DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

London Borough of Havering Community Safety Partnership

Report into the death of DEBBIE

May 2023

Report produced by Simon Steel – Perse Perspective Consultancy Ltd

Report Completed on 28/10/24

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The following tribute has been prepared by Debbie's three children.

Debbie was hardworking, dedicated, and an accomplished business owner, deeply loved and cherished by all who knew her through her work.

Upon her very recent retirement, her life was one of hope, laughter, and endless enthusiasm. She found delight in life's simple pleasures - daily walks, coffee with friends, dining out, yoga, music, and dancing. A passionate cook, she loved sharing recipes and preparing meals for those she cared about. Her nurturing spirit was also evident in her love of gardening, especially her fondness for flowers.

Debbie embraced every opportunity for adventure, from theatre and concerts to sightseeing and traveling abroad, finding joy in every experience. Her kindness, compassion, and unwavering love for her family and friends left a lasting impact on everyone she met. She filled our lives with laughter and light, celebrating our achievements and offering unshakable support in difficult times. Though her absence leaves an immeasurable void, the love, and memories she shared with us will remain in our hearts forever.

Lisa, Sarah and Mark

FOREWORD

The London Borough of Havering Community Safety Partnership would like to express their condolences to all those affected by the sad loss of Debbie. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar events happening again in the future.

The independent Chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to embed a preventative approach to addressing domestic abuse.

Following this death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action to protect victims and to deal effectively with the perpetrators of domestic abuse and the Chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. INTRODUCTION

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Debbie who was a resident of London Borough of Havering prior to her death in May 2023.

1.2 The subsequent investigation led to the arrest and conviction of Manny for Murder in November 2023.

1.3 The review will consider the agency contact and involvement with Debbie and Manny from May 2018. At the initial panel meeting agency, members shared a summary of their engagement with Debbie. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that recommendations and learning would be based on existing policies, procedures, and training. As a result, this was considered a proportionate timeframe, however, agencies were informed should they note anything relevant outside of that timeframe they were to include that detail in their individual management review (IMR.) The Chair would constantly monitor this information and would amend the terms of reference (TOR) if required. In addition to agency involvement, the review will also examine the past to try and identify any relevant background or trail of abuse, prior to the death, whether support was accessed, within the community. By taking this holistic approach, the review attempts to identify solutions that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons

to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened following each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Debbie for their loss and thank them for their contributions and support for this process.

2. TIMESCALES

2.1 The police referred this matter to the London Borough of Havering Community Safety Partnership (CSP) on the 9th May 2023. The letter recommended that the case be considered for a Domestic Homicide Review. The Home Office were informed by the Partnership of their intention to carry out a Domestic Homicide Review into this matter on the 13th September 2023 and replied on the same day.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the Chair) for this review on the 8th December 2023. The completed report was passed to the Community Safety Partnership (CSP) on the 6th November 2024. It was submitted by the CSP to the Home Office Quality Assurance Panel on the 10th December 2024.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

- To support engagement with the family. The Chair and panel were conscious of barriers that Debbie may have faced and consequently took every possible measure to ensure thorough considerations in their interactions with the family, including the involvement of Sikh Women's Aid in this review.

- The panel, mindful of the anniversary of Debbie's passing in May 2024, chose to postpone the IMR panel to June 2024. This decision was made to avoid coinciding with the anniversary and to provide the family an opportunity to meet with the panel without it being near the time of their mother's anniversary.

3. CONFIDENTIALITY

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed, between member agencies during the first panel meeting and all information was treated as

confidential. Nothing was disclosed to third parties without the agreement of the responsible agency's representative.

3.3 Each agency representative was personally responsible for the safekeeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel used a secure email system exclusively, ensuring that all information is transmitted in this manner only and is protected by a password.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonym Debbie was chosen by the family. The wider family members names were agreed by the family. The pseudonym for the perpetrator was chosen by the Chair following advice.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Debbie	Deceased	77	Indian
Manny	Perpetrator	79	Indian
Sarah	Daughter of Debbie	Adult over 18	British-Indian
Lisa	Daughter of Debbie	Adult over 18	British-Indian
Mark	Son of Debbie	Adult over 18	British-Indian

3.6 As per the statutory guidance, the Chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the Chair circulated the Terms of Reference (TOR), to the agencies that had contact with Debbie and Manny. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Debbie's death and for actions to be taken in response to that learning with a view to preventing similar deaths and ensuring that individuals and families are supported in the future.

