Mr Mohammadi.

5.3.2 Mrs Mohammadi was referred to Bolton Primary Care Psychological Therapy Service on two occasions during the period of this review. The first of these was by her GP on 11.02.2011 for *'low mood and stress related symptoms relating to Mr Mohammadi being in Iran and feeling her life was on hold and worries about the future of her marriage'.* The Bolton Primary Care Psychological Therapy Service records show that no risks were identified by the referring GP. A letter was sent to Mrs Mohammadi requesting she contact the service to book an appointment. As no contact was made by her she was discharged from the service.

5.3.3 Mrs Mohammadi was again referred by her GP for a second time on 23.01.2012 for *'low mood/anxiety and concerns over family relationships'*. A letter was sent requesting Mrs Mohammadi to make contact to arrange an appointment and as no response was received from her she was discharged on 03.02.2012. However Mrs Mohammadi then contacted Bolton Primary Care Psychological Therapy Service stating that she had not received the letter and an appointment was then made for her.

5.3.4 She was seen and assessed on 06.03.2012 and no risks were identified either to herself or to others. The IMR author reports that the assessment did not disclose any evidence of abuse or violence within the family nor were any concerns raised about these issues. It was evident that Mrs Mohammadi was distressed about the breakdown of her relationship with Mr Mohammadi and was having difficulty in making decisions about the future. She described to the Bolton Primary Care Psychological Therapy Service that she felt as if her family was falling apart; in the absence of a mental disorder it was felt more appropriate that these issues be dealt with by counselling. As these services were not provided by Bolton Primary Care Psychological Therapy Service Mrs Mohammadi was given a list of contact numbers for voluntary sector counselling services in the Bolton area. There is no evidence that Mrs Mohammadi accessed such services. A summary of the assessment was sent to her GP and Mrs Mohammadi had no further contact with Bolton Primary Care Psychological Therapy Service. Policies have since changed, a list of services is no longer handed out to the client and instead referrals to other services are coordinated.

## 5.4 GP Services provided by Bolton General Practitioner Services

5.4.1 Both Mr and Mrs Mohammadi were registered with a local GP practice (GP Practice 1). In 2008 Mr Mohammadi was asked to leave GP Practice 1 because of repeated verbal abuse and aggression to the staff at the practice. Subsequently he registered at GP Practice 2. Both parties were seen regularly by their GP and therefore only those consultations considered relevant to this DHR are discussed in this report. The author of the IMR is a GP.

**GP Contact with Mrs Mohammadi**

5.4.2 The IMR author reviewed medical records and spoke to GPs at both practices who provided general medical services to Mr and Mrs Mohammadi. The author concludes that Mrs Mohammadi presented as articulate, fluent in English and westernised; dressing in western clothing, wearing make-up and always well presented. While both were registered at GP Practice 1, Mrs Mohammadi was always accompanied by Mr Mohammadi. After Mr Mohammadi was asked to leave GP Practice 1, she visited alone. Mrs Mohammadi had an above average attendance at GP Practice 1 although this is not unusual in this practice according to the partner GPs. In the last twelve months of her life she was seen by a GP on sixteen occasions, eight of which were within three months of her death. This compares to seven consultations in the preceding twelve months. The national average is approximately [3]six consultations per year.

5.4.3 The IMR author is of the opinion that Mrs Mohammadi had a confiding relationship with her doctor at GP Practice 1 who was aware that Mr Mohammadi was controlling in their marriage. Mrs Mohammadi told her GP that she had requested a divorce from her husband but that he refused. The GP believed Mr Mohammadi controlled her finances but spent long periods of time with his family in Iran where he wished to return but she did not. It was believed by the GP that Mr Mohammadi took money from their joint resources to support his family in Iran leaving her to struggle with bills in the UK.

5.4.4 Having reviewed the matters, the author states that Mrs Mohammadi's symptoms were dealt with on a physical basis and that she underwent multiple investigations and presented frequently with symptoms directly attributable to domestic stress. Medical records reviewed by the IMR author indicate that Mrs Mohammadi was seen on 21.06.1989 by an unknown GP in connection with a pregnancy who noted; '*stress symptoms disclosed specifically related to marital relationship'.* She was seen by an unknown GP in connection with her 2nd pregnancy on 10.07.1992 who diagnosed depression and prescribed medication. There is no suggestion that the GPs triangulated that information.

5.4.5 On 05.06.2008 Mrs Mohammadi consulted her GP regarding stress symptoms and the note records *'stress-family problems - husband wishing to return to Iran'.* No medication or referral appears to have been made. GP Practice 1 recorded the receipt of a letter from Guy's and St Thomas' NHS Foundation Trust on 29.01.2009 in which the Cardiologist seems to suggest appropriate medication to *'calm her down'.* There is no record in the Guy's and St Thomas' NHS Foundation Trust chronology to cross reference this event or that the GP followed this up or prescribed any medication.

5.4.6 A record held on computer for 29.11.2010 indicates a further consultation with her GP for stress and a note that her husband had been in Iran for the last 6 to 12 months. Significantly, there is a letter recorded as received by GP Practice 1 on 10.02.2011 containing a mental health score sheet. This most probably refers to the consultation Mrs Mohammadi had with Bolton Primary Care Psychological

[3] The average member of the public sees a GP six times a year; double the number of visits from a the previous decade . Health and Social Care Information Centre, Trends in consultation rates in general practice as quoted in a British Medical Association Media brief July 2014.

Therapy Service around this time (see paragraph 5.3.4). It is noteworthy that Mrs Mohammadi answered 'no' to the question about feeling at risk of abuse.

5.4.7 On 13.03.2012 the practice recorded the receipt of a letter from Bolton Primary Care Psychological Therapy Service which described the assessment of her as *'normal limits'* and refers to family and relationship difficulties and that her sons are *'both away at University and expressing unhappiness about* [their]*strict upbringing'.*

5.4.8 Mrs Mohammadi again consulted her GP about stress on 14.04.2012 when it is recorded that she is *'bullied by her husband, rift between her and sons, socially isolated, PCMHT[4] didn't understand. Advised CITIZEN ADVICE BUREAU and solicitor'.* The IMR author notes there was no follow up to this presentation at a subsequent consultation on 27.07.2012. On 24.10.2012 the GP records show the receipt of the letter referred to in paragraph 5.2.2 from Guy's and St Thomas' NHS Foundation Trust and the IMR author notes that these stress symptoms were not followed up either by her GP.

5.4.9 Between 17.12.2012 and 08.11.2013 six further consultations were made by Mrs Mohammadi for unexplained episodes of pain in the back (two episodes) knee and wrist. Significantly one of these consultations on 06.03.2013 is for stress symptoms and is recorded as '*worsening stress at home, not sleeping'.*

5.4.10 The final consultations with her GP are recorded on 26.11.2013 and 06.12.2013 and relate to memory impairment which is recorded as being not substantial and for which on the last visit she was then referred to the memory service. These visits are believed to be connected with the poor memory referred to by Bolton University. The IMR author opines that these may well represent features of depression and stress.

**GP Contact with Mr Mohammadi**

5.4.11 Mr Mohammadi was known at both GP surgeries. He spoke fluent English when engaging with his GP. A letter supplied to Mrs Mohammadi's GP dated 06.12.1989 noted that a specialist at Royal Bolton Hospital had refused to see Mrs Mohammadi *'because of her husband's abusive behaviour'*. No further information is available to indicate what this referred to. On 13.02.2001, and again on 08.10.2002, Mr Mohammadi had consultations with his GP which related to stress symptoms. The first of these was recorded as *'stress following armed robbery'* (this is well documented elsewhere and the event is not relevant to this DHR); the second consultation relates to *'stress-father CVA[5] in Iran'*

5.4.12 As mentioned earlier, at some point in 2008 Mr Mohammadi was asked to leave GP Practice 1 and he transferred to GP Practice 2. There is no record of concerns about his behaviour at this practice. Although Mr Mohammadi was removed from the GP Practice 1 list, and they were aware of his controlling behaviour, Mrs Mohammadi remained. The panel believe the issue here is that the GP Practice 1 did not use or build upon their knowledge or history to inform their assessment of Mrs Mohammadi. It could be assumed that if he behaved in such a way out of the

[4] An abbreviation used by the GP to describe primary care mental health trust.
[5] CVA is felt to indicate Cerebrovascular Accident (Stroke) indicating that his father had had a stroke.

home, then it was likely that he could not moderate his behaviour within the home, thereby increasing the risks to other residents there.

5.4.13 On 29.01.2009 Mr Mohammadi consulted his GP following the death of his mother in Iran and again on 02.06.2009 and 04.06.2009 he visited his GP in connection with depression and stress. He declined the offer of counselling on the first occasion and was prescribed medication at both consultations.

5.4.14 On 16.02.2011 Mr Mohammadi visited GP Practice 2 in connection with elbow pain and it is recorded that he was *'confrontational and demanding inappropriate Rx'* (Rx is assumed to mean Px which is the commonly used abbreviation for Prescription). On 25.05.2011 he consulted a GP at GP Practice 2 concerning the death of his father and on 14.10.2011 for *'mental and behavioural disorder'*. A consultation for the same disorder was recorded on 04.11.2011. There is no reference to the prescription of any medication nor of any referral to other services.

5.4.15 Mr Mohammadi was seen on 10.04.2012 and there is a record of his alcohol intake being recorded as two units per week. On 01.11.2012 Mr Mohammadi visited a GP at GP Practice 2 in connection with stress/depression related to the death of his mother. The accompanying notes refer to *'wanted to talk? issues covered ?referral considered'.* There is no record of a referral being made nor of any medication being prescribed.

5.4.16 The final recorded visit by Mr Mohammadi to his GP was on 08.11.2013 for a routine matter.

## 6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

### *6.1 How did agencies identify and assess the domestic abuse risk indicators in this case*

6.1.1 Mrs Mohammadi did not disclose domestic abuse to most of the organisations she was in contact with. However, she did present with indicators of abuse which were not identified by the organisations. Greater Manchester Police have no records of any relevant contacts with the family.

6.1.2 The exception to this generality relates to the actions of GP's from the two surgeries who saw the couple. In respect of Mrs Mohammadi, there is documented evidence that she spoke to her GP on a number of occasions concerning stress in the family and in relation to her husband being in Iran. She specifically told her GP that she was being bullied by her husband (14.04.2012) and there were significant marital problems and increased stress noted on 24.10.2012. While she was offered support, advice and referral to the Citizens Advice Bureau and a solicitor, she was not explicitly asked about any physical violence in the relationship nor was there any record she was referred to a specialist domestic abuse service.

6.1.3 The IMR author for the GP services noted; *'marked increases in her consultation rate in the last 12 months of her life, predominantly with non-specific symptoms, one was related to family stress (06.03.2013) - there was a failure to recognise that this consultation pattern may have been a marker for domestic abuse…'.* One of the GP's, when spoken to by the author stated that she was of the professional opinion that the relationship between Mr and Mrs Mohammadi was emotionally and financially abusive but there was never any disclosure about physical violence, although she confirmed that she never directly questioned Mrs Mohammadi about this possibility.

6.1.4 Neither practice could evidence they had a policy or procedure relating to domestic abuse nor did they use any specific tool to risk assess women presenting in abusive relationships. Consequently there is no indication that the GP had assessed any domestic abuse risk indicators. However, in considering the issue of domestic abuse policies, the DHR panel have been advised by the Clinical Commissioning Group member that, while some GP practices may not have a domestic abuse policy, that guidance will be incorporated within an overarching practice safeguarding policy. It is not clear in this case whether there was a discrete policy or an overarching one at either GP practice.[6] Irrespective of this the panel felt that all professionals have a general duty to ensure that safeguarding concerns are addressed.

6.1.5 While Guy's and St Thomas' NHS Foundation Trust had much more limited contact with Mrs Mohammadi, as she only presented for annual check-ups, Mrs Mohammadi did disclose information to her consultant there in 2012 that there was significant

[6] The Royal College of General Practitioners has clear guidelines for GPs on domestic abuse policies. www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

marital stress, although she did not talk about domestic abuse. The consultant did not explore this issue further and there was not an opportunity to consider whether domestic risk indicators were present. He did not feel the issue required any further response from Guy's and St Thomas' NHS Foundation Trust other than to share the information with the GP. Unfortunately this did not appear to trigger any follow up enquiry within GP Practice 1. The IMR author for Guy's and St Thomas' NHS Foundation Trust believes that, given the nature of the service, it was reasonable for the consultant, in the absence of specific concern regarding domestic abuse, not to have sought advice from the Guy's and St Thomas' NHS Foundation Trust Safeguarding Adults Team. Notwithstanding that view, the author has made a specific recommendation for their agency in relation to raising awareness of domestic abuse with clinicians.

6.1.6 While this analysis concerns the role of agencies it is important to stress there were people who, not only could have identified domestic abuse risk indicators, but actually had direct evidence of domestic violence: these were the friends, work colleagues and family of Mrs Mohammadi. There were numerous occasions when Mrs Mohammadi disclosed to them in the weeks leading up to her death that she had been subjected to significant emotional, verbal and physical bullying by Mr Mohammadi to a point at which she clearly wanted to leave him. Unfortunately these people either did not want to disclose the information they held, did not know the importance of what they knew or, critically, did know what to do with the information they held.

### *6.2 Were the risk levels agencies set appropriate and what did agencies do to keep them under review*

6.2.1 As discussed above there were no attempts by agencies to conduct a risk assessment on either Mrs Mohammadi or Mr Mohammadi and therefore no opportunities to set levels of risk. It is possible that, had a specific domestic abuse risk assessment been carried out and accepted by Mrs Mohammadi, support could have been provided to help her understand her options in being able to leave the relationship as she seems to have wished to do so.

6.2.2 The one exception to this was Bolton Primary Care Psychological Therapy Service who saw Mrs Mohammadi as the result of a referral from her GP on 06.03.2012. On this occasion, in line with their policy, they carried out a risk assessment and found no risks to herself or from others. There were no opportunities open to Bolton Primary Care Psychological Therapy Service to keep these under review as they concluded that, in the absence of a common mental illness, the appropriate pathway for Mrs Mohammadi was onward referral to counselling provided by one of the voluntary sector organisations.

### *6.3 Was the impact of mental health issues properly assessed or suitably recognised and what action did agencies take in identifying and responding to these issues*

6.3.1 Bolton Primary Care Psychological Therapy Service carried out an assessment for common mental illness on Mrs Mohammadi but did not identify any. There was no formal mental health assessment carried out by any other health agency on either Mrs Mohammadi or Mr Mohammadi. The GP IMR author comments that this is not

unusual as capacity is presumed in adults and only considered if the decisions being made are outside perceived norms or likely to negatively impact on others.

### *6.4 What focus was put on understanding Mr Mohammadi's behaviour towards Mrs Mohammadi and Mrs Ahmedi*

6.4.1 There is no evidence that any agency focussed upon understanding Mr Mohammadi's behaviour toward Mrs Mohammadi. The only agency which had the information with which to potentially focus such understanding were the GP services. It is clear that Mrs Mohammadi's GP knew about the behaviour of Mr Mohammadi towards her and that GP Practice 1 were clearly aware of his predisposition towards verbal aggression given that in 2008 they had asked him to leave the practice. There is also an entry dating back to 06.12.1989 in the GP records indicating that a consultant at a local hospital had refused to see Mrs Mohammadi because of Mr Mohammadi's abusive behaviour.

6.4.2 When seeking to understand why there was no such focus it is important to consider what the IMR author says in their findings regarding the GP services. That is; that Mrs Mohammadi "did not appear to have presented as a 'victim' but rather as an individual able to stand up for herself which is a factor in why she was never directly asked about abuse". While there are potentially some cultural issues underlying why such an understanding was not reached, (see paragraph 6.8) the panel feel that some training in domestic abuse and violence for GPs would be beneficial.

### *6.5 What services did agencies provide for Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk*

6.5.1 As outlined earlier, with the exception of Bolton Primary Care Psychological Therapy Service, no agency identified any levels of risk in relation to Mrs Mohammadi, Mrs Ahmedi or Mr Mohammadi. Therefore, it is not possible to assess whether the services provided matched risk levels. In relation to Bolton Primary Care Psychological Therapy Service they were the only organisation that carried out a risk assessment. They referred Mrs Mohammadi onto a counselling service provided by a voluntary organisation in the absence of a common mental illness which was proportionate. However, Mrs Mohammadi later complained to her GP on 10.04.2012 that Bolton Primary Care Psychological Therapy Service did not understand her needs.

6.5.2 Other agencies such as Guy's and St Thomas' NHS Foundation Trust, the University of Bolton and the Citizens Advice Bureau all appear to have had very limited opportunities or none at all, to provide services that were relevant to addressing the risks of domestic abuse. Both the Citizens Advice Bureau and the University appear to have been responsive to the needs of Mrs Mohammadi and, in the case of the University, seem to have put considerable effort into trying to identify and support the potential barriers to learning that she presented with. With no information about Mrs Mohammadi's personal circumstances within their knowledge, the advice they gave her in relation to consulting her GP was reasonable and appropriate. Had Mrs Mohammadi's GP chosen to explore it further, the issue of memory impairment could have presented another opportunity for them to ask appropriate questions.

6.5.3 Notwithstanding the lack of appropriate exploration of issues relating to domestic abuse, the GP service provided to Mrs Mohammadi is felt by the IMR author to have been supportive and accessible. They also believe Mr Mohammadi was similarly well managed in primary care and that both parties were referred to appropriate secondary services when indicated for physical health problems.

6.5.4 Given that Mrs Ahmedi had only moved to the Bolton area on 01.12.2013 there were no opportunities locally to provide her with services and therefore for her to disclose information that might have led to the identification of domestic abuse within the relationship between Mr Mohammadi and Mrs Mohammadi.

6.5.5 Information provided by health services Mrs Ahmedi accessed in London in relation to her treatment for her illness did not indicate evidence that disclosures had been made by her or Mrs Mohammadi which suggested domestic abuse was present. Mrs Mohammadi and Mr Mohammadi appear to have been present at the last consultation held with specialists on 04.12.2013 during which he is described as showing great concern that treatment for Mrs Ahmedi commence as soon as possible.

### *6.6 How did agencies ascertain the wishes and feelings of Mrs Mohammadi and Mrs Ahmedi about their victimisation and were their views taken into account when providing services or support*

6.6.1 There were no opportunities to ascertain the wishes and feelings in relation to Mrs Ahmedi as she never made any disclosures or provided any information which indicated she was a victim of domestic violence.

6.6.2 While Mrs Mohammadi did make disclosures to her GP about the relationship with, and treatment by Mr Mohammadi, she was never regarded as a victim of domestic abuse (see paragraph 6.4.2). It is therefore not possible to ascertain how her views were taken into account by her GP when providing a service in response to her needs as a victim of domestic abuse. Similarly, Guy's and St Thomas' NHS Foundation Trust did not regard her as a victim of domestic abuse and therefore neither did they ascertain Mrs Mohammadi's wishes.

6.6.3 The mental health assessment did not raise a concern that Mrs Mohammadi was a victim, or potential victim, of domestic abuse. However the DHR panel wonders whether any direct questions were asked despite the presenting features being home related issues. The information provided by the GP to Bolton Primary Care Psychological Therapy Service when referring Mrs Mohammadi on 11.02.2011 was because she had *'low mood and stress related symptons relating to Mr Mohammadi being in Iran and feeling her life was on hold and worries about the future of the marriage'.* On 23.01.2012 the reason for referral was similarly *'low mood/anxiety and concerns over family relationship'.* On neither occasion did the referring GP from GP Practice 1 identify any risks and the IMR author for Bolton Primary Care Psychological Therapy Service states there was no evidence found of abuse or violence nor concerns raised about these issues. Consequently Mrs Mohammadi was not treated as a victim of domestic abuse and the referral that Bolton Primary Care Psychological Therapy Service made was for matters relating to her marital and family relationships which in the view of the IMR author is the correct pathway for relationship/adjustment.

6.6.4 From the GP notes (14.04.2012) it appears that Mrs Mohammadi made a comment about her contact with Bolton Primary Care Psychological Therapy Service. However, the GP note only refers to the fact that Bolton Primary Care Psychological Therapy Service *'did not understand'* and there is no information as to the detail of exactly what Mrs Mohammadi said nor does the GP appear to have explored this comment further.

### *6.7 How effective were agencies in gathering and sharing relevant information and did they meet any resistance*

6.7.1 There were opportunities for agencies to gather and share information about the deteriorating relationship between Mrs Mohammadi and Mr Mohammadi but these were generally limited. The greatest of these opportunities, in the view of the DHR panel, were from Mrs Mohammadi through the consultations she had with her GP. Mrs Mohammadi appears to have enjoyed a good relationship with her GP and as the IMR author states she appeared willing to discuss her difficult marital circumstances and it was reasonable to assume she could make her wishes known. This willingness to disclose extended to Mrs Mohammadi telling her GP on 14.04.2012 about stress brought on by bullying as a result of which the GP advised her in relation to the Citizens Advice Bureau and a solicitor.

6.7.2 Unfortunately the next step in gathering information, which was to ask Mrs Mohammadi directly about domestic abuse and violence, was never taken. The IMR author provides a possible explanation for this when stating the decisions reached by the GP Practice 1 practitioners were in line with those that would be reached by other GPs who had limited understanding of the risk factors for domestic abuse who rarely ask potential victims a direct question. Failing to ask potential victims a direct question is a feature of other domestic homicides that have been reviewed.

6.7.3 This DHR panel feels that more effective gathering of information about Mrs Mohammadi within the GP service could have revealed the risk indicators of domestic abuse. In reaching that view the DHR panel is cognisant of guidance produced for GP's by the Royal College of General Practitioners, the underlying message of which is equally applicable to all other agencies in this case and is repeated, in part, below;

*'In many cases of domestic violence general practice is the first formal agency to which women present for help. However the possibility of violence is seldom raised directly and it has been estimated that only a quarter of women seeking medical help actually reveal that they have been beaten. Many use the 'calling card' an apparently unimportant physical symptom to seek help directly……to ignore the calling card is to collude with the continuing concealment of domestic violence behind closed doors. Much can be done to protect women and empower them to change their situation' (Heath, Iona RCGP Policy-Domestic Violence the GP's role)'*

6.7.4 Only one opportunity arose to gather information within Guy's and St Thomas' NHS Foundation Trust and that was when Mrs Mohammadi disclosed to her Cardiologist on 24.10.2012 that she had *'significant marital problems at home'*. There was a possible opportunity here to gather further information by asking a direct question but it appears the cardiologist did not take it as he did not have any concerns regarding her being a victim of abuse. The IMR author believes this was reasonable

given the nature of the Guy's and St Thomas' NHS Foundation Trust service and the very intermittent contact with Mrs Mohammadi.

6.7.5 While her cardiologist at Guy's and St Thomas' NHS Foundation Trust did not gather all the information that may have been available it is clear he did share what he knew with her GP at GP Practice 1, as evidenced by the letter sent on 24.10.2012. However, the GP involved does not appear to have followed this information up at the next available consultation with Mrs Mohammadi on 17.12.2012 which could have provided an opportunity to explore important underlying issues with her. Other agencies such as the Citizens Advice Bureau and Bolton University had very limited opportunities to gather relevant information given the nature of Mrs Mohammadi's contact with them.

6.7.6 Finally, the IMR author for GP services has identified one important feature that she believes is worthy of comment in relation to sharing of information. That is, that both Mr Mohammadi and Mrs Mohammadi were registered at separate surgeries whereas families generally all register at the same practice. The author found that neither practice would consider sharing information between practices unless they had the consent of the individual registered with them. However, where all families are registered at the same practice, then informal information is often shared between GPs that informs clinical decision making. As the author points out *'split registration can pose challenges in handling confidentiality when assessing and managing safeguarding issues'.*

6.7.7 The panel discussed this issue and the comments of the IMR author about information sharing. In considering these comments the panel recognise that the information referred to actually originated and remained within Mrs Mohammadi's GP practice and therefore they do not consider information sharing is a significant issue. They were also made aware by the Clinical Commissioning Group representative on the panel that revised flagging within the Greater Manchester area has been initiated through the safeguarding arrangements for adults and children which was revised on 14.05.2014. This now prompts practices to consider and flag patients with a history of domestic abuse or a victim of domestic abuse. The underlying issue is therefore whether, if these circumstances were to be repeated, the surgery would recognise domestic abuse and flag the patient's records.

### *6.8 How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, including honour based violence, when completing assessments and providing services to Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi.*

6.8.1 Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi were all born in Iran albeit they had resided in the UK for many years. Mr and Mrs Mohammadi spoke good English although Mrs Ahmedi needed her daughter to interpret for her when she undertook a consultation on 04.12.2013. Mrs Mohammadi was described as wearing makeup and western style clothes and had friends and acquaintances from both Iranian and British backgrounds. She had studied in the UK previously and had recently enrolled at the University of Bolton. She appeared to be comfortable mixing with, and confiding in, people from different backgrounds.

6.8.2 It is believed that Mr and Mrs Mohammadi did not attend a mosque. It is reasonable to assume that Mrs Mohammadi had a good understanding of how agencies such as health and education operated, how to access their services and how to give and receive information from them. Her race, culture, language and faith do not appear to have presented barriers to the way in which she accessed services in this case. However, the panel believe these factors may have impacted upon the way in which services were provided to her and this point is discussed in more detail later in this section.

6.8.3 Less is known about Mr Mohammadi although it is reasonable to assume that, having arrived in the UK as a small boy and having been educated here he had a similar level of understanding about services as Mrs Mohammadi. It is clear he maintained contact with family in Iran and made several journeys there often staying for many months. From comments made by one of his sons it appeared that he had recently started reading the Koran. His race, culture, language and faith do not appear to have presented barriers to the way in which he accessed services in this case. Again the panel believes these factors may have impacted upon the way in which services were provided to him and again this point is discussed in more detail later in this section.

6.8.4 As far as most agencies providing services to Mrs Mohammadi, Mrs Ahmedi and Mr Mohammadi are concerned, race, culture, linguistics and faith were not issues with the exception of GP services. Here the IMR author found that, as Mrs Mohammadi was from an Iranian background, there was potentially a cultural variation in presentation from that of the largely Pakistani community served by the GP practice. Mrs Mohammadi did not present as a 'victim' but rather someone who could stand up for herself which is a factor in why she was not asked directly about abuse.

6.8.5 As mentioned earlier the GPs involved from the practice are aware that a lot of the women they are seeing are experiencing domestic violence and abuse. However this awareness only came to light after a review of these issues. The IMR Author states there is no evidence in the records of the victim or perpetrator that their Iranian background was specifically taken into account when assessing their presentation and that *'there is a danger that given the high prevalence that they are aware of, along with the fact that the victims are culturally conditioned to accept domestic violence as the norm'* there could be a risk that, in this context, GPs may miss opportunities to explore indicators of on-going abuse as they feel helpless to intervene (because the victims do not wish to take action and are adults with capacity).'

6.8.6 While there is no evidence that women from BME backgrounds are any more likely to be the victims of domestic abuse[7] the panel are mindful that women from such backgrounds may face additional cultural hurdles compared to women from white communities. For example, they may feel more isolated, or may have to overcome religious and cultural pressures, and there may be 'family honour' issues.

6.8.7 A factor the panel discussed were the levels of tolerance of violence and force in some communities. One of the reasons behind this tolerance is that force within the mother country by family and state are sometimes higher than in the UK. For

[7] Women's Aid-The Survivors Handbook

example, within the family and school corporal punishment may well still be quite acceptable and force may be used to make children comply with their parents' wishes. Similarly the state may use or sanction much greater levels of force than would be acceptable in the UK. All of these factors could lead someone from a BME background such as Mrs Mohammadi to experience and tolerate greater levels of abuse within their own family and home.

6.8.8 Many Iranian women from the social background of Mrs Mohammadi (particularly those brought up or coming to the UK before the Iranian revolution of 1979) are likely to take particular care in the way in which they dress, present themselves well and be very well educated. Indeed this appears to have been the case with Mrs Mohammadi who the GP IMR author describes as presenting as *'articulate, fluent in English and westernised, dressing in western clothing, wearing makeup and always very well presented'.*

6.8.9 As highlighted within the GP IMR, GP Practice 1 has a significant number of patients from the Pakistani community. Women from this community are less likely to have adopted western dress and customs than Iranian women and may be less confident in the way they act and speak with people such as GPs particularly if English is not their first language. For example, the GP Practice 1 use a translation service for consultation when needed.

6.8.10 While women from Mrs Mohammadi's background may be more confident and adopt a higher degree of visible western practices, such as dress, it does not necessarily follow that their marital relationship will enjoy the same degree of equalities and freedoms as those in the west. Consequently someone who is not familiar with Iranian culture may not fully understand many of the tensions and issues that would be involved in a troubled relationship such as between Mr and Mrs Mohammadi. The panel therefore supports the view that the GP IMR author proposes; that Mrs Mohammadi's cultural background *'may not have been fully understood as there was a belief that being well presented was not a feature of being the victim in an abusive marital relationship'.* This in turn may explain why Mrs Mohammadi was never directly asked about abuse.

6.8.11 So called honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

6.8.12 Again, because of the expertise the panel has been able to draw upon, they have discussed in detail the issue of so called HBV within the context of a marital relationship between two people of Iranian birth. The panel have considered all the information available to them and find there is no evidence at all that Mrs Mohammadi had formed an intimate or flirtatious relationship with another man which may have breached a cultural or religious belief or presented a threat to the honour of the family. However, other factors, such as, for example Mrs Mohammadi's statements to him that she wanted to leave, may well have become issues of honour. The panel has discussed these factors and therefore believe that so called HBV cannot be excluded.

### *6.9 Were single and multi-agency domestic abuse policies and procedures followed including the MARAC[8] and MAPPA[9] protocols, are the procedures embedded in practice and were any gaps identified*

6.9.1 During the period under review the GP practice cannot evidence that domestic abuse policies and procedures were in place and no use was made of a specific risk assessment tool. The IMR author believes that, had a risk assessment been used with Mrs Mohammadi, then there is evidence in the medical records that a MARAC may have been indicated. Training to raise awareness and understanding of the risk assessment tool and MARAC process for GPs would be of benefit. A single agency recommendation is therefore made in respect of these gaps (see Appendix D)

6.9.2 Guy's and St Thomas' NHS Foundation Trust has policies in place which cover domestic abuse and procedures to follow. In this case the presence of such policies was not an issue as the consultant concerned did not explore with Mrs Mohammadi whether she was a victim of abuse and consequently did not seek guidance from the Trusts Safeguarding Team. While their policies are comprehensive, appear to be well embedded and are supported by training, the IMR author has made an agency recommendation regarding raising clinician awareness (see Appendix D)

6.9.3 As Mr Mohammadi did not have any criminal convictions and was not a known sexual or violent offender he was not subject to MAPPA processes.

### *6.10 Do any agencies' policies / procedures / training require amending or new ones establishing as a result of this case*

6.10.1 (See paragraph 6.9 above)

### *6.11 How effective was agency supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case*

6.11.1 In relation to GP services, because of their structure, there are no senior managers involved when safeguarding concerns are raised. Within GP services there will be both clinical leads and safeguarding leads, who may be GPs, and to whom other GPs can call on for advice. GPs are consulted by patients and then a decision is made by the GP as to whether action should be taken in relation to the symptoms they present. Both Mr and Mrs Mohammadi were seen by GPs and presented with stress related symptoms and were both referred onto Bolton Primary Care Psychological Therapy Service. Advice in relation to safeguarding is available from safeguarding leads within the Foundation Trust or CCG but they were not consulted as Mrs Mohammadi was not suspected to be a victim of domestic abuse or violence.

6.11.2 Similarly, in relation to Guy's and St Thomas' NHS Foundation Trust, consultants there do not report to managers in relation to their clinical decisions. Advice would have been available from the Trust's Safeguarding Team but again as the consultant involved did not suspect abuse no such advice was sought.

[8] Multi-Agency Risk Assessment Conference-a forum in which agencies come together to consider the risks of T

[9] Multi-Agency Public Protection Panels-The Criminal Justice Act 2003 provides for the establishment of these and they are designed to protect the public from serious harm by sexual and violent offenders.

### *6.12 Were there any issues in relation to capacity or resources within agencies or the Partnership that affected their ability to provide services to the victim and perpetrator or to work with other agencies*

6.12.1 There do not appear to have been any issues in relation to capacity or resources within any of the agencies or the Bolton Community Safety Partnership which affected their ability to provide services in this case.

## 7. LESSONS IDENTIFIED

7.1 The IMR agencies' lessons are not repeated here because they appear as actions in the Action Plan at Appendix D.

7.2 The DHR Lessons Identified are listed below. Each lesson is preceded by a narrative.

### 1. Narrative:

On a number of occasions Mrs Mohammadi gave information to her GP that should have been recognised as signs of domestic abuse and she was not asked direct questions which may have revealed more information.

**Lesson**:

More training around domestic abuse and cultural issues could encourage GPs to ask direct questions about this information which may present opportunities to take positive action to address the needs of victims.

### 2. Narrative:

Neither GP practice could evidence that a current domestic abuse or violence policy was in place. Although some GP surgeries do have overarching practice safeguarding policies it is not clear whether this was the case at the time in either surgery. Neither surgery made use of a risk assessment model. Consequently there was poor awareness of the concept of risk and no mechanism for assessing the level of risk that Mrs Mohammadi faced or Mr Mohammadi presented.

**Lesson:**

Failure to understand and assess risk means that identified victims continue to face danger without the benefit of an appropriate risk management plan.

### 3. Narrative:

Friends, acquaintances and colleagues of Mrs Mohammadi and Mr Mohammadi held facts which could have helped identify domestic abuse and violence and identified increasing levels of risk to Mrs Mohammadi from Mr Mohammadi. It does not appear they knew the value of these facts nor how to help Mrs Mohammadi deal with the abuse, violence and threat she faced.

**Lesson:**

There is a need to provide publicly available information about the signs of domestic abuse and violence and the risks to victims and how those who come into possession of facts that indicate it is happening can either help the victim or share the information with agencies.

## 8. CONCLUSIONS

8.1 Mr and Mrs Mohammadi were both born in Iran, had lived in the UK for the majority of their adult lives and had married here 25 years ago. Mr Mohammadi was well educated and a qualified architect albeit, he had not practiced for some time. They lived in their own property in a pleasant neighbourhood and had two sons who had studied at University.

8.2 While a close friend of the couple believed they were happily married, there is evidence from disclosures Mrs Mohammadi made as long back as 1989 during a pregnancy related appointment that there were marital difficulties. Both Mr and Mrs Mohammadi were susceptible to stress and there are a number of occasions when both presented to their GPs with these symptoms. A GP said that Mr Mohammadi was very short tempered and frequently aggressive to reception staff, as a consequence of which he was asked to register with an alternative GP service.

8.3 Following the death of his father in Iran Mr Mohammadi started to spend extended periods there trying to resolve financial affairs which are said to relate to a large inheritance. He appears to have become consumed by these issues and this may well have started to change his character and could have been the reason why he became aggressive and had mood swings which affected his relationship with his sons. It may also have been the tipping point that led to the deterioration of his relationship with Mrs Mohammadi who disclosed on a number of occasions to her GP and on one occasion her cardiologist that she had significant marital difficulties.

8.4 The direct disclosure of domestic abuse made by Mrs Mohammadi to her GP on 14.04.2012 should have led to further questions being asked of her in order to assess the risk posed by Mr Mohammadi and to ensure appropriate measures to protect her were in place. Further opportunities were missed during presentations by Mrs Mohammadi to her GP with symptoms that on further investigation could have led to the exploration of domestic abuse and her identification as a victim.

8.5 Despite the GP Practice being aware that Mr Mohammadi was controlling, and emotionally and financially abusive towards his wife, she was never explicitly asked if she perceived herself as abused nor was she asked about any physical violence within the relationship. She was never offered a referral to specialist domestic abuse services. This was a missed opportunity, probably due to an absence of any domestic abuse and violence policies, or a risk assessment policy and a lack of training. The implementation of domestic abuse and violence policies including risk assessment together with enhanced training would be beneficial to improve understanding of domestic violence within the GP Service.

8.6 The panel also believes that a lack of cultural awareness also played a part in these events. Mrs Mohammadi was not like many of the patients who presented at the practice with signs of domestic abuse. She was educated, intellectually capable, and presented as smartly dressed, westernised and articulate. She did not appear to present as a victim but rather someone who could stand up for herself. However, it needs to be taken into consideration that a woman who is articulate and educated may still suffer violence and may not present herself as vulnerable. Particularly, for someone from an Iranian background and marriage, there were factors and issues which may not have been fully understood and therefore led to direct questions not being asked.

8.7 Mr Mohammadi made fewer presentations to his GP services which towards the end of his life were provided by GP Practice 2 following his removal from the GP Practice 1. His presentations with symptoms that could have been indicative of relationship problems were also not adequately explored. Because Mrs Mohammadi and Mr Mohammadi consulted GPs at separate practices there were no opportunities to share information informally which could have led to a better understanding of the deteriorating relationship between the couple and consequently greater opportunities to identify the risks to Mrs Mohammadi.

8.8 The illness of Mrs Ahmedi and the desire by Mrs Mohammadi for her to spend time at the marital home may have increased the pressures on the relationship between the couple. There is an abundance of evidence from friends, colleagues and family that Mr Mohammadi's behaviour deteriorated around this time and Mrs Mohammadi disclosed many times that she was a victim of both abuse and domestic violence at the hands of her husband. For example, Mrs Yousef says Mrs Mohammadi told her that Mr Mohammadi grabbed her by the throat and hit her with a pan causing a small lump on her head.

8.9 With regard to Mrs Mohammadi's employers it is clear that the company have attempted to gain a full understanding of how local managers responded to the disclosures made by Mrs Mohammadi and the incidents in the workplace, and to provide a full and frank narrative to assist learning, but some of the information submitted to the panel has been conflicting. However, based on the information the company received at the time, the panel is satisfied that there was a pattern revealed within the work-place which indicated that Mrs Mohammadi may have been suffering domestic abuse but this was not recognised as such. This is understandable as, without specialist training or guidance it is difficult for staff working in the private sector to identify the indicators, and properly assess and respond to the risks, of Domestic Abuse. The panel feel it would be helpful for the future if links were developed between the Community Safety Partnership and local employers so they can receive contemporary information and advice about domestic abuse.

8.10 It is clear Mrs Mohammadi wanted to leave Mr Mohammadi and set up home elsewhere. In the last few days of her life she told friends and her sons that she wanted to end the marriage and it is highly probable that she told Mr Mohammadi as well at some point proximate to her death. There are a number of documented occasions on which Mr Mohammadi threatened to kill both her and her sons and on one occasion used the phrase *'you leave me, I will kill you and kill myself'.* It is well documented that women are at the most heightened risk at the point of, or just after separation, and this was most definitely the case with Mrs Mohammadi.

8.11 The investigation into the fire at address 1 was thorough and underpinned by substantial scientific and eye witness testimony. The Coroner found that Mrs Mohammadi and Mrs Ahmedi had been unlawfully killed and recorded an open verdict on Mr Mohammadi. It is not within the legal power of Coroners to attribute blame for a death and consequently no finding was given as to who unlawfully killed Mrs Mohammadi and Mrs Ahmedi. Greater Manchester Police have recorded that Mrs Mohammadi and Mrs Ahmedi were murdered and that Mr Mohammadi was responsible.

## 9. PREDICTABILITY/PREVENTABILITY

9.1 The Panel considered whether the homicide of Mrs Mohammadi and Mrs Ahmedi could have been predicted and/or prevented. It is clear that there was an opportunity to delve more deeply into the disclosures made by Mrs Mohammadi to her GP and this could have led to an increased understanding of the relationship between Mr and Mrs Mohammadi. Whether such a process would have revealed that Mrs Mohammadi and Mrs Ahmedi faced a risk is open to doubt; it would be conjecture to conclude that further enquiry into any disclosure made by Mrs Mohammadi could have led any agency to believe that Mr Mohammadi posed them a medium or high risk of serious injury or death.

9.2 Mrs Mohammadi had contact with a number of other agencies, such as the Citizens Advice Bureau and the University of Bolton, and did not make disclosures to them, nor provide information that might have led to a belief that she was a victim of domestic abuse or violence. Therefore, it is the view of this panel that, regarding all agencies concerned with the victims and based upon the information they had, the homicides of Mrs Mohammadi and Mrs Ahmedi were neither predictable nor preventable.

## 10. RECOMMENDATIONS

10.1 The agencies' recommendations appear in the Single-Action Plans at Appendix D.

10.2 The DHR panel recommendations appear below and in the Multi-Agency Action Plan at Appendix C;

i. The Be Safe Bolton Strategic Partnership considers ways in which friends, colleagues and families can better understand the risk factors and indicators in relation to domestic abuse and violence and are provided with clear and simple advice in relation to the action they can take to reduce risk and harm to someone they suspect is at risk of domestic abuse or violence as well as HBV, forced marriage and Female Genital Mutilation (FGM);

ii. The Be Safe Bolton Strategic Partnership engages with private sector employers in their area so as to;

(a) Raise awareness amongst employers, managers and their staff about the need to recognise the indicators of domestic abuse and what to do if they suspect it is happening;
(b) Encourage employers to have policies or procedures in place for handling disclosures about, or suspicions of, domestic abuse and violence as well as HBV, Forced Marriage and FGM within their workplaces. Such engagement might be achieved by contact with representative organisations such as the Chamber of Commerce or Federation of Small Businesses;

iii. That the Be Safe Bolton Strategic Partnership explores opportunities to improve awareness of domestic abuse amongst communities in general and Black Asian Minority Ethnic Refugee (BAMER) communities in particular Asian people through tactics such as printing leaflets in community languages, and group work including women only sessions, improve access to specialist advice to improve empowerment and help build confidence;

iv. Be Safe Bolton Strategic Partnership to coordinate collaboration between primary care and third sector organisations specialising in Domestic Abuse, to create enhanced identification by GPs of Domestic Abuse Indicators and improved pathways from GPs to specialised Domestic Abuse Services.

# Appendix A

## Definitions

### Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) was:

   "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

   *Controlling behaviour is:* a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

   *Coercive behaviour is:* an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

3. Therefore, the experiences of Mrs Mohammadi fell within the various descriptions of domestic violence and abuse.

### Honour Based Violence

4. Guidance from the Crown Prosecution (CPS) state there is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

4. It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

5. The CPS, Association of Chief Police Officers (ACPO) and support groups have a common definition of HBV:

   *"'Honour based violence' is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community."*

   http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/

   Iranian and Kurdish Women's Rights Organisation (KWRO) Definition of HBV :

6. "Honour" Based Violence is an act (crime/ incident) predominantly against women and girls, often collectively organised by the victim's/survivor's family or community, to defend their perceived honour, because it is believed that person has done something to bring shame on the family or the community.

7. HBV can take many forms including; "honour" killing, forced marriage, rape (group), forced suicide, acid attack, mutilation, abduction, imprisonment, beatings, death threats, blackmail, emotional abuse, surveillance, harassment, disownment and forced abortion.

# Appendix B

**Risk Assessment Terms**

**DASH risk assessment model**

1. Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently by many police forces and other agencies.

2. DASH is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC].

3. There are three parts to the DASH risk assessment model:

    i. Risk identification by first response police staff

    ii. The full risk assessment review by specialist domestic abuse staff

    iii. Risk management and intervention plan by specialist domestic abuse staff

4. The definitions of risk used by the Bolton Community Safety Partnership are:

    - Standard: Current evidence does NOT indicate likelihood of causing serious harm
    - Medium: Identifiable indicators of risk of serious harm. Offender has potential to cause serious harm but unlikely unless change in circumstances
    - High: Identifiable indicators of risk of imminent serious harm. Could happen at any time and impact would be serious

      All High risk cases go to MARAC.

**Appendix C – Multi-Agency Action Plan**

**Recommendation 1**

**Be Safe Bolton Strategic Partnership to consider ways in which friends, colleagues and families can better understand the risk factors and indicators in relation to domestic abuse and violence and are provided with clear and simple advice in relation to the action they can take to reduce risk and harm to someone they suspect is at risk of domestic abuse or violence as well as HBV, forced marriage and Female Genital Mutilation (FGM).**

| Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|
| 1.1 The Domestic Abuse & Violence Partnership to develop a bespoke campaign aimed at raising awareness of domestic abuse and violence, as well as HBV, forced marriage and Female Genital Mutilation (FGM) amongst family and friends so that they are better placed to offer support and advice. | Targeted campaign in place covering:<br>• Domestic Violence Disclosure Scheme<br>• Materials and resources available and in place<br>• Progress recorded in the Domestic Abuse & Violence Strategy Action Plan | Enhanced awareness amongst friends and families, including an increase in the number of requests made under the Domestic Violence Disclosure Scheme | **Nick Maher**<br><br>**LOCAL SCOPE** | **March 2017** |

**Recommendation 2**

**Be Safe Bolton Strategic Partnership to engage with private sector employers in their area so as to raise awareness amongst employers, managers and their staff about the need to recognise the indicators of Domestic Abuse and what to do if they suspect it is happening, and to encourage employers to have policies or procedures in place for handling disclosures about, or suspicions of, Domestic Abuse and violence as well as HBV, Forced Marriage and FGM within their workplaces.**

| Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|
| 2.1 Develop links with the Bolton Chamber of Commerce to promote the 'Corporate Alliance' resources for businesses<br>2.2 Identify toolkits to raise awareness about DV as well as HBV, Forced Marriage and FGM with employers e.g.: Public Health's 'Violence Toolkit for Businesses' and utilise these locally. | • Businesses sign-up to the Corporate Alliance pledge and run campaigns within their organisations.<br>• Progress recorded in the Domestic Abuse & Violence Strategy Action Plan | Improved policies and practices in place within local businesses to support employees that are suffering domestic abuse and violence. | **Nick Maher**<br>**LOCAL SCOPE** | **March 2017** |

**Recommendation 3**

**Be Safe Bolton Strategic Partnership to explore opportunities to improve awareness of domestic abuse amongst communities in general and Black Asian Minority Ethnic Refugee (BAMER) communities in particular through tactics such as printing leaflets in community languages, and group work including women only sessions, improve access to specialist advice to improve empowerment and help build confidence.**

| Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|
| 3.1 Develop targeted campaigns with the aim of raising awareness amongst BAMER and marginalised communities<br>3.2 16 Days of Activism Against Gender Violence – theme of campaign: BAMER & marginalised groups<br>3.3 Contribute to any GM-wide targeted themed campaigns | • Design and production of targeted campaigns<br>• Groups identified and awareness sessions booked and delivered by<br>• Task and Finish Group established and 16 Days Campaign Programme developed | Enhanced awareness amongst BAMER and marginalised communities about how to access support for domestic abuse and violence. | **Nick Maher**<br><br>**LOCAL/REGIONAL SCOPE** | **Jan 2017** |

**Recommendation 4**

**Be Safe Bolton Strategic Partnership to coordinate collaboration between primary care and third sector organisations specialising in Domestic Abuse, to create enhanced identification by GP's of Domestic Abuse Indicators and improved pathways from GPs to specialised Domestic Abuse Services**

| Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|
| 4.1 The Domestic Abuse & Violence Partnership to continue to work with the Clinical Commissioning Group in fully implementing the IRIS project across all General Practice in Bolton and ensure IRIS project includes raising awareness of all types of violence against women and girls including 'Honour' Based Violence, Forced Marriage and Female Genital Mutilation (FGM) | • Continued funding for IRIS in place<br>• Session 1 and 2 IRIS training delivered to all GPs<br>• The number of referrals from GPs increases. | All GPs trained under the IRIS project and are making referrals to Advocate Educators based on disclosures. | **Nick Maher**<br><br>**LOCAL/REGIONAL SCOPE** | **January 2017** |

# Appendix D

### Single–Agency Action Plans

## General Practitioner Services - Bolton Clinical Commissioning Group

| No | Recommendation | Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|---|---|
| **1** | Training for GPs and their staff about risk factors for DVA and available resources | - Delivery of IRIS training<br><br>- training about MARAC process<br><br>- improve understanding around confidentiality in safeguarding<br><br>- CCG safeguarding policy easily available to GP practices | - Attendance at initial training and of regular updates, to be available to CCG /CQC<br><br>- Practice has either their own procedure or adopts CCG procedure for managing disclosed domestic abuse | Increased referrals from primary care to specialist DVA services, leading to better outcomes for those affected, along with victim and staff empowerment | **Pam Jones**<br><br>Associate Director of Safeguarding/ Designated Nurse Safeguarding<br><br>NHS Bolton CCG | 27th Jan 2016 |
| **2** | Practices should have a clear, simple guide to safeguarding people at risk of domestic | Practices should have a procedure to identify, support and manage people experiencing Domestic | This procedure should be available for inspection by CCG/CQC | Referral process clear and standardised, easily available to all staff | **Charlotte Mackinnon**<br><br>**Named GP** | 1st March 2016 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | abuse | abuse, including access to a reputable risk assessment tool | | | NHS Bolton CCG | |
| **3** | Practices should recognise the links between DVA and safeguarding children and young people | Practices should have a safeguarding lead and meet regularly to discuss safeguarding issues Where possible this should include multiagency representation (CCG safeguarding lead, HV, DVA advocate/educator) | Minutes of meetings, along with actions identified and evidence of implementation | Better communication between agencies and clinicians<br><br>Increased awareness and intervention for children at risk of emotional abuse | **Pam Jones**<br><br>Associate Director of Safeguarding/ Designated Nurse Safeguarding<br><br>NHS Bolton CCG | January 2017 |

# Guys and St Thomas' NHS Foundation Trust

| No | Recommendation | Key Actions | Evidence | Key Outcomes | Lead Officer | Date |
|---|---|---|---|---|---|---|
| **1** | To raise the awareness of clinicians of their role in offering locally available support to people who disclose domestic abuse through safeguarding adults training | Issue to be raised as a discussion topic within Safeguarding Adults Training –On Trust Induction for all new staff, on mandatory training updates for all medical, nursing and therapy staff | Training Materials | Increased awareness of indicators of potential domestic abuse.<br><br>Increased referrals to Trust Domestic Abuse advice & support services | Mala Karasu –<br><br>Trust Safeguarding Adults Lead/ Trainer | **30/06/14** and ongoing |

# Appendix E

## Feedback from Home Office Quality Assurance Panel

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Tony Kenyon
Bolton Council
Community Safety Services,
Department of Place
3rd Floor, Bolton Town Hall,
Victoria Square,
Bolton
BL1 1RU

10 11 2016

Dear Mr Kenyon,

Thank you for submitting the Domestic Homicide Review report for Bolton to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 2 September 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a thorough report and appreciated the pseudonyms used. The Panel would like to commend the Chair for completing the equality and diversity section exceptionally thoroughly.

There were some aspects of the report which the Panel felt could be revised, which you will wish to consider before you publish the final report:

- The Panel would like clarification on why there were no police on the panel;
- Please either remove paragraph 6.6 on page 15 of the Executive Summary or reword it to align with the Overview Report;

INVESTORS IN PEOPLE

- Please check Executive Summary for spelling and grammatical errors;
- The Panel would like to see issues around preventability to be explored in paragraph 9.2 in the Overview Report;

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for Greater Manchester information.

Yours sincerely

**Christian Papaleontiou**
Chair of the Home Office DHR Quality Assurance Panel

# Appendix F

## Be Safe Bolton Strategic Partnership response to

## Feedback from Home Office Quality Assurance Panel

**Feedback**
"The Panel would like clarification on why there were no police on the panel (Independent Review Panel)"

***Response***
*Be Safe Bolton Strategic Partnership do not have a fixed Independent Domestic Homicide Review Panel but instead, we convene panels on a bespoke basis to suit particular DHRs. On receipt of notification of a DHR a Core Screening Panel is convened and, amongst other issues, the panel considers the appropriate membership of the Independent Review Panel. This is also discussed with the Independent Review Chair for further guidance and views.*

*The Core Screening Panel in the case of Mohammadi and Ahmedi met on 24th Feb 2014 and included a representative from Greater Manchester Police. In deciding which agencies should sit on the Independent Review Panel the Core Screening Panel considered the nature of involvement that individual agencies had with the key persons. This was anticipated to be a small-scale review due to the limited contact with agencies so it was decided to appoint a smaller panel to reflect this. Greater Manchester Police involvement with the parties was reviewed;*

*The victims, Mrs Mohammadi and Mrs Ahmedi had never been an offender or a victim of a crime nor had they been involved in any domestic incidents reported to the police. Mr Mohammadi had not been an offender for a crime. He had been a victim of crime on three occasions since 1998, but none of these were related to domestic abuse. He had not been involved in any domestic incidents reported to the police. Both the older and younger sons of Mr & Mrs Mohammadi had been victims of a crime but, again, these were not related to domestic abuse and they had not been involved in any domestic incidents reported to the police. There were no incidents (other than the fire) reported at the address where the family lived.*

*The Core Screening Panel decided that due to the lack of relevant contact with Greater Manchester Police it would not be asked to provide a representative on the Independent Review Panel. However, in order to provide a criminal justice sector view-point, Greater Manchester Probation Trust (as it was then known) was asked to provide a representative.*

*The CSP then met with the Chair of the Review Panel and he agreed with the decision not to include a representative from Greater Manchester Police on the Review Panel.*

*Be Safe Bolton Strategic Partnership recognise that this does not follow to the letter the guidance set out in Section 27 of the Guidance for conducting DHRS; '…. The Review Panel must include individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004. …' but it was considered to be the best course of action taking into consideration the resource implications for the agency and the lack of contact with the parties involved.*

*While not a member of the DHR Panel the police provided information to it and answered ad -hoc questions. An example of such questions was whether they had recorded the homicides and classified them as detected using the National Crime recording Standards. The answer was 'yes'.*

**Feedback**
Para 6.6, page 15 Exec Summary. Either remove or reword it to align with the Overview Report

***Response***
*The wording of this version of the Overview Report together with the relevant wording in the Executive Summary has been slightly amended to clarify this.*

**Feedback**
The Panel would like to see issues around preventability to be explored in paragraph 9.2 in the Overview Report.

***Response***
*A more effective solution has been achieved by re-wording* paragraph *9.1*