SAFER SANDWELL PARTNERSHIP

Overview Report

Domestic Homicide Review

Independent Chair and Author

Malcolm Ross M.Sc.

December 2014

Glossary

A&E	Accident and Emergency Department (Hospital)
ADI	Acting Detective Inspector (Police)
CAADA-DASH	Co-ordinated Action Against Domestic Abuse-Domestic Abuse, Stalking and Harassment - Risk Assessment Tool
DAATs	Drug & Alcohol Action Teams
DHR	Domestic Homicide Review
FIT	Financial Inclusion Team
FME	Forensic medical Examiner
GP	General Practitioner
H1	The Victim's divorced husband
IDVA	Independent Domestic Violence Advisor
IUCD	Inter Uterine Contraceptive Device
ISVA	Independent Sexual Violence Advisor
LPUs	Local Policing Units (Police)
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service
NPIA	National Police Improvement Agency (Now College of Policing)
P2	Victim's partner who she intended to move in with
RASSO	Rape and Serious Sexual Offence (Police)
RWHT	Royal Wolverhampton Health Trust
SARC	Sexual Assault Referral Centre
SIO	Senior Investigating Officer (Police)
SSP	Safer Sandwell Partnership
STO	Specialist Trained Officer (Police)
UKBA	United Kingdom Border Agency

Contents

SECTION ONE: INTRODUCTION AND BACKGROUND

Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 34 year old Indian woman in July 2011. She was living in Sandwell at the time of her death. Her partner at the time of her death had been charged with her murder.

For the purposes of this review report and in order to protect the identity of those involved a code will be used to identify each individual. The deceased will be known as the victim, the husband as H1, the partner for whom she left her husband as the perpetrator P1, and the man who was assisting her to move away from the perpetrator before her death, as P2.

The victim was born in India in 1977. She has a daughter who is now 15 years of age and who lives in India. This child is from a previous marriage that ended in divorce.

The victim's language was Punjabi. She did not speak English. She met H1 in India and it is reported that she had an arranged marriage with him on 9th July 2007. She came to England in 2009.

H1 had previously been married and has children from that relationship. It is known that there had been issues around domestic violence with that previous relationship. There are no children from the relationship between H1 and the victim.

After initially living in Wolverhampton the couple settled in Sandwell, West Midlands. Sandwell is a borough comprising of six towns under the administration of Sandwell MBC. The population has a large Black Minority Ethnic community making up of around 20% of the population of Sandwell. Housing is largely rented either from the Local Authority or from Housing Associations making up some 30% of the housing market. Unemployment in Sandwell stands at some 12% - 18% for men and 9% - 17% for women. The Asian population unemployment figures are between 12% and 14%. (White population being 22% and Black 20%)

On several occasions the victim presented at her GP with injuries and informed the GP that her husband had been violent towards her. Her GP advised that she should report matters to the police. On one occasion she stated that she had been raped by her husband. Following one violent episode, during which the victim said that her husband was drunk, she left to live with a friend.

The victim commenced a relationship with P1, the Perpetrator, who was born in India June 1971. The victim and the perpetrator lived together in several addresses before settling in Sandwell.

In July 2011 the perpetrator attended his local Police station stating that he had killed his girlfriend the victim. Officers attended the address to find the body of the victim therein. She had been strangled. It is thought that the victim intended to leave the perpetrator with the assistance of another man (P2)[1] to start a new life.

The perpetrator was arrested and charged with the murder of the Victim. He appeared at the Crown Court, in June 2013 and after a trial he was convicted of murder. The following day he was sentenced to Life imprisonment, with a recommendation that he serves a minimum of 12 years. H.M. Coroner opened an inquest into the death of the Victim and following the trial of the perpetrator the Coroner recorded an unlawful killing verdict.

It is thought that at the time of this offence the perpetrator was an illegal entrant into the UK.

Purpose of a Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[2] on 13th April 2011. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

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

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

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

[1] The Victim's partner who she intended to move in with
[2] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what the 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 the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

Process of the Review

In compliance with Home Office Guidance[3], West Midlands Police notified the circumstances of the death in writing to the Safer Sandwell Partnership.

In October 2011 the Chair of the Safer Sandwell Partnership advised the Home Office that the circumstances did meet the criteria for a Domestic Homicide Review and as such a review should be conducted under Home Officer Guidance as well as guidance from the Safer Sandwell Partnership[4].

The Home Office was notified of the intention to conduct a DHR. An independent person was appointed to chair the DHR Panel and to write the Overview Report, and the first review panel was held, and terms of reference drafted, within a month of this date.

Timescales

Home Office Guidance[5] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review. The Home Office have been kept regularly informed of the progress of this DHR and has agreed to the timescales set for completion.

[3] Home Office Guidance Page 8
[4] Safer Sandwell Partnership – Process for undertaking a Domestic Homicide Review Protocol – Sandwell Metropolitan Borough Council – Nov 2011
[5] Home Office Guidance page 8

Safer Sandwell Partnership has requested extensions to the timescales due to the pending criminal proceedings. Extensions have been agreed by the Home Office.

Independent Chair

Home Office Guidance[6] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

Mr Malcolm Ross was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years experience in writing over 70 Serious Case Reviews and Chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. He has had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended and chaired the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

Domestic Homicide Review Panel

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the Panel and is also the author of the Overview Report. Other members of the panel and their professional responsibilities were:

Paul Betts	- Detective Chief Inspector West Midlands Police replaced by
Jane Parry	- Detective Chief Inspector West Midlands Police
Penny Darlington	- Head of Adult Safeguarding Quality Assurance, Community Directorate, Wolverhampton City Council
Simon Lomas	- Head of Sandwell Probation, Staffordshire and West Midlands Probation Trust – later replaced by:
Jane Connelly	- Head of Sandwell Probation, Staffordshire and West

[6] Home Office Guidance page 11

		Midlands Probation Trust
Eileen Welch	-	Designated Nurse Safeguarding Children, Sandwell PCT (now Sandwell and West Birmingham Clinical Commissioning Group)
Allan Craig	-	Social care Director BCPFT
Maryrose Lappin	-	Community Safety & DV Manager Sandwell MBC
Rashpal Pahal	-	Safeguarding Adults Board Manager Sandwell MBC

The Panel consisted of professionals with significant experience in Domestic Abuse issues. However, the Panel sought independent advice from Wolverhampton Domestic Violence Forum during the process.

The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

Links to Parallel Investigations

There were no other parallel investigations other than the criminal and HM Coroner's to consider. There has been constant contact between the Chair/Author of this review and the Senior Investigating Officer (Police) in charge of the prosecution case.

Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the Safer Sandwell Partnership (SSP) to identify agencies that had involvement with the victim and perpetrator prior to the homicide. A letter was sent to a family member early into the scoping process in order to include the family's views at this stage, but no reply was received.

Individual Management Reviews

Where there was no involvement or insignificant involvement, agencies advised accordingly. The following agencies were requested to prepare chronologies of their involvement with the victim and her family, carry out Individual Management Reviews and produce Reports (IMR reports)

- West Midlands Police

- Black Country Cluster on behalf of Wolverhampton GPs
- UK Border Agency
- Royal Wolverhampton Hospitals Trust
- Crisis Point
- The Haven

The following agencies were requested to provide a chronology and, as their involvement was minimal, to provide a narrative report, the information from which would be used to inform the Overview Report:

- Wolverhampton Homes
- West Midlands Ambulance Service

These agencies prepared chronologies of their agency's involvement which form the content of an integrated chronology that is included in this report and which informed the IMR Reports.

Wolverhampton Drug Addiction Services were asked to provide information that informed the Overview Report.

The following agencies were approached for information and submitted a 'nil return', indicating that they had no information about the victim or her family:

- Sandwell Adult services
- Education
- Magistrates Courts
- Connexions
- Care Quality Commission
- Probation
- CAFCASS
- Sandwell and West Birmingham NHS Hospital Trust – only had dealings with P1 after he was charged and on remand
- Changing Our Lives
- Dudley and Walsall MHPT
- Sandwell Homes
- Black Country Partnership NHS Foundation Trust (Mental Health) – only had dealings with P1 after he was charged and on remand.

Guidance[7] determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

Agencies were encouraged to make recommendations within IMRs and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Overview Author.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt. Where necessary the IMR authors critically examined the processes of their respective agency and the involvement in this case.

Terms of Reference

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?

[7] Home Office Guidance Page 17

- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and the decisions made?
- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered?
- Is it reasonable to assume that the wishes of the victim should have been known?
- Was the victim informed of options/choices to make informed decisions?
- Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
- Was consideration for vulnerability and disability necessary?
- Were Senior Managers or agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and the perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, the following agencies are asked to respond specifically to individual questions:

West Midlands Police

1. Do the circumstances of this case raise any concerns in respect of the current risk assessment framework for incidents of domestic abuse?
2. Was the victim fully advised of options available to her and were appropriate referrals made to other organisations that could provide support?
3. Were there any specific barriers for the victim reporting to the Police?

GP

1. Was the victim fully advised of options available to her and were appropriate referrals made to other organisations that could provide support?
2. What are the care pathways for victims of domestic abuse in Wolverhampton and were they followed?
3. Was the GP aware of adult safeguarding responsibilities and were they followed?

UK Border Agency

1. As the perpetrator was an illegal entrant, what was the responsibility of the UK Border Agency to find and deal with him and what actions were taken?

The Haven, Wolverhampton

1. What is your role?
2. What provision do you have for different groups within the community?
3. How was the risk to the victim assessed?
4. What happened in the initial contact?
5. Did you put any specific support or signposting in place?
6. Is there a link with Crisis Point? If so, please explain further.
7. What other information does the Haven have about this case?
8. What are the Haven's links to MARAC and SARC?

Crisis Point

1. What is your role?
2. What provision do you have for different groups within the community?
3. How was the risk to the victim assessed?
4. What happened in the initial contact?
5. Did you put any specific support or signposting in place?
6. Is there a link with the Haven, Wolverhampton? If so, please explain further.
7. What other information does Crisis Point have about this case?
8. What are the Crisis Point's links to Wolverhampton MARAC and the West Midlands SARC?

A helpful report which includes a chronology of involvement is requested from Wolverhampton Homes and the West Midlands Ambulance Service.

Individual Needs

Home Office Guidance[8] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

[8] Home Office Guidance page 25

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the 9 protected characteristics under the Act:

- age
- disability
- gender
- marriage and civil relationship
- pregnancies and maternity
- race
- religious beliefs
- sex
- sexual orientation

The only issue that arose from evidence contained in the IMRs was when the victim attempted to disclose to a GP issues regarding her treatment at home involving details of sexual behaviour by her husband. The GP was unable to understand the language of the Victim and asked another person to sit in the surgery to interpret. This issue is explored later in the report.

Family Involvement

Home Office Guidance[9] requires that:

> "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
>
> and:
>
> "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

[9] Home Office Guidance page 15

In this case the Overview author made contact with the Senior Investigating Officer (SIO) from West Midlands Police at an early stage. Contact with the family of the victim was aggravated in that her parents live in India and did not speak English. Contact was made by the Community Safety Partnership and a duly translated letter was forwarded to her parents with the help of the police Family Liaison Officer. No reply was received from her parents and a registered letter sent to her nephew in the south of England was returned 'uncollected'.

On 15th June 2012 with the assistance of an interpreter, the Report Chair/Author and a member of the panel spoke with the victim's brother and father in India as well as a female relation of the victim who lives in England. The process of the review was explained and information about the life of the victim as illustrated in paragraphs 2.2 – 2.8 was obtained. The family were asked if they wished to contribute to the process and they were told that contact will take place again in the future.

The Father stated that he and the rest of the family were aware of the arranged marriage of the Victim to H1 and were in favour of that marriage. There is nothing to suggest that this marriage was a forced marriage as defined by the Government Guidelines.[10]

> 'There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the family of both spouses takes a leading role in arranging the marriage but the decision to accept the arrangement or not remains with the prospective spouses. In forced marriages, one or both spouses do not, or through lack of capacity cannot, consent to the marriage. The definition of forced marriage stipulates that duress, including physical, psychological, sexual, financial and emotional pressure, is a factor.'

Following the conviction of the perpetrator for the murder of the Victim, the report author, assisted by a panel member and an interpreter, again spoke to the Victim's father in India by telephone. The findings of the report were explained to the Victim's father as were the details of the recommendations made in the review report. The Victim's father expressed his disappointment regarding the sentence imposed on the Perpetrator, saying he thought life should mean life imprisonment. He also stated that he thought his daughter should have been told about the services available to her in such circumstances. He felt that the systems in the UK were in need of improvement and hoped that if there was an improvement, such events

[10] Forced Marriage and Learning Disabilities Multi-Agency and Practice Guidelines 2011 Page 8 HMG

would not happen to anyone else. He wished that the outcome could have been different. He was unaware that his daughter had been to the police about her problems and wished that she had gone to her family for help. He agreed with the recommendations made regarding the UKBA, saying that he thought that parents in India also had a responsibility to find out more about intended partners of their daughters. He stated that he thought there should be facilities to be able to check intended partners both in India and here in the UK.

Whilst appreciating that the Victim's husband, H1 is a significant witness in the trial of the perpetrator, contact was made by letter explaining the process and expressing an intention to see him in the future after the criminal trial to seek any information that he feels will assist in the review process. Following the trial, two letters were sent to H1's current address. He replied to neither. The author made telephone contact with H1, and after several attempts, spoke with him on 4th October 2013. The purpose of the review was explained to him and he was asked if he wanted to contribute any information. He explained that he did and arrangements were made to call him again on Monday 7th October 2013, when he knew were and what hours he would be working. He works part- time on various building sites. On Monday 7th October 2013, the author again spoke to him. He appeared reluctant to speak and questioned why he was being contacted. He said that he had no idea until he and the Victim were married, that she had been married previously or that she had a child back in India. He stated that that had caused problems in their relationship. He mentioned that he had 'spent a fortune' getting her to England and once she was settled she 'ran off with another man.' He appeared angry and reluctant to speak further. The author offered to ring again when he knew more details of where he would be working on Thursday 10th October, the only date he was available to speak for a longer period.

On Thursday 10th October 2013, the author rang H1. His phone rang out and then stopped. Further attempts at contact during that day and since have been met with ' the number is not contactable.' It was clear from H1's apparent demeanour on Monday 7th October 2013 that he was not happy talking to the author. He has been sent numerous letters and had ample opportunity to contribute but is reluctant to do so. It is the opinion of the author that H1 declines to partake in this review.

A month after his conviction, the perpetrator was written to at H.M. Prison explaining the review process and asking if he wished to be seen and contribute. His legal representative and the Prison Governor were also written to with copies of the letter sent to the perpetrator. In August 2013, the Community Safety Partnership received a reply from the perpetrator

stating that he had received the letter, the contents had been explained to him and he understood the meaning of the letter, but he declined to partake in the review process.

SECTION TWO; SUMMARY OF KEY EVENTS AND ANALYSIS OF AGENCY INTERVENTIONS

Summary of Key Events

It is useful to understand the sequence of events that led to the victim being resident in the UK.

The victim was born in India in 1977. She has one brother and three sisters, one of whom lives in Italy. It is thought that her father is reasonably wealthy as he owns factories in the town where she was born. She confided in her sister in Italy but it appeared that she did not do so with her wider family in India.

At the age of 15 years, by arrangement, she married a local man. There is nothing to suggest that this was anything other than a cultural requirement and an arranged marriage. There is an expectation that an arranged marriage will take place at some point. They had a baby girl. When the daughter was 2 or 3 years of age the family were making arrangements for the three of them to move to live in Italy and on a journey to deal with passport matters, the victim's husband was involved in a road traffic accident, in which he was seriously injured, leaving him disabled and reliant on the use of a wheel chair. According to her father she nursed him for some 5 years but he became aggressive and he decided to instruct the victim to leave him as he felt he was no good for her in his condition. Her husband's parents returned the victim back to her parents. The child was taken by the husband's family and neither the victim nor her family have had any contact with the girl since. The daughter is now 15 years old. The husband has since died.

The marriage to H1 in India in July 2007 was also an arranged marriage. The family said that the victim was happy to marry H1 and that she had a choice in the matter.

The family also stated that once in the UK the victim would contact her family but not very often. She would speak about her daily life and her work, but made no mention of domestic violence to her father. She did however disclose to her mother that H1 was unemployed, an alcoholic and that he had thrown her out of the home on occasions. She would not speak to her brother. The advice she got from the family was not to leave H1 but that she had to 'stick it out' (Father's Comments) this was her second chance at marriage and she had to make it work. The Panel recognise the pressure from the family on the victim to remain married at all

costs and this may have affected her thinking and judgement in remaining in the marriage despite its complexities.

The Father reported that 2 months before her death the Victim had requested money from her family, explaining it was for a visa. Father sent the equivalent of £2000 to her. The Father reported to the Panel that she informed him that she was scared but he never asked any more questions about that comment. H1 later stated that she was a burden on his finances. Her father stated that she never sent any money home to India; it was her family who assisted her financially.

The family in India stated that they were not aware of the perpetrator. The victim would contact another relative in the UK and on a number of occasions she disclosed that the perpetrator had been violent to her and wanted to marry her to get UK status and thereby enabling him to stay in the country. According to comments made by the nephew's wife during a telephone conversation with the author through an interpreter the family in the UK would not do anything about this for fear of repercussions with the family in India. She was clearly trying to identify her concerns about the relationship to her family, but it appears that assistance from her family to encourage her to make positive steps was not forthcoming.

H1 was a UK national. He was 13 years older than the victim. On 29th May 2008 the victim submitted an application to the British High Commission in New Delhi for a visa to travel to the UK as the spouse of a British national, H1. The application was assessed on paper, which means that she did not attend the High Commission in person. The application was refused on 2nd June 2008 as the Entry Clearance Officer assessed that the spouse, H1, did not have the financial means to support the victim. This type of application carries with it a Right of Appeal, which was exercised by the victim from abroad. Her appeal was received from abroad on 27th January 2009. On 18th February 2009 her appeal was heard at the Asylum and Immigration Tribunal in the UK. The refusal was revoked and a visa was issued valid from 18th February 2009 to 18th May 2011. Shortly after the granting of the visa, the victim travelled to the UK. In February 2011 an application was made to the Home Office, UK Border Agency (UKBA), sponsored by H1 for indefinite leave to remain in the UK, meaning she could reside in the UK without any conditions. This was granted on 14th March

Neither the victim nor H1 had any further dealings with the Home Office.

H1, who had divorced his first wife in 2007 and left her and four children, was known to the police for domestic abuse against his first wife in the area of his former marriage. In September 1999, he punched his, then, wife in her face injuring her mouth. He was conditionally discharged by the courts in October 1999. In September 2000, whilst subject of

that conditional discharge he again punched his wife in the face causing swelling and bleeding. He was made subject of a probation order for 18 months. A statement made by his wife at the time, indicates that she suffered some 20 years of domestic violence, most of which went unreported to authorities. All records of his convictions before he moved to the West Midlands have been destroyed under the local probation service policy. He was also known to Police regarding offences of drunkenness and breaching the peace. His record of drunken episodes date back to August 2005 when he was taken to hospital in an alcoholic state. He was treated and discharged.

Two similar incidents occurred in February 2006 when he was treated and discharged for a drug overdose. Twice in May 2006 he was arrested for breach of the peace offences involving drunkenness and on both occasions he was released without charge.

In May 2006 H1 was treated in hospital after presenting in an alcoholic state. He was discharged after treatment.

In June 2006 he was found drunk and confused and he was arrested under the Mental Health Act 1983. On this occasion he was examined and assessed. He was not sectioned and was released without charge.

He reported to hospital in October 2006 with a minor nose injury, treated and discharged. There is no more information about that injury.

In February 2008 and March 2008, H1 was arrested for being drunk and abusive and a breach of the peace. On both occasions he appeared before Magistrates Courts, was fined and bound over to keep the peace. Police records indicate that on both of these most recent arrests there was no evidence of mental health issues raised. During 2008 he attended an Addiction Services Centre for his alcohol problems.

Having entered the UK in February 2009, the victim and H1 lived initially with H1's parents, but in October 2009 they moved to another address. The victim found employment as a seamstress. H1 had no paid employment.

On 2nd March 2009, the victim registered with a GP at Practice No 1. This was the same practice that H1 was initially registered at, but it is known that in about March 2008, he was removed from the register at the practice, and no forwarding GP details were given. He had previously been registered with a GP in another county where he had lived before.

As the victim registered with her GP, she produced a copy of her marriage certificate and stated that she had previously been unmarried and living in India. Her husband, H1, had

previously been divorced and was living both in the UK and India. It was noted that she did not speak English and Punjabi was her native language. She was examined and found to be slightly underweight and anaemic, for which she was prescribed iron tablets to be taken three times daily. (It is of interest to note that she remained on this medication for the next two years despite her haemoglobin level returning to normal on at least two occasions.)

Between registration and 10th June 2009, the victim presented to her GP on no less than ten occasions, mainly for routine problems, but of interest on 21st April 2009 she requested contraceptive advice. She stated that she had an 11 year-old daughter; she had remarried and does not plan any more children. She opted for an Inter Uterine Contraceptive Device (IUCD), but there is nothing to indicate that this was ever taken up by her.

On 13th June 2009 H1 presented to hospital emergency department with depression. He was treated and discharged. Again on 3rd September 2009 he attended emergency department with abdominal pain and alcohol problems. Again he was treated and discharged.

The victim continued to attend her GP's surgery between September 2009 and March 2010 for routine matters, but in March 2010, a note indicates that she was living outside the GP's area and needed to change GPs. The victim was employed as a seamstress and H1 was unemployed.

On 1st September 2009 H1 made a housing application to Wolverhampton Homes. The application was in his sole name. According to his application he was not looking to move in with anyone else.

H1 moved from that address on 29th November 2009. Wolverhampton Homes decided that as he was already housed in adequate privately rented accommodation, his application was graded as Band 4, the lowest band which includes people with no housing needs. In total he made 5 bids for properties advertised on 'Homes in the City' between 18th and 26th April 2010.

On 29th July 2010 the victim attended her GP requesting fertility treatment. She explained that she has a 13 year old daughter in India and her husband had 4 children, but she was not eligible for NHS infertility treatment. This request was contrary to the consultation of April 2009 when she stated she did not plan to have any more children and wanted a coil fitted.

The victim's next appointment was on 1st November 2010 with GP2, who did not speak Punjabi. In order to assist her, another patient interpreted for her. Elsewhere in Health documentation it states that the interpreter was a friend of the victim. However, the victim stated that her husband had been physically abusing her, hitting her and locking her up in the house. She also informed of her husband raping her. She was examined by the GP who found

superficial bruising to her right hip and fingers, and tenderness to her neck and chest. There was no examination regarding the allegation of rape. She stated that her husband had thrown her out of the house and she was now homeless. The GP advised her to report the matter to the police. She stated that she would wait and see GP1, who could speak Punjabi, in two days' time as she felt uncomfortable talking about these issues with the interpreter present.

On 3rd November 2010 she returned to her GP and saw GP1. She said that she had been suffering for the past two years and was trying to do two jobs to help as her husband had a drink problem, the inference being she helps support them financially due to his expenditure on drink. She reiterated the fact that she was kept locked in the house and he had assaulted her, and that he had swung her round by her neck scarf. She was again advised to report the matter to the police. There is nothing to suggest that the allegation of rape against her husband was mentioned. However, taking account of her concerns of reporting these issues, the cultural barriers, and the expectation of the family to 'stick at the marriage', these may have been the causes of the non-disclosure at this time. There is nothing to indicate that either GP followed up their advice about contacting the police or made a referral to MARAC or any other services.

On 22nd November 2010 H1 made a further housing application for Council Housing, and this time he included the details of the victim. Some 6 months later on 11th May 2011, H1 called into the housing offices requesting that details of his wife the victim be removed from the housing application form. He stated that she no longer lived at the property.

On 10th December 2010 the victim attended at her GP again and saw GP2, who, after hearing about her recent domestic problems and finding no physical abnormality, reassured her, but did not take any further action or make referrals to any other agencies or enquire about recent domestic abuse issues.

On 15th February 2011 the victim submitted an application for indefinite leave to remain in the UK. On the same day H1 applied for the victim to remain indefinitely which was granted.

On 14th March 2011 a decision was made to grant the settlement application, which meant that the victim could remain in the UK without conditions.

On 17th March 2011 she went back to her doctor and saw GP1. She presented with multiple aches and pains and feeling sleepy. A repeat prescription for calcium and vitamin D was issued. There was nothing to suggest that any enquiry was made by the GP into her home circumstances.

On 5th April 2011, the victim went to the police and reported that her husband had taken her passport and that on 3rd April he had raped her at the family home and this was a regular occurrence when he was drunk. On this occasion she stated that there had been an argument and she had locked herself in the bathroom. Her husband had kicked the bathroom door down and had assaulted her before raping her. She was initially seen by uniform officers.

The Acting Detective Inspector directed that she was to be forensically examined and video interviewed. The offender was to be arrested and she was to be referred to the Haven which provides housing and other support for victims of domestic abuse. She was subject to a Domestic Abuse, Stalking and Harassment (DASH) risk assessment and considered a 'high risk'.

She was later seen by 2 officers from the Public Protection Unit. She agreed to a medical examination, although it was anticipated that any forensic evidence may well be inconclusive due to the time delay in reporting the rape offence. It is noted in the Police IMR that:

> 'previous injuries had been noted by the GP and could offer a degree of corroboration', but this was some 5 or 6 months previously.

With the Police Officers the victim was taken to the local Sexual Assault Referral Centre (SARC) where victims can be medically examined and interviewed by appropriately trained officers in properly equipped interview rooms suitably designed to comfort victims and 'Achieve Best Evidence.' The SARC is also a gateway for the victim to access other services to help them deal with the trauma of rape. She was examined by a Forensic Medical Examiner (FME), who could only speak Urdu. There was no interpreter present during the examination. Later the victim made a short written statement with the aid of an interpreter stating she had been raped by her husband and giving written consent for the examination. By the time the examination had finished the officer was due to finish duty. She was given emergency contraception and Genitourinary advice and a referral was made to a specialist unit.

The victim was taken back to her town for interview. Victims are usually interviewed at the SARC. The reason for her being returned to her town is not known. However it is clear that during this 48 hour period when the victim was at the SARC, there were some 11 victims of rape were interviewed and dealt with there, so an assumption is made that interview facilities at the SARC were not available at that time due to the number of victims present.

She was assigned a new Specialist Trained Officer (STO) to conduct that interview. However she had to wait 5 hours from her initial contact with the police before the new officer was introduced to her. The STO PC2 was a female Sikh officer who took a statement from the

victim explaining why she no longer wished to substantiate her allegation of sexual abuse against her husband. She had already decided to leave her husband, which could have been perceived to be regarded as a stigma within her community and family. The victim made a written statement stating that she had decided not to pursue the complaint. The victim was taken to her address to collect her property and was taken to safe accommodation which was the home address of the perpetrator.

The Panel considers that using an officer from the same cultural background may have been an issue for the Victim to illustrate in such detail the nature of the offence, rather than the use of an informal interpreter or a female officer who was not from her cultural background. She had previously expressed concerns about the stigma involved in disclosing the details of such an offence.

The Police Officers involved did not allow the victim time to reflect on her decision, but the victim was referred to Crisis Point and The Haven, both Independent Support Organisations for women in these circumstances. The Police did not arrest her husband and he was not recorded as being suspected of this offence or interviewed about the allegation.

On the morning of 6th April 2011, Crisis Point received an e mailed referral for the victim from the SARC and the police. Latter the same day, at 15.08hrs, the victim was contacted by telephone by an Independent Sexual Violence Advisor from Crisis Point, but as the advisor could not speak Punjabi, another arrangement was made for the following day when a Punjabi worker did speak to her. There was only limited information contained in the referring e mail. According to Crisis Point, the victim did not provide the police with her last name and the referring e mail states that the victim stated to the police that she didn't have a last name. The following day at 10.10hrs the victim was contacted by telephone and had a conversation with the Punjabi speaking advisor. The victim reiterated that she did not wish to pursue the allegation or have any dealings with Crisis Point. She declined to give any information about the event and she didn't wish to take the matter any further. She didn't want her parents to know and feared what people would think of her. She was previously concerned about the stigma of such an offence and the disclosure of such. She stated that her belongings were at her husband's house and she was advised to contact the police regarding this matter. The victim was told that she could make contact if she wished to at any time in the future. Crisis Point contacted the Police who stated that they were closing the case due to the victim's reluctance to continue with the complaint.

On 5th April a referral was made by the police to an Independent Domestic Violence Advisor (IDVA) at The Haven. The following day the advisor referred the information by e mail to another colleague due to the victim being Punjabi speaking.

On 12th April 2011 another member of the Haven Community Team who was Punjabi speaking made contact with the victim and she stated that she didn't want Community Support but she needed accommodation. She initially expressed an interest in a refuge.

As the victim had expressed an interest in a refuge, another colleague from the Referrals and Admissions was contacted. She made telephone contact with the victim to carry out The Haven's referral process. It was noted that she was having problems with her husband. During that conversation the victim stated that she didn't want a refuge but she wanted her own flat She was at this time staying with a friend. As a result of this request she was advised to contact the local authority. Notes record that she had no passport and was not in receipt of any benefits at that time. The Haven had no further contact with the victim after 12th April 2011.

The Acting Detective Inspector (ADI) filed the police report indicating that:

- The victim was not supporting the prosecution
- The Police investigation should be victim led
- Without consent to access her medical records a critical additional element of evidence was missing (there were no apparent injuries sustained in the most recent rape)
- The potential for Honour Based Violence should the complaint be taken further

It was the ADI's view that although the victim was recorded as a High Risk victim, because referrals to The Haven and Crisis Point had been made, she would be provided with the necessary support required. It is clear that the police were unaware that the victim had declined services from The Haven. They did know that she had refused services from Crisis Point. She was therefore getting none of the service provision envisaged and no referral to MARAC was made by the police or other agencies.

Once her property had been collected from her home address, with the assistance of the police she was taken to alternative accommodation, where it is believed the perpetrator was the tenant. The perpetrator entered the UK illegally and without leave of an immigration officer. There are no records as to when this was. He was seen by an Immigration Officer from the UK Border Agency in September 2012 and was served papers informing him that he was in the UK without leave and was liable for removal.

As far as the police are concerned there is nothing to suggest that the victim had any more dealings with her husband or returned to the home address. It is also understood that her

husband was unaware of her new address. Having said that, the Police did place a warning marker on the address in case of any further connected issues arising there.

From 21st April 2011 H1 again attended the Addiction Services Centre for treatment. He had requested for help to stop drinking and was offered interventions including alcohol/health education, gradual reduction advice, motivational work, detoxification and relapse prevention advice. He made some progress but relapsed again. He failed to attend his last two appointments. The Addiction Service Centre records show that he was unemployed and was receiving benefits, and also that his family found it difficult to cope with his drinking and he had asked his parents for money to buy alcohol.

On 11th May 2011 H1 contacted Wolverhampton Homes stating that the victim no longer lived with him and she was removed from the application.

On the same day, the victim presented at her GP1 stating that she had been beaten by her alcoholic husband and was now staying with a friend. There is no record of any injuries being noted although the GP's notes do not indicate how much of an examination was conducted. She was given a prescription for Paracetamol and vitamin D. She was advised to contact the police to retrieve her possessions.

That was the last contact the GPs would have with the victim.

In July 2011 the victim was found dead at an address which she shared with the perpetrator.

It appears that the victim knew of P2 from India and he would give her a lift to her work. She had disclosed to P2[11] that she was being pestered by another man (the perpetrator) to marry him. It is thought that P2 was going to assist the victim to move to new address.

On the night before the homicide occurred, P2 attended at the victim's home when the perpetrator was out, and moved some of her possessions to the new address. The removal of the remainder of her belongings was to take place the following day, indicating a clear intention of the victim to leave the perpetrator.

During the police investigation, it came to light that during the morning of the homicide, According to the Police IMR, the perpetrator alleged he looked at the victim's phone and found a message saying, 'I love you'. P2 said that he had a missed call from the victim at 06.42 and rang her phone back but it was turned off.

The perpetrator said that he confronted the victim about this that morning and she had told him that she was leaving and that she had used both him and her husband for money. The

[11] The Victim's partner who she intended to move in with

perpetrator told the police that he had put his hands around her neck telling her how much he loved her and her nose had bled. Leaving her at the house, he caught the train to London. He called a friend and told him what he had done and the friend advised him to return home to tell the police, He caught a coach back to Birmingham and surrendered to the police.

P2 and his friend reported to the police that the victim was missing. The report was graded as being medium risk. Three and a half hours later at just after 7.00pm the same day officers were despatched to the address of the perpetrator and the victim, and at about the same time the perpetrator had presented at the police station. An ambulance was summoned and as the ambulance crew arrived they were shown to a cupboard where they saw the body of a female who, it appeared was deceased.

Since the homicide of the victim, H1 has been admitted into hospital on several occasions with alcohol related illnesses and depression. He has been treated on each occasion and has been referred to the Mental Health Team and psychiatric services.

Analysis of Agency Involvement

As stated earlier in this Overview Report the agencies that had significant involvement with the victim and her family are:

- West Midlands Police
- Black Country Cluster on behalf of Wolverhampton GPs.
- UK Border Agency
- Royal Wolverhampton Hospitals Trust.
- Crisis Point
- The Haven

It may be useful to summarise the involvement each agency had and give a brief overview of the recommendations that have been made respecting individual agencies.

West Midlands Police

It is worthy of note that West Midlands Police had only one contact with the victim in this case, when she reported that she had been raped by H1. She, however, sought not to pursue her initial allegation and the Police decided they could take the enquiry no further forward. H1 was not arrested. Her then husband, H1, was known to the Police for domestic abuse of a former wife in another area of the UK. The perpetrator was not known to the Police at all.

At the time of this review, West Midlands Police had been formed into Local Policing Units (LPUs) and each LPU had a Detective Inspector responsible for the conduct of adult or child serious crime investigations.

This structure was supported by numerous policies and procedures, some locally designed, others mandated by National Policy from the then National Policing Improvement Agency (NPIA). All of the staff involved with the victim in this case were suitably trained for the role they performed, although there were issues identified within the Police IMR around dealing with an Asian lady without having an interpreter present, there was a failure by officers investigating the allegation of rape to seek H1's previous police intelligence from the other police force he had had dealings with and issues around the appropriate assessment of risk regarding the victim's relationships were also identified.

The Police IMR makes recommendations regarding each of these areas and the Author of this report is confident that those IMR recommendations are robust enough to prevent a repeat of these issues.

Black Country Cluster on behalf of Wolverhampton GPs

The GP practice is a two partner inner city practice with a list size of circa 3,500 patients of mixed ethnicity (70% South Asian the majority Punjabi speaking, 30% Caucasian + others) . Both partners are male and only GP1 speaks Punjabi, the main language of the victim. Telephone interpretation services are available in consulting rooms by means of a three way telephone system when needed but may be provided by accompanying adults if the patient is happy with the arrangement. Individual one to one interpreters can be booked for longer consultations. During the 3 years in question there have been no major organisational changes within the practice in terms of staff, IT or premises.

The practice has its own vulnerable adult's protocol in place, which states that the practice uses the Wolverhampton Safeguarding Vulnerable Adults policy and Procedures and makes referrals using the local SA1 form. The protocol states that it was last reviewed in September 2011. The practice provided an electronic copy of the Wolverhampton procedures and it was noted that this was of the original version of the procedure dated 31/05/2001. Wolverhampton has now adopted an updated West Midlands Policy for Safeguarding Adults and this is now included on the Wolverhampton Council website.

At the time the DHR was underway, the partners had received training in adult safe guarding three years previously but staff were overdue training in respect of adult safeguarding and domestic abuse. Staff had been booked on 2 PCT courses in the past year but both were cancelled. There is now internet accessed adult safeguarding training available for practice staff but no one in the practice had completed this. Since this DHR has been completed, an

assurance visit has been undertaken by an officer from the Clinical Commissioning Group and confirmation provided that all outstanding training by the GP practice has been completed.

Throughout this review there were issues raised regarding the risk assessment processes used to identify vulnerable women who may be subject to domestic abuse. Such was the case in this review, when the victim visited her GP in order to complain about sexual and physical abuse by her then husband H1, and she received an inadequate service from the GP, who failed to identify risks. This issue is dealt with in recommendations at the end of this report. As far as IMR recommendations are concerned, the PCT makes three, covering issues around reviewing and implementing safeguarding protocols including risk assessment and management so that they understood by all clinicians and staff in the practice so that the PCT can assure itself that practices are aware of best practice in safeguarding adults. A further IMR recommendation concerns the development of an audit tool to encourage practices to make better use of interpreting services.

UK Border Agency

The UK Border Agency were responsible for granting permission for H1 and eventually the victim to enter into and stay in the UK. The victim's application was initially refused on the basis that it was considered that H1 was not financially strong enough to support her whilst she was in the UK. However she appealed against that decision and her appeal was upheld and she was granted Indefinite Leave.

Royal Wolverhampton Hospitals Trust

The main area of contact the RWHT had with H1 was in response to his attendance at Emergency Department on occasions when he was under the influence of alcohol, or in depressive states connected with intoxication. The Trust identify that there were opportunities to seek more information about his home circumstances and to this end the Trust have initiated the implementation of an Alcohol Liaison Service which is designed to signpost patients with alcohol related problems to support agencies. This is catered for adequately in the Trust's IMR recommendations.

Crisis Point

Crisis Point provided an Independent Sexual Violence Advisor (ISVA) service offering practical support and guidance to the victim. The ISVA role is to offer practical support and guidance to victims within and outside the criminal justice system. Part of this is to try and help clients re-consider the aspect of involving the criminal justice process. The ISVA has three volunteer support workers working with her to maintain a caseload and provide a comprehensive care package. Crisis Point service provision is client led, it is the clients' own choice to engage or not with Crisis Point.

There are comprehensive policies in place that cover referrals which maintain confidentiality. The referrals policy has a robust information sharing strategy that ensures all front line Crisis Point staff provide a comprehensive breakdown of current risk/threat and other agency involvement. The referral form also invites other agencies to provide an information share and a section that details whether the referring agency are sharing information or not based on clients' wishes.

The Haven

The Haven supports women and children who are suffering Domestic Violence/ Homelessness. It offers refuge accommodation across the city for up to 53 families including women who may have Drug/Alcohol dependency, Mental Health Issues and a history of offending. It offers Community and Advocacy Support for women who do not require refuge accommodation but who are also victims of Domestic Violence. It also offers support through the Criminal Justice System, Support via Financial Inclusion Team (FIT), Legal Advice Drop in Sessions alongside Options and Guidance Drop in Sessions. All of the above services are open to families from all backgrounds, cultures and Ethnicities.

SECTION THREE – COMMENTARY AND RECOMMENDATIONS

Safer Sandwell Partnership's guidance for the process for undertaking a domestic homicide review[12] states:

> 'the overview report aims to bring together the management reports and critically analyse the information and judgements within those reports'.

Government guidance[13] states:

> 'this part of the review should examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken.'

The Independent Overview Author has attempted to bring together all of the circumstances of this case and critically analyse the event and with the assistance of the panel members to then create recommendations and identify best practice in order that this report goes some way to preventing a similar incident occurring.

Both 'No Secrets'[14] and 'Who decides'[15] state that 'the vulnerability of a person is related to how able they are to make and exercise their owned informed choices free from duress, pressure and undue influence of any sort, and to protect themselves from abuse, neglect and exploitation'.

'No Secrets' further includes, 'Physical, sexual, financial, emotional, discriminatory or psychological violation or neglect of a person unable to protect him/herself to prevent abuse from happening or to remove him/herself from abuse or potential abuse by others.'

There is ample research to support the fact that vulnerable women in the circumstances that the victim found herself are more susceptible to domestic violence and sexual violence. The victim was a woman who came to the UK with H1, a man she had married in India. She had been married previously and was divorced by her terminally ill husband declaring the marriage over. She had to leave her first child in India with whom she has no contact. That may have been traumatic for her. She then appeared to have a further arranged marriage to H1 and then she arrived in the UK with very limited understanding of the English language, in a

[12] Process for Undertaking a Domestic Homicide Review Safer Sandwell Partnership Nov 2011 page 20
[13] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011 page 28
[14] No Secrets Guidance Dept. Health 2000
[15] Who Decides: Lord Chancellors Dept. 1997

strange country and it appears without much support from her husband's extended family members. Her husband may have been suffering from an alcohol problem and required numerous general hospital attendances. His mental stability was unpredictable and there were clearly incidents of domestic violence over a long period of time including physical violence, imprisonment and the confiscation of personal property. There were allegedly repeated incidents of rape and sexual abuse by her husband so much so that she finally reported these matters to her GP and the Police. The police did not follow the rape allegation through and there was no referral to MARAC.

The panel are aware that the Victim had reported her concerns about her second marriage but received no support only to be informed that she needed to work at the relationship. There is a recognition that English was not her first language. She was receiving no support from her family to address the difficulties and disclosing such personal information had a stigma for her.

In order to escape the concerns of her relationship with H1 she drew on the support of the Perpetrator. However it appears that the relationship deteriorated within a few months due to possessive and violent behaviour by the perpetrator and eventually she decided to move again to live in Birmingham. This appears to be the catalyst for her being murdered by the second partner, once she informed him that she was moving away.

On a number of occasions the victim sought assistance from agencies and professionals, particularly the police and GPs, because she was a victim of domestic abuse. It would appear that she was let down by agencies and professionals she disclosed to, which may have contributed to her making choices she did. She may have perceived that she only had limited options. This part of the Overview Report will illustrate those issues and make the necessary recommendations.

It is of interest to note that Itzin, Taket and Barter-Godfrey[16], when writing about Race and Cultural issues within Domestic Violence state:

> 'Most women have experienced abusive practices within the family, including assaults, imprisonment, harassment, rape and sexual abuse, emotional blackmail and coercion, demands for a dowry, forced marriage, abduction and attempted murder'.

The Victim experienced several of these issues during her life in the UK.

There are several issues worthy of note that emerge during the examination of the facts of this review and they are dealt with in detail as follows.

[16] Domestic and Sexual Violence and Abuse – Tackling the Health and Mental Health Effects Catherine Itzin, Ann Taket, & Sarah Barter-Godfrey 2010 Routledge page114

Husband's alcohol abuse 2005 - 2011

Some four years before the victim and H1 were married in India, H1, who was a British Citizen, was having problems with his drinking whilst he was in the UK. He had 6 presentations to hospital with drink and drug related injuries and illnesses and he had been arrested on 3 occasions by the police for drunkenness offences. The victim arrived in the UK in early 2009, but H1's drinking continued. He was arrested twice more in 2008 for being drunk and abusive and it was during that year he attended an addiction centre for treatment. In 2009 he attended hospital emergency department, in June with depression and in September with abdominal pains due to drinking.

H1's GP practice was the same practice as the victim. As H1 was not admitted at any stage during any of his presentations at the hospital emergency department, his care was passed back to his GP, but he was removed from the GP's practice list in March 2008. He is known to have received other NHS services; indeed Royal Wolverhampton Hospital makes reference to referring him back to a GP but details of which GP have not been found. There is also reference to the fact that H1 was under the care of psychiatric services for support for his alcohol dependency. There is no reference to any details of his family circumstances being obtained from him whilst he was in the emergency department. The Royal Wolverhampton Hospital IMR states: *'As is usual with an A&E department the focus was on treating the presenting medical condition'.*

The local Mental Health Trust records that H1 had been attending Addiction Services since April 2011, requesting help to stop drinking in which he made some progress but then lapsed again. He failed to attend his last 2 appointments.

At the time of his visits to the emergency department there was no system in place that recognised signs of alcohol abuse and how to escalate those concerns, and it has been recognised by the NHS Trust that the emergency department requires greater links with alcohol services.

With this in mind the RWH Trust has now introduced training for staff to recognise signs of alcohol abuse and to escalate those concerns by appointing two senior alcohol dependency nurses to work closely with A&E Services. They will identify those who require on-going support and liaise with community services ensuring that with the persons consent they access the support required.

H1 has been receiving treatment at the Emergency Department at hospital and receiving assistance from the local mental health trust since 2011. There must have been contact with a GP with the results of A&E visits and also regarding the on-going treatment from a psychiatrist, but there are no records.

Between the pertinent dates of 2009 and 2011 whilst he was receiving treatment, there were concerning allegations of serious domestic abuse taking place on his wife, where she was presenting to her GP. In November 2010 she reported abuse and rape and within 2 days she presented at her GP again highlighting that her husband's drinking was causing abusive incidents and also financial problems.

It appeared then that there were numerous occasions when H1's drinking problem came to the notice of GP's and hospital and other than treating each presentation in isolation, a more holistic view of his alcohol abuse was not considered. He was constantly sign posted to alcohol services but rarely engaged with them.

Recommendation No 1

Wolverhampton and Sandwell Drug and Alcohol Action Teams (DAATS) in commissioning alcohol support services should ensure that there are clear links to the prevention and reduction in Domestic Violence by the providers.

There is ample research to indicate that alcohol is thought to be a contributory factor in a third of all domestic violence incidents,[17] and children who grow up in families where there is domestic violence and/or parental alcohol and drug misuse are at an increased risk of significant harm.[18]

The local RWH Trust has now recruited two posts, Alcohol Liaison Nurse and senior Alcohol Liaison Nurse whose role it is to deliver a specialist nurse led alcohol liaison service for patients presenting to the A&E or inpatient departments of the acute hospital who have substance misuse problems. They will also provide the patient a pathway provision in primary collaboration with the hospital and other partners. Currently they are focussing on A&E, with the aim of encouraging a 'Single Alcohol Question' to be raised when appropriate with each patient. The team along with one of the Health Trainers will then screen and signpost these

[17] Finney, A. (2004) *Alcohol and intimate partner violence: Key findings from the research,* Home Office Findings No. 216, Home Office. www.homeoffice.gov.uk/rds/pdfs04/r216.pdf
[18] Humphreys, C. and Stanley, N. (eds.) (2006) *Child Protection and Domestic Violence: Directions for Good Practice*, Jessica Kingsley Publishers

patients and they are also piloting a questionnaire in the waiting room for patients to self-complete.

It is hoped by introducing this system, that anyone presenting with H1's problems and regularity will be identified and pointed towards a much greater range of services.

The Victim's disclosure of abuse and rape

It is clear from the evidence available that the victim suffered long periods of abuse at the hands of H1, both physical and sexual. In November 2010 she reported to her GP (non-Punjabi speaking GP) that her husband was abusing and raping her. He suggested that she should report the matter to the police. Within 2 days she attended to see the Punjabi speaking GP and reported domestic violence. There is nothing to suggest that she discussed the rape on this occasion but the details of her disclosure should have been recorded on the GP's notes from the previous visit 2 days earlier. Again she may have been embarrassed to repeat the details of such events. She was advised to report the matters to the police. She did not seek assistance from the police and there was no follow up by the GP to ensure that she had. Therefore the matters lay as far as the GPs were concerned.

Health Service staff and GP's in particular have a specific contribution to make in respect of domestic abuse as the NHS is the one service that almost all victims of domestic abuse will come into contact with at some point in their lives. It is estimated that one in nine women presenting to health services at any one time will be currently living with abuse (BMA [19]1998) There can be few health care professionals who have not seen patients whom they suspect are being abused at home, but have not known what to do about it. However all health care professionals who have contact with patients/client need to be aware of the risks of all forms of domestic abuse and be alert to the possible indicators that it is taking place (Henwood M 2000)[20]. "You should never assume that someone else will take care of domestic abuse issues, you may be the woman's first and only contact.'[21]

The health service alone cannot meet all the needs of those experiencing domestic abuse but it is uniquely placed to ensure that they access services which can help change their situation. Since 2004, Primary Care Trusts have had a statutory responsibility to work with local

[19] Domestic violence: A health care issue, BMA, London (1998)
[20] Henwood M, 2000, Domestic Violence: A Resource Manual for Health Care Professionals
[21] " Responding to Domestic Abuse[21] P35 DOH 2006

agencies to reduce crime and domestic violence forms a quarter of all violent crime (Responding to Domestic Violence DOH 2005).

The GPs in this case did not adhere to Department of Health Guidance or their local policies and procedures following a direct disclosure of domestic abuse by the victim which could possibly have endangered the well-being of the victim.

The victim's visit to the GP on 3rd November 2010 when she explained her predicament at home resulted in her being told to report the matter to the Police. There was no consideration given to her ability to speak English which was not her first language, or to safeguarding her and no exploration about who else may possibly be affected by her husband's violence, depression and drinking.

On 10th November 2010 the victim was 'reassured' by the GP about her domestic problems, indicating another poor response. This constant attitude by the GPs raises the question of whether they were ignorant of the appropriate treatment for victims of domestic abuse, which would be hard to comprehend, or was there an issue of cultural acceptance of this dilemma within families, one will never know.

It is felt that the response of the GP on 1st November 2010 was poor practice, when again she disclosed physical abuse, rape, being locked away and presented with bruising. She also stated that her husband had thrown her out of the house and she was homeless. Either a patient or a friend was used as an interpreter. Even with all of these circumstances she was advised to report the matters to the police. The GP's reaction to this was wholly inadequate and the use of the 'interpreter' could have had implications for the victim's personal safety.

It is well documented[22] that over 32% of women are abused many times (up to 35 times) before reporting, and 25% have been abused two or three times. The GP failed to safeguard the Victim.

All of the above examples are a series of extremely serious missed opportunities to help a very vulnerable woman who was seeking for help.

In June 2012 the RCGP issued guidance[23] for GPs in relation to domestic abuse to the effect that each surgery should have a designated person responsible for coordinating domestic abuse support services and referrals, establishing a domestic abuse care pathway by

[22] Domestic Violence, Sexual assault and stalking: Findings from the British Crime Survey 2011
[23] Responding to domestic abuse: Guidance for General Practices. Royal College of General Practitioners, CAADA et al. June 2012

identifying the signs and symptoms of such abuse and requiring training for both health and non-health staff including GPs.

Recommendation No 2

Safer Sandwell Partnership to request that the Black Country Cluster disseminates the guidance 'Responding to Domestic Abuse from Royal College General Practitioners dated June 2012, and ensures that a nominated person from each GP practice has been identified to implement the guidance and provide a list of the nominated persons to Safer Sandwell Partnership as evidence that this has been completed within the next 12 months from the date of this report.

Since this DHR was commenced Practice Safeguarding Leads have been established within GP Practices. The role of the Practice Safeguarding Lead is to support members of a GP Practice within their safeguarding duties. This could be by: promoting awareness of local safeguarding referral processes, promoting team discussions in respect to actual or potential safeguarding concerns and to direct professionals towards key information and guidance in respect to safeguarding for both adults and children. Practice Safeguarding Leads have now been established across Birmingham, the Black Country and Solihull. Usually these professionals are either GPs or Practice Nurses; however there are some Practice Managers who undertake this valuable role. These individuals are supported by their local CCG Safeguarding Leads.

It took another 5 months before she gathered enough courage to seek assistance from the police for all of the reasons previously identified. In April she reported her passport had been taken from her by her husband and she had been raped. To report this to the police against considerable cultural influences was a significant step for the victim to take. This was followed by another considerable decision to leave her husband.

Family honour (izzat) and shame (sharam) constrain Asian women in particular from contacting the police or social services, or separating from their partner. Many Asian women believe they have no safe option or support from family and community when leaving; they stay to prove that they are a dutiful wife. This would have been compounded by this being the Victim's second marriage and being isolated in the UK.

Sanderson[24] points out 'Alongside Domestic Violence many Asian women also commonly encounter abusive and oppressive practices in the family including forced marriages, abduction, imprisonment in the home, restrictive lifestyle….lack of independence and self-worth, and lack of social contact. A common form of domination and control by Asian males is allegations of unfaithfulness and punishment for lack of sexual cooperation.'

On reporting the rape to the police it was decided by a supervising detective that the victim should be forensically and medically examined. Her disclosure should have been recorded on video tape, (the usual practice in these circumstances). A DASH risk assessment was made and recorded as High Risk. She was taken to the local SARC and examined by an FME, but without an interpreter being present. The male FME spoke Urdu, a language that she may not have fully understood. She then made a short statement of complaint in the presence of an interpreter and she was referred to a support centre.

The victim was then taken back to Wolverhampton for a full interview. It appears that the SARC was busy dealing with numerous victims and it was thought better to return the victim to Wolverhampton for the statement to be taken. It was 5 hours between initial contact and the statement being taken, at which point the offer to pursue the criminal allegation was not taken any further. Her report was subsequently filed by the police. A record indicates that the reasons for the police not proceeding were their perception of the 'cultural stigma and that the victim was not willing to provide any further details via interview or statement'. She was given no time to reflect on her decision. Enquires into the antecedent history of H1 were not completed.

The Police IMR helpfully points out;

> '*What is also clear is that the filing decision was taken too quickly without many of the appropriate investigation lines of enquiry*'
>
> and;
>
> '*The failure to identify [H1's] past offending meant that possible similar fact evidence was never discovered. In a domestic rape allegation the investigative strategy should include obtaining information from previous partners about the relationship and specifically sexual behaviour, including changes in sexual behaviour. Investigators should also research any previous allegations which have been withdrawn or discontinued*.

[24] Counselling Survivors of Domestic Abuse - Christiane Sanderson 2011 Jessica Kingsley Publications page 32

The victim had made a short statement, so to infer that she would not make a statement was incorrect. Based on that initial disclosure and the fact that the matter had been recorded by the police, H1 should have been arrested and duly processed by the police. A power of arrest existed and it was not used by the police. The Victim had already been assessed as a 'High Risk' victim and there was clearly a risk that H1 would continue to pose a risk to any other women in domestic settings. Police IMR states: 'The consequences of this (not arresting) were that a search [against his name] would not reveal the allegation or possible risk he posed. Only if an officer conducted a search against the home address would the allegation come to light'.

The Police IMR points out that as a result of this case, a review of practices within the force area for a 12 month period of similar rape allegations made by Asian women against their husband or partner was conducted. There were 30 such cases (which included this case) and in all cases except this case, irrespective of a withdrawn allegation, the suspect was arrested and interviewed. This was the only case where the alleged offender was not arrested and interviewed and examination of the police records show that H1 was not even classed as a suspect on any police system, meaning that any officer researching his name would not have discovered anything about this allegation.

The fact that H1 was not arrested was a missed opportunity for the police to prevent further offences being committed against the victim. Had this happened this may have given the victim confidence that the allegation had been taken seriously and therefore more choices would have been apparent to her.

A daily monitoring system has now been established whereby all such reports are examined by senior management team members across the force area. The filing of Rape and Serious Sexual Offences (RASSO) is now only allowed by a Senior Investigating Officer (SIO)

Recommendation No 3

West Midlands Police to review the manner in which complaints of serious domestically related offences are investigated and ensure compliance with the NPIA Guidance on Investigating Domestic Abuse, especially with regard to cases where the complaint is withdrawn and where there is evidence to support to original allegation.

The victim was taken to the West Midlands Sexual Assault Referral Centre (SARC). It was established in pursuance of the Department of Health National Support Team Response to Sexual Violence and its purpose is to develop services and care pathways for victims of sexual violence that have experienced rape, serious sexual assault or sexual abuse. Walsall SARC services the western side of the force area and of course includes Wolverhampton. It is designed as a one stop location where victims regardless of gender or age, can receive medical care and counselling and have the opportunity to assist a police investigation, including undergoing forensic examination

The victim was seen by a Police Specially Trained Officer (STO) as per procedures, but the first STO booked off duty part way through dealing with her. A second STO, who could speak Punjabi saw her later and the police IMR points out that this officer showed a great deal of empathy towards the victim and appreciated her concerns. During her stay at the SARC procedures went ahead without a suitable interpreter being summoned to assist her. West Midlands SARC Integrated Care Pathway Guidance [25]state that among its principles is to 'ensure all victims feel in control and to access services that are sensitive to their individual needs'. It goes on to say that the Crisis Workers will 'establish if there are any additional support needs to assist the victim in access to the SARC e.g. support from an interpreter.

The victim needed the assistance of an interpreter during the SARC process. During her dealings with the SARC, Crisis Point and The Haven, they stated she declined to provide her last name, so these agencies knew her only by her first name. However the Police were aware of her last name, which seems not to have initially been passed on to Crisis Point, The Haven or the SARC, nor did any of those agencies rectify or question the matter with the police.

The victim was referred to Crisis Point and the Haven by the SARC although it is known that despite being contacted by these centres she did not have any further dealings with either. There was no follow up by the police regarding the referrals that were made to ensure that she had attended other than to inform Crisis Point and Haven that the referral had actually been made.

Crisis Point received the referral on 6th April 2011. A Crisis Point volunteer support worker contacted the police to seek more information about the referral and was told that the police had decided to close the file due to 'the victim not wishing to pursue the complaint.'

[25] West Midlands SARC Integrated Care pathway and standards for adults that have experienced rape and sexual assault version 3 January 2012

During that afternoon a duly trained Independent Sexual Violence Advisor (ISVA) contacted the victim but the ISVA did not speak Punjabi, so only limited contact was made. The following day a Punjabi speaking support worker contacted the victim by telephone to discuss a support package based on her needs. The Victim did not give any further personal information and stated that she didn't wish to pursue the complaint. She was left with an offer of further help should she feel the need.

It is Crisis Point's position that the service provided is client led and it is the client's choice to engage or not with the service.

There was no contact with the police or the SARC to indicate that the victim was not taking up the Crisis Point offer of help. She made mention of her property and belongings being at the home address and she wanted them removed. She was advised to contact the police to assist her. If contact had been made with the police about this issue by Crisis Point, information about domestic abuse may have been communicated to Crisis Point, who would then have offered and considered alternative support for her. However, with the victim not wishing to disclose any further information that may have been difficult to achieve Crisis Point was only aware of the allegation of sexual abuse. There was clearly a breakdown in communication of information between Crisis Point and those services that were aware of the history of domestic violence between the victim and H1, i.e. the Police and SARC.

The referral to The Haven was made by the police on 5th April 2011. The following day the referral was allocated to a worker who could speak Punjabi. On 12th April, 7 days after the referral the victim was contacted by telephone and it was soon apparent that she did not want refuge accommodation but stated she wanted a flat; she was living at that time with a friend now known to be the perpetrator. As a result of this request she was pointed towards the local authority and she received no further contact.

The Haven could have advocated to Wolverhampton Homes on her behalf when the victim expressed an interest in a flat rather than refuge accommodation rather than simply signposting her to the local authority. Similarly, both organisations could have referred the case to MARAC. No risk assessment was completed on the basis that she had now moved away from her abusive relationship and was staying with a friend. Therefore the risk was not assessed and no referral to MARAC was made.

As a result of this case The Haven will introduce a process whereby the implementation of a risk assessment will be offered and carried out at the first point of all new contacts.

Throughout the victim's dealing with these three agencies, SARC, Crisis Point and The Haven, there was a distinct lack of full information sharing. SARC did not have her last name, neither did Crisis Point or The Haven, which made the retrieval of records difficult once this Domestic Homicide Review commenced. Crisis Point was unaware of the issues around domestic violence within the family and there was an assumption that she would engage with the agencies once she had been referred to them, which, sadly, was not the case. There was no follow-up from the referring agency, be it the police or SARC. The police IMR points out:

> 'It is possible that had a Crisis Point Independent Sexual Violence Advisor been allowed to counsel the victim, she may have felt empowered to proceed with the complaint'

Since this case a new information sharing protocol has been introduced by Safer Sandwell Partnership that rectifies these problem areas and there is little need for a recommendation in this report regarding these issues.

Use of Interpreters

The victim was a woman who required the support of an interpreter. She found herself in situations of having to explain to the male GPs, male police officers and male FME intimate sensitive details of her being raped by her husband and this was done without an interpreter present. On occasions, no consideration was given to her needs in this regard and on other occasions the reliance of a friend to interpret was accepted by the GP.

It has already been mentioned above about the lack of interpreting at the SARC. The SARC has now allocated additional funds for interpreters for victims and the new Pathway document extends the role of a crisis worker to act as advocate, thereby ensuring that the victim understands what is happening and makes choices about the examination and the process in general.

For a victim who cannot speak English to go through processes involving different agencies without being properly supported to disclose her concerns and be informed of the processes that need to take place to assist agencies to deal with her disclosures was poor practice.

Recommendation No 4

Safer Sandwell Partnership and Safer Wolverhampton Partnership to seek assurance that there exists within all agencies identified in appendix No 1 a robust policy for providing interpreting service.

Risk assessments and MARAC

The victim's risk assessments were conducted in isolation of each other by differing agencies. On reporting the rape to the police she was subject to a CAADA-DASH risk assessment, (Co-ordinated Action Against Domestic Abuse – Domestic Abuse, Stalking and Honour Based Violence) and she was recorded as a 'High Risk' victim. This was formed on the basis of the circumstances of the allegation and the history of violence in the family setting. The Police IMR Author's opinion of this assessment is that it was completely justified in the circumstances. The IMR goes on to point out that albeit the risk was High, the ADI filed the matter because referrals had been made to Crisis Point and The Haven. It was not known at the time of filing the report if the victim would eventually go back to her husband and thereby be at further risk. The report was filed before a full investigation had been completed.

Guidance[26] on risk assessments explain the focus of a MARAC (Multi Agency Risk Assessment Conference) is to protect High Risk victims of domestic abuse and a meeting is convened to share the information known to enable an effective risk management plan to be developed. The guidance continues (page 44) 'Those cases assessed as high risk will be referred to a MARAC'. This is also enshrined in West Midlands Police force policy on Domestic Violence. The focus of the multi- agency meeting is the victim and to ensure that a plan is put into place to protect the victim.

There was no consideration to refer the victim's case to MARAC. The Crisis Point IMR states:' there was no evidence of a MARAC situation given on the referral or in discussion with [the officer]. … If the police were aware of domestic violence within social/familial environment of the victim and this was on the risk assessment, Crisis Point could have contacted other agencies who may have been on the risk assessment to provide a multi-agency care package'. Essentially this is the purpose of MARAC.

Interestingly guidance (page 44) states; 'Any agency can identify cases in their area that are the most serious domestic abuse cases and can refer them directly to MARAC. Given that she presented at her GP on numerous occasions with injuries and symptoms that were clearly domestic abuse related, the GP could have and should have referred her case to MARAC, either directly or through other agencies, even if she had decided not to seek and accept any other form of support.

[26] MAPPA Guidance 2009 Version 3.0 National Offender Management Service Public Protection Unit Ministry of Justice 2009 page 43

CAADA-DASH Risk Identification Checklist illustrates the referral criteria for MARAC, and states three criteria.

Firstly - Professional Judgement – if one has serious concerns about a victim's situation they should refer to MARAC. Examples give – extreme levels of fear, cultural barriers to disclose, immigration issues or language barriers particularly in cases of honour based violence.

Secondly – Visible high risk – the number of ticks on the check list

Thirdly – Potential for escalation – the number of reports of domestic abuse – this can be used where there is not a positive identification of a majority of risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation by sharing information

The overriding caveat is to pay particular attention to the professional's judgement.

The victim's case whilst she was with her husband was dealt with in isolation by each agency. There was a lack of appreciation of the significance of his antecedents. A free flow of information was desperately required. By a referral to MARAC, that information exchange would have been possible and a multi-agency care plan established. Would that have saved her life? Possibly, if she had received the correct support structure to move towards independent living rather than moving into a relationship with P2. She may also have been offered and taken up other sources of help or assistance which may have given her more options and choices, including whether to move away from the perpetrator earlier or move in with P2.

Research carried out by West Midlands Police since the inception of the Domestic Homicide Review process commenced, indicates that there is a need to ensure that decisions concerning the risk assessments of domestic abuse offenders take proper account of historic offending with other victims and that this is taking into account with the DASH assessment.

Whilst it is appreciated that the DASH assessment is not suitable to be used by all agencies (Mental Health for example) there needs to be a common understanding of the results measured by all risk assessment processes and the most efficient way of achieving this would be to have regular exchange of information to assess the combined risk an individual poses through the MARAC process.

Recommendation No. 5

Safer Sandwell Partnership and Safer Wolverhampton Partnership to ensure a clear referral pathway to MARAC for high risk victims is devised and disseminated to agencies contained in Appendix No 1.

The other area of risk measurement concerning the victim was the risk attached to the report to the police of her being missing by P2 and his friend on the day of the murder. Initially the report was appropriately graded as a medium risk, (the risk posed is likely to place the subject in danger or they are a threat to themselves or others) given all of the circumstances known at that time. As the time went by and information about the victim was gathered, there was a handover of Police Inspectors which resulted in the new Inspector being requested to carry out a check at the home address, (albeit the new Inspector cannot recall being asked to do these tasks). It should have been a routine task after a few hours of a person being reported missing to examine their home address. There was a review of the action by the officers but not until 5 hours after the initial report.

A medium risk Missing Person (MISPER) requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting. Guidance[27] goes on to state that; 'The case should not be left for long periods of time without active investigation taking place'

The Police IMR points out that the risk to the victim would have escalated to High as a result of the phone call made by the perpetrator to P2 whilst the perpetrator was outside the police station, when he said that she was dead. At the same time as P2 reporting that to the police the perpetrator surrendered himself.

Shortcomings with the police response to the victim being reported missing have been fairly identified within the police IMR and not only have recommendations been made within the IMR, changes to procedures have already been made to rectify those shortcomings. There is no need therefore to make any recommendations regarding those matters within this report.

Wolverhampton Domestic Violence Forum

Wolverhampton Domestic Violence Forum (WDVF) has existed in various forms since 1974 and its work with victims is well known throughout the City. It is a multi- agency team based in the City and its aims are to:

[27] The Guidance on the Management, Recording and Investigation of Missing Persons 2nd Edition 2010 ACPO and NPIA page 35

- Empower women who have been affected by domestic violence
- Meet the needs of children affected by domestic violence
- Provide services run by women which are based on listening to survivors
- Challenge the disadvantages which result from domestic violence
- Support and reflect diversity and promote equality of opportunity
- Promote cohesive inter-agency responses to domestic violence and develop partnerships

Contact with the forum is open to any agency and there is easy access to Independent Domestic Violence Advisers (IDVAs), children's social workers, housing officers and adult and child protection police officers. There is hardly a problem that can arise that the forum cannot either deal with directly or make a suitable referral. There is no evidence that any agency, especially the GPs' involved with the victim thought to make contact with WDVF or indeed suggest to her that she consider a self- referral.

Recommendation No 6

Safer Sandwell Partnership seek assurance from Safer Wolverhampton Partnership that all relevant agencies are aware of the referral to Wolverhampton Domestic Violence Forum process and that each agency has knowledge of the Forum's guidance.

The victim's relationship with the perpetrator

During the Police Investigation into the death of the victim, it came to light that the perpetrator had known her for some time, and there is some uncorroborated suggestion that he had visited India with her and H1 in the past. As the relationship with H1 deteriorated plans were made for the victim to leave her husband and move in with the perpetrator, which she did.

After a few months the new relationship failed and the victim made further arrangements to leave the perpetrator and move into Birmingham. It was stated by P1 in interview with the Police that this was the catalyst for him to take her life.

The perpetrator was a complete stranger to all agencies. The UKBA knew nothing of him. It is suspected that he is an illegal entrant. He had not come to light of any of the services before this incident. The Police had had no previous dealings with him. As far as the perpetrator was concerned, he was 'under the radar'. It is of concern to the DHR Panel that there appears to be limited mechanisms to identify and track such individuals.

The panel are also concerned that the victim's acceptance into the UK was based on a financial threshold and without any consideration of a risk assessment of her safety in respect of potential domestic abuse given the history and antecedents of H1.

Recommendation No 7

Safer Sandwell Partnership formally write to the UK Government requesting a review of the criteria and threshold for allowing foreign nationals permission to enter the UK without consideration of a risk assessment of the applicant and sponsors, especially with regard to domestic violence and sexual abuse.

Recommendation No 8

Safer Sandwell Partnership should ensure that systems are in place to evidence the progress in relation to the recommendations made in this report.

SECTION FOUR: CONCLUSIONS

There were areas of the victim's life that could have been supported more positively by agencies. H1's drinking problem was referred to counselling agencies although he failed to take the offers of help up, and this was never pursued.

Given all of the facts it has to be appreciated that the history of the victim's relationships are based on reporting from men who possibly wanted to put themselves in a good light and may well have wished to have implied that they were having sexual or intimate relationships with her. The conversation with family members paints a different picture. The fact is that the truth may never be known about those relationships and the degree of coercion or intimidation, if any, she may have been exposed to. There were also limited options and the issues of culture and family reputation to consider, which are made clear in the comments from the family that she had to make the second marriage work, instead of offering constructive support to this vulnerable woman.

If agencies had acted appropriately towards the victim, and provided appropriate support and assistance that was available she may have left H1 after gaining confidence that assistance was available to her. This is also the case with regard to any move from the perpetrator.

The Panel are of the opinion that there is a need for some research to be done regarding an holistic view of the difficulties in reporting, managing and investigating Domestic Abuse referrals regarding the 'hard to reach' communities. The Panel do not make any

recommendations with respect to this issue as members are aware that the Police and Crime Commissioner for West Midlands has commissioned work to be undertaken concerning the recommendations of West Midland Domestic Homicide Reviews. This is also in conjunction with the recommendations made in DHR Case No 3 for Sandwell and the local Community Engagement Programme currently underway with respect to the 'hard to reach' groups in Sandwell.

Finally, the victim's situation can be summed up by referring to 'Asian Women, Domestic Violence and Mental Health'[28]:

> For Asian women the decision is especially hard. The stigma of being divorced or separated has very grave consequences, as the woman's respectability, status and honour is dependent on her marital status.
> Notions of honour (izzat) and shame (sharam) play an important role in containing and policing many Asian women. Marriage (determines) reputation, respectability and status. Women are considered the upholders of the honour of the family and it is their behaviour which becomes the mark of family honour.

For all of the reasons set out in this review, the victim did not get the support she warranted, which limited her choices and affected her decision making.

It is the view of the Panel that the victim's death was not predictable but may have been preventable.

Addendum following Home Office feedback to DHR Report July 2014

This overview report was submitted to the Home Office Quality Assurance Panel 25th March 2013. The Home Office replied on 8th July 2014 stating that the report was adequate but requested some minor amendments to be carried out. Those adjustments have been made to the report.

In addition, the Home Office Quality Assurance Panel requested that common themes and issues that were also present in two other similar reviews submitted from Sandwell recently be identified and an assurance given that those common issues will be acted upon through a joined up approach by Sandwell Community Safety Partnership.

The DHR panel who undertook this review affirms that the Action Plan addresses the issues raised in the report, and the recommendations have been fully implemented. Since the statutory responsibility to carry out domestic homicide reviews which came into force in April 2011 Sandwell has undertaken 4 domestic homicide reviews. The reviews have outlined a number of recommendations, common themes to the area and lessons learnt. A Domestic

[28]Asian Women, Domestic Violence and Mental health – A Tool Kit for health Professionals. EACH 2009

Homicide Review Standing Panel was established in December 2012 to oversee all of Sandwell's DHR cases and ensure that recommendations from DHRs are implemented and lessons learnt disseminated to partner agencies. The Standing Panel also ensure that a joined up approach is taken to identify common themes and lessons learnt. The DHR Standing Panel consists of statutory and voluntary organisations including: West Midlands Police, Probation Community Rehabilitation Company, the National Probation Service, Health, Sandwell Women's Aid, Sandwell Metropolitan Borough Council Domestic Abuse Team, Adults Social Care and Safeguarding Team, and Children's Social Care. The DHR Standing Panel reports to the Domestic Abuse Strategic Partnership and Safer Sandwell Partnership Board. Two Learning Events have also taken place to disseminate the lessons learnt from DHRs and Serious Case Reviews. The events have been well attended with 200 people from various organisations including voluntary and statutory partner agency frontline officers and managers. Sandwell has also contributed to research undertaken by the University of Middlesex: - Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands DHRs.

A number of other sub groups have also been established by the Domestic Abuse Strategic Partnership partly in response to lessons learnt following DHRs. A Domestic Violence Campaign Group has developed an awareness campaign and is working to raise awareness of domestic abuse issues and support services available. A Learning and Development sub group has been set up to undertake a Training Needs Analysis on Domestic Abuse and provide recommendations to the DASP on the development and implementation of a Learning and Development strategy/plan. A Quality and Audit sub group has also been established to ensure that partner organisations have effective protocols and procedures in place to ensure victims of domestic abuse and their families are being effectively safeguarded in Sandwell and work with domestic abuse perpetrators is effective.

Recommendations

Recommendation No 1 **Page 33**

Wolverhampton and Sandwell Drug and Alcohol Action Teams (DAATS) in commissioning alcohol support services, should ensure that there are clear links to the prevention and reduction in Domestic Violence by the providers.

Recommendation No 2 **Page 36**

Safer Sandwell Partnership to request that the Black Country Cluster disseminates the guidance 'Responding to Domestic Abuse from Royal College General Practitioners dated June 2012, and ensures that a nominated person from each GP practice has been identified to implement the guidance and provide a list of the nominated persons to

Safer Sandwell Partnership as evidence that this has been completed within the next 12 months from the date of this report

Recommendation No 3 **Page 38**

West Midlands Police to review the manner in which complaints of serious domestically related offences are investigated and ensure compliance with the NPIA Guidance on Investigating Domestic Abuse, especially with regard to cases where the complaint is withdrawn and where there is evidence to support to original allegation.

Recommendation No 4 **Page 41**

Safer Sandwell Partnership and Safer Wolverhampton Partnership to seek assurance that there exists within all agencies identified in appendix No 1 a robust policy for providing interpreting service.

Recommendation No. 5 **Page 43**

Safer Sandwell Partnership and Safer Wolverhampton Partnership to ensure a clear referral pathway to MARAC for high risk victims is devised and disseminated to agencies contained in Appendix No 1.

Recommendation No 6 **Page 45**

Safer Sandwell Partnership seek assurance from Safer Wolverhampton Partnership that all relevant agencies are aware of the referral to Wolverhampton Domestic Violence Forum process and that each agency has knowledge of the Forum's guidance.

Recommendation No 7 **Page 45**

Safer Sandwell Partnership formally write to the UK Government requesting a review of the criteria and threshold for allowing foreign nationals permission to enter the UK without consideration of a risk assessment of the applicant and sponsors, especially with regard to domestic violence and sexual abuse.

Recommendation No 8 **Page 45**

Safer Sandwell Partnership should ensure that systems are in place to evidence the progress in relation to the recommendations made in this report.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011*www.homeoffice.gov.uk/publications/crime/DHR-guidance*

Process for undertaking a Domestic Homicide Review Protocol – Sandwell Metropolitan Borough Council – Nov 2011MAS Guidance

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011

No Secrets Guidance Dept. Health 2000

Who Decides: Lord Chancellors Dept. 1997

Domestic and Sexual Violence and Abuse – Tackling the Health and Mental Health Effects Catherine Itzin, Ann Taket, & Sarah Barter-Godfrey 2010 Routledge

Alcohol and intimate partner violence: Key findings from the research*,* Home Office Findings No. 216, Home Office. *www.homeoffice.gov.uk/rds/pdfs04/r216.pdf*

Child Protection and Domestic Violence: Directions for Good Practice, Humphreys, C. and Stanley, N. (eds.) (2006) Jessica Kingsley Publishers

Domestic violence: A health care issue, BMA, London (1998)

Domestic Violence: A Resource Manual for Health Care Professionals. Henwood M, 2000,

Responding to Domestic Abuse[1]P35 DOH 2006

Domestic Violence, Sexual assault and stalking: Findings from the British Crime Survey 2011

Responding to domestic abuse: Guidance for General Practices... Royal College of General Practitioners, CAADA et al.June 2012

Counselling Survivors of Domestic Abuse - Christiane Sanderson 2011 Jessica Kingsley Publications

Integrated Care pathway and standards for adults that have experienced rape and sexual assault version 3 West Midlands SARC January 2012

MAPPA Guidance 2009 Version 3.0 National Offender Management Service Public Protection Unit Ministry of Justice 2009

The Guidance on the Management, Recording and Investigation of Missing Persons 2nd Edition ACPO and NPIA 2010

Asian Women, Domestic Violence and Mental health – A Tool Kit for health Professionals. EACH 2009

Appendix No 1

Agencies both statutory and voluntary to which recommendations No's 4 and 5 refer.

Sandwell MBC

Wolverhampton City Council

Black Country PCT cluster

Staffordshire & West Midlands Probation Service

West Midlands Police

Black Country Partnership Mental Health Trust

Sandwell Homes

Wolverhampton Homes

UK Border Agency

Royal Wolverhampton Hospitals Trust

Sandwell & West Birmingham Hospitals Trust

West Midlands Sexual Assault Referral Centre

Sandwell Women's Aid

Crisis Point

The Haven, Wolverhampton

Wolverhampton Domestic Violence Forum

Sandwell Organisations Against Domestic Abuse (or future replacement organisation, if appropriate)

Home Office

Safeguarding
& Vulnerable People Unit
2 Marsham Street
London
SW1P 4DF

T 020 7035 4848

F 020 7035 4745

www.homeoffice.gov.uk

Mr John Garrett
Sandwell Council Deputy Chief Executive
Sandwell Council House,
Oldbury
West Midlands
B69 3DE

8 July 2014

Dear Mr Garrett,

Thank you for submitting the Domestic Homicide Review (DHR) report from Sandwell (Chaired by M. Ross) to the Home Office Quality Assurance (QA) Panel.

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

There were some issues that the QA Panel were concerned about and felt would benefit from further consideration before you publish the final report:

- A review of the language and tone used in the report which the QA Panel felt may be construed as victim blaming in places;

- The QA Panel was not clear whether forced marriage had been considered by the DHR Panel. If it had, text to outline this consideration would be helpful;

- Additional text to confirm that any cultural issues that may have impinged on the victim seeking help have been properly explored; and,

- Review the text and consider using pseudonyms to ensure the report provides a clear narrative for the reader.

The QA Panel also noted that Sandwell submitted three reports in this period. The QA Panel felt this was an opportunity to ensure that a joined up approach had been taken with particular reference to lessons learnt and common themes to the area. The QA Panel accordingly asks that you review the Action Plan in this case ahead of publication.

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when the report is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel

Head of the Interpersonal Violence Team, Safeguarding & Vulnerable Peoples Unit