4.2 The review panel comprised of agencies from the London Borough of Havering Community Safety Partnership, as Debbie lived in their area at the time of her death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process.

4.3 Key Lines of Enquiry: During the review the Chair and panel have considered the 'generic issues' as set out in the generic guidance and those relevant to this case. Various discussions have led to the following case specific issues being agreed.

- Dynamics of gender within relationships
- Was age a factor?
- Was identity, faith and/or culture a barrier?

5. METHODOLOGY

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse. This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.

    I. A and B are each aged 16 or over and are personally connected to each other and.

    II. The behaviour is abusive

- Behaviour is abusive if it consists of any of the following -

    1. physical or sexual abuse.
    2. violent or threatening behaviour.
    3. controlling or coercive behaviour.
    4. economic abuse (see subsection (4)).
    5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate

partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial and emotional.

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

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

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

5.5 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This document was reviewed by the Chair, then Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Debbie, were requested.

5.6 Document Reviewed

In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

- Website for commissioned service for domestic abuse support.
- Home Office Documents referring to key findings from analysis of previous DHR's.
- Reducing the Risk report on London DHR's.
- Home Office library of DHR (4 in relation to Sikh women as a victim).
- Citizens Advice document regarding "What is Public Sector Equality Duty".
- Havering CSP website – Domestic Homicide Reviews.
- The Cochrane Report – Screening Women for Inter-Partner Violence in Healthcare Settings.
- The Royal College of Nursing – Roles and Responsibilities of Health Care Staff.

5.7 Panel Meetings

Review Panel meetings took place on the 15th January 2024, 4th March 2024, 13th June 2024 and the 12th September 2024. The Chair held several individual agency discussions with panel representatives and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

5.8 Interviews Undertaken

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

The Chair wishes to record their appreciation for the time and assistance given by those who have contributed to this review.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community

6.1 Following the decision to conduct this DHR, the partnership conducted extensive enquiries with supporting agencies to seek to determine if any were supporting the family. Victim Support (VS) were supporting Sarah and, through this organisation, the Chair and the CSP reached out to Sarah via letter on the 13th December 2023. Subsequently, the Chair met Sarah in person, along with Victim Support on 28th December 2023. (Contact with the family is at Appendix 2.)

6.2 Subsequently, the Chair also met with Lisa, Sarah and representatives from Victim Support. During this meeting, both Sarah and Lisa explained to the Chair that they believed Debbie met Manny around the age of 20 while in India and later married. Shortly afterwards, they moved to England, initially settling in the Yorkshire area, then the West Midlands, and finally settling in London. They had 2 daughters, Lisa and Sarah, and a son, Mark.

6.3 Sarah and Lisa explained to the Chair that they grew up in a household of Sikh faith. They do not recall any celebrations of traditions; however, they would worship as a family once a week.

6.4 Sarah and Lisa informed the review that their mother was subjected to domestic abuse by Manny since their childhood. They recounted instances when, following assaults by Manny, Debbie and the children were taken to the West Midlands area on a number of occasions. During these times, Debbie and the children were left with Debbie's family members, which they perceived as an attempt by Manny to humiliate their mother in front of her own family.

6.5 Sarah and Lisa explained their mother had worked hard all her life and only retired a few years before her death.

6..6 The Chair wrote to and met with probation in relation to Manny. Probation discussed with Manny that he could voluntarily meet with the Chair if he wished. He accepted this invitation and the Chair subsequently travelled and met with Manny in prison. At Manny's request his probation officer was also present.

6.7 The Chair asked Manny whether there was any intervention that could have taken place that could have prevented the events that transpired. Manny was not able to sight anything. The Chair also confirmed with Manny that interactions between Debbie, Manny, and relevant agencies were limited.

6.8 Manny said that he felt the local authority (LA) in Havering needed to do more for Sikh people. He stated that he was aware of a local support group, Havering Asian Social & Welfare Association (HASWA) but felt it was often the LA's response to signpost people to HASWA who were not suitably equipped or funded to assist people. He felt the local authority could do more for the local community.

6.9 He expressed a wish this report would not be published as he felt he was a prominent figure in the local community. The Chair informed him that while it was not within his jurisdiction to

make that decision, he would relay the request to the panel.. However, the Chair informed Manny that, from his experience, he did not feel that there was any reason for this report not to be published. The panel subsequently agreed with the Chair with the recommendation to publish this review.

7. Contributors to the Review

7.1 Contributions from the agencies that were involved with any of the parties are shown below:

Agency	Contribution
Barking Havering Redbridge University NHS Trust (BHRUT)	Chronology and IMR
North East London NHS Foundation Trust (NELFT)	Chronology and Report
London Ambulance Service (LAS)	Chronology and IMR
GP service	Chronology and IMR

7.2 Quality and Independence of the IMR authors. IMRs were completed by authors who were independent of any prior involvement with Debbie and Manny. The only exception being the GP author, where it is acknowledged that they are a partner in the practice, however, were independent in relation to Debbie and Manny. The Chair acknowledges the national GP IMR challenges and notes the lack of a consistent approach in this area of work. It is important to note, however, the support given by the named GP from the ICB services to this process and the panel are very grateful. The IMR's allowed the panel to analyse the contact with Debbie & Manny. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received prior to, or at, subsequent panel meetings.

8 Review Panel Members

Name	Role/Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Paul Archer	Designated Nurse for Safeguarding Children	Childrens Safeguarding ICB
Jo Kavanagh	Dementia lead and Adults Safeguarding	BHRUT
Lurleen Trumpet	Interim Director for Ageing Well	LBH Safeguarding team
Joy Maguire	Havering Designated Nurse for Safeguarding Adults and Local Area Contact	Adults Safeguarding ICB
Fiona Robinson	Detective Inspector	MPS East Area, Public Protection and Community Safety
Sahdaish Pall	CEO	Sikh Women's Aid

Shaminder Ubhi	Director	Ashiana Network
Thilini Perera	Safeguarding Partnership Coordinator	Safeguarding partnerships coordinator for safeguarding adult board and safeguarding children partnership.
Vicki Thomas	CEO	Havering Women's Aid
Diane Egan	Community Safety and Intelligence Manager	London Borough of Havering Council
Kerry Wright	Senior Community Safety Officer	London Borough of Havering Council
Irvine Muronzi	Integrated Care Director Havering (Interim)	Integrated Care director for Havering Services, NEFLT
Byrony Harding	Safeguarding advisor	Adults team, NEFLT
Matthew Lazard	Head of Safeguarding Adults - Lead for Domestic Abuse	Safeguarding Lead, Adults team, NEFLT
Justin Armstrong	Review officer - Specialist Crime Review Group	Metropolitan Police (MPS)
Henry Akhigbe	Detective Inspector CAIT, Team 1 & 3, East Area Public Protection	MPS
Simon Hutchinson	Superintendent Neighbourhood Policing	MPS

9 Author of the Overview Report

9.1 Simon Steel was appointed by the London Borough of Havering Community Safety Partnership as Independent Chair and Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police Detective. He has considerable experience in the field of Domestic Abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews.

9.3 Simon also has worked as the Head of Adult Support for an Autism Charity within the voluntary sector who are commissioned by Local Authorities and Integrated Care Boards (ICB). Simon also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.5 Simon has no connection with the London Borough of Havering Community Safety Partnership, or any agencies involved in this case.

10 Parallel Reviews

10.1 Criminal Trial: Manny plead guilty to the Murder of Debbie and was sentenced to life imprisonment in November 2023.

11 Equality and Diversity

11.1 The review panel considered all nine protected characteristics under the Equality Act 2018, namely:

- Age
- Disability
- Gender Assignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

11.2 The panel carefully reflected upon each characteristic while evaluating the various services provided to Debbie. It is incumbent on this review to consider the duty on public authorities to[2]; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities.

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Debbie.

11.4 The protected characteristics that the panel agreed was pertinent to this review was to examine the circumstances through the lenses of sex, age, race and religion.

11.5 Sex & Gender: The panel acknowledges that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse, whilst also recognising that other genders also suffer similar issues of violence and abuse. Analysis[3] indicates gender-specific patterns of victimisation in both intimate partner and familial homicides, with females constituting the majority of victims and males comprising the majority of perpetrators.

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[2] https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

[3] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

11.6 Debbie was female, and Manny is male. The gendered nature of domestic abuse is reflected in a number of reports and also by specialist organisations. An analysis[4] of DHRs reveals gender-specific victimisation in both intimate partner and familial homicides, with females constituting the majority of victims and males comprising the majority of perpetrators. Women's aid reports[5], "There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)."

11.7 Race: In relation to prevalence of domestic abuse, Safelives[6], in responding to the Race Report, concluded, "there is clear evidence that Black and Asian women are disproportionately at risk of being killed by a domestic abuser. This is supported in recent research 'Identifying predictors of harm[7] within Black, Asian, and other racially minoritised communities' that '*The proportions of Black, Asian and racially minoritised communities within the population is a statistically significant predictor of the domestic count and rate at the LSOA level along with other structural and community cohesion variables, suggesting that ethnicity matters.*'.

11.8 Women's Aid note[8], "Whatever their experiences, women from Black, Asian or minority ethnic communities are likely to face additional barriers to receiving the help that they need." The same internet article directed at survivors suggests, "It may be particularly hard for you to admit to having problems with your marriage, and you may experience additional pressure from your extended family to stay with your partner. You may even have been forced or persuaded into marrying him in the first place. If your marriage fails, it may be seen as your fault, and you may be blamed for damaging the family honour; and you may be afraid that, if you leave your husband, you will be treated as an outcast within your community." Two organisations that have websites with much learning and information are Imkaan[9], and Southall Black Sisters[10] and the author encourages anyone who works in this field to consider further research.

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[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[5] Domestic abuse is a gendered crime - Womens Aid

[6] SafeLives' detailed response to the Race Report | Safelives

[7] FINAL Predictors of Harm UOS report.pdf

[8] Women from BME communities - Womens Aid

[9] Imkaan

[10] https://southallblacksisters.org.uk/

11.9 Religion: There are areas of work that consider the implications of faith on survivors, such as the Faith & Communities Programme by Standing Together in London[11], that summarises some of the challenges confronting victims, "Many survivors with a faith feel that some specialist services and society, in general, are unable to understand their experiences of abuse, and their barriers to accessing support due to their religious identity, their faith community and any spiritual abuse that they may experience at the hands of their perpetrator".

11.10 This is supported by various studies, including[12] 'A Qualitative Systematic Review of Published Work on Disclosure and Help seeking for Domestic Violence and Abuse among Women' from Ethnic Minority Populations in the UK, that drew a number of relevant conclusions including: "community influences are significant barriers to disclosure; - the cultural community influenced the disclosure and help-seeking practices of women with lived experience of domestic violence and abuse. The implication of this, is that many women will seek help from within their immediate community, either through faith-based organisations or social groups".

11.11 The pioneering community-led British Sikh Report or BSR [13] (British Sikh Report 2017) surveyed 2000 Sikhs and found that 72% of Sikh-identifying males and females considered that violence and sexism affected British Sikh women's lives. 70% of the women who responded reported themselves as survivors of DA yet only 34% had told anyone before.

11.12 Sikh Women's aid report[14]in 'From Her Kings are Born' report that there is rampant hidden violence against women and girls in the Sikh/Panjabi community. They are demanding culturally appropriate support organisations for women.

11.13 Age: Safelives[15] report on average, older victims experience abuse for twice as long before seeking help as those aged under 61 and nearly half have a disability. Yet older clients are hugely underrepresented among domestic abuse services.

11.14 Within the report Safe Later Lives[16] it is identified that many of the problems facing older victims are common to all of those experiencing domestic abuse. However, older victims' experiences are often exacerbated by social, cultural and physical factors that require a tailored response. The Insights dataset shows that clients over 60 are less likely to have attempted to leave than those under (17% vs 29%).

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[11] Faith & Communities Programme — Standing Together

[12] A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK (whiterose.ac.uk)

[13] British-Sikh-Report-2017-Online.pdf (britishsikhreport.org)

[14] https://www.sikhwomensaid.org.uk/files/Sikh_Womens_Aid_From_Her_Kings_Are_Born.pdf

[15] Spotlight #1: Older people and domestic abuse | Safelives

[16] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)

11.15 The panel recognised the intersectional factors that Debbie would have experienced and as a result the panel representation included Ashiana Network[17] and Sikh Women's Aid. It is against the background of concerns raised in such reports and research, and with the contribution of family, Ashiana and Sikh Women's Aid[18], that the review will consider the circumstances of Debbie's death.

12. DISSEMINATION

12.1 Once finalised by the review panel the Executive Summary and Overview Report will be presented to the following CSP panel members for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

12.2 The recommendations will be owned by London Borough of Havering Community Safety Partnership, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of these reports.

Agency
London Borough of Havering CSP
London Borough of Havering Safeguarding Adults board
Violence Against Women & Girls Strategic Partnership
All Panel Members
Home Office
The Domestic Abuse Commissioner

12.4 The report will be published online, on the London Borough of Havering CSP website.

13. BACKGROUND INFORMATION (THE FACTS)

13.1 At the time of her death Debbie was a 77-year-old woman living in the London Borough of Havering CSP area. She had lived at her home address for many years with her husband Manny. Their son also lived at the address.

The Death

[17] Home - Ashiana Network

[18] Sikh Women's Aid Domestic Abuse Charity (sikhwomensaid.org.uk)

13.2 One day in May 2023 Manny walked into a local police station where he stated he had just killed his wife. Officers attended the home address where Debbie was sadly discovered deceased.

13.3 Debbie had significant injuries, and a rounders bat was found at the scene. The postmortem examination found the cause of death to be blunt force head injuries.

14 COMBINED NARRATIVE CHRONOLOGY

The following section summarises contact between Debbie, Manny and agencies in the TOR timeframe leading up to Debbie's death. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the source of information and assist the reader.

Organisation	Role	Pre-Face
GP service	Primary Care	GP
Barking Havering Redbridge University NHS Trust (BHRUT)	Hospital	BHRUT
North East London NHS Foundation Trust (NELFT)	Hospital	NELFT
London Ambulance Service NHS Trust (LAS)	Ambulance Service	LAS

14.1 JANUARY 2019

14.1.1 **GP.** On the 25th Debbie had an essential hypertension review.

14.2 JULY 2019

14.2.1 **GP.** On the 25th Debbie presented with 4 weeks of pain in both hips, aggravated by walking. She had now retired for the last 2 weeks and is eased by rest. She had previously worked on her feet as owner of cash and carry.

14.3 SEPTEMBER 2019

14.3.1 **GP.** On the 2nd Debbie presented with shoulder pain. She was referred for an MRI. On the 23rd communication text message sent to Debbie states "*re MRI scan shows a progression in your right shoulder changes from previously. At this stage you need to see a specialist team and I have referred you to the musculoskeletal service.*" On the 27th further text message "*Just to let you know, your GP has referred you to Orthopaedics, who will contact you directly with an appointment.*"

14.4 OCTOBER 2019

14.4.1 **GP.** On the 16th Debbie had a shoulder pain review in surgery. Discussion regarding a private referral. On the 19th a text message is sent to Debbie *"Your referral letter is ready for collection thanks"*

14.4.2 **GP.** On the 23rd Debbie had a telephone consultation. It was explained, she needs to collect the letter and see a consultant in a private hospital. On the 24th a further text message was sent to Debbie; "*I have done referral to Orthopaedic on NHS referral form. You will get appt through post."*

14.5 DECEMBER 2019

14.5.1 **GP.** On the 5th Debbie was seen re varicose veins.

14.5.2 **NELFT.** On the 17th Debbie did not attend her first assessment for muscular skeletal (MSK) Physiotherapist. Rearranged for 24/02/2020.

14.5.3 **GP.** On the 18th Debbie was seen in orthopaedic clinic from a private Hospital.

14.6 JANUARY 2020

14.6.1 **GP.** There is a review of Debbie's shoulder pain (suspected muscular issue) and noted she has a private physio. Reference also made to blood tests in February 2020.

14.7 FEBRUARY 2020

14.7.1 **NELFT.** On the 19th Debbie telephoned to cancel her 24/02/2020 appointment for MSK and advised that does not require the service.

14.8 MAY – JULY 2020

14.8.1 **GP.** 2 messages were sent to Debbie regarding routine health matters this month.

14.9 AUGUST 2020

14.9.1 **GP.** On the 14th Debbie was seen in an out of hours centre. She stated she feels dark shadow in eyes, first started 5 to 7 days ago, lasts 10 mins and it is then clear, no pain, no change in vision, eyes are fine. Advised to call 999 if persistent for over 20mins, advised to see optician and to see own GP for follow up.

14.9.2 **GP.** On the 17th Debbie had a telephone consultation reporting she had tightness of her head and disorientation in the park a few days previously. Follow up with GP regarding this matter on the 18th.

14.10 SEPTEMBER 2020 – DECEMBER 2020

14.10.1 **GP.** Debbie's interactions with the surgery were for routine matters such as seasonal inoculations.

14.11 MARCH 2021

14.11.1 **GP.** On the 16th Debbie had a telephone consultation as she had been seen by an optometrist and advised to obtain the report and then she could be referred for cataract. Also advised to get BP check from the Practice Nurse (PN). Other contacts this month related to COVID 19 vaccine.

14.12 JULY 2021

14.12.1 **LAS.** On the 13th Debbie made contact with NHS 111 reporting palpitations and jaw pain when chewing. History of having a cardiogram that morning. The outcome was that Debbie was to go to an Urgent Treatment Centre for further assessment.

14.12.2 **BHRUT.** On the 14th Debbie attended Emergency Department (ED) following a blackout lasting a few seconds which was associated with palpitations.

14.13 FEBRUARY 2023

14.13.1 **BHRUT.** On the 4th Debbie attended ED following history of foreign body in throat after eating a vegan sausage roll. On examination no foreign body seen. A further follow up appointment was offered and attended on the 21st.

14.14 MAY 2023

14.14.1 In this month Debbie was murdered by Manny.

15. OVERVIEWS

This section summarises what information was known to each agency, and the professionals involved, within the review period. Any other relevant facts or information is also included in this section.

15.1 BARKING HAVERING REDBRIDGE UNIVERSITY NHS TRUST (BHRUT)

15.1.1 The involvement between BHRUT and Debbie has been related to 3 attendances only. This was in regard to an ED attendance and 2 rapid access (HOT) clinic attendances. The function of the HOT clinic is to assess and address patient's needs rapidly.

15.2 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

15.2.1 Debbie had one interaction with NELFT in relation to a muscular skeletal appointment which subsequently was not attended.

15.3 LONDON AMBULANCE SERVICE (LAS)

15.3.1 Debbie had one interaction with LAS in relation to one NHS 111 call.

15.4 GENERAL PRACTICE (GP)

15.4.1 Debbie and Manny had been both registered at the same practice for many years. As with GP IMR, finding an uninvolved author is challenging. A practice partner, impartial regarding Debbie and Manny but not the practice, completed the report. The ICB Adult Safeguarding Lead also supported it.

16. Analysis

Hindsight Bias

16.1 As the report author, the Chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome biases' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

16.2 The analysis of the combined chronology, IMR's and discussions with panel members and IMR authors revealed themes that are further explored within the individual agency analysis that follows.

16.3 Pattern of Abuse

16.3.1 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine that based only on what agencies knew, there was not a history of reported Domestic Abuse, This conclusion is based on all the information provided by agencies, however, the review panel recognises the information made known to the murder enquiry and subsequent information provided to the review by Sarah and Lisa which outlined the domestic abuse that Debbie sustained from Manny throughout her adult life. The significance of this unreported domestic abuse is of course exactly why the panel have sought to understand what barriers there were for Debbie and ultimately anyone else who finds themselves in a similar situation.

16.4 Barking Havering Redbridge University NHS Trust (BHRUT)

16.4.1 On 14th July 2021, Debbie self-presented to Queen's hospital emergency department having palpitations. She was unaccompanied at presentation. Debbie reported that she had suffered 3 episodes of palpitations the day before and experienced a 'blackout'. Investigations were carried out and results were noted to be within a normal range. It was noted that a diagnosis of arrhythmia was given. Debbie was subsequently discharged home. During Debbie's attendance, there is evidence that the Dr explored some family dynamics. Debbie advised she lived with her husband and son. At no point during any of these attendances did Debbie disclose any domestic abuse and there is no evidence this was discussed within any documentation.

16.4.2 The second interaction with BHRUT was on 4th February 2023 when Debbie self-presented to Queen's hospital emergency department (ED) with a relative (the panel have been unable to determine who this relative was) with a complaint of a foreign body in throat after eating. On examination, no foreign body was seen. A further follow up appointment was offered and attended on 21st February 2023 at the Ear, Nose and Throat (ENT) HOT clinic, which confirmed no abnormalities were identified. This was the final interaction between Debbie and BHRUT. There is no evidence of any safeguarding concerns at any of the interactions with BHRUT.

16.4.3 In 2021 BHRUT completed a systems transition, and a new Safeguarding tool was implemented. The Safeguarding tool is a 'Trigger Checklist' consisting of tick box entries which the triage nurse completes during the triage process. The safeguarding questions that are considered within ED when an adult attends are:

HISTORY: Have any safeguarding concerns been shared on initial presentation by the person, their family/carers or referring personnel (London Ambulance Service, Police)

FREQUENT ATTENDER: Is this person a frequent attender? Consider whether their frequent presentation is appropriate to their physical or mental health needs?

EXISTING VULNERABILITY/SUBSTANCE MISUSE: Is there any vulnerability e.g. Learning Disability, Physical Disability, Sensory Impairment, Dementia, Drug/Alcohol misuse that means the person is unable to protect themselves from harm or abuse?

Is there a recent history of mental illness, self-harm, overdose or health needs in either the person or their carer?

Consider the risk(s) if the person is homeless or rough sleeping?

EXPLOITATION AND TRAFFICKING: Do you suspect that the person could be trafficked, groomed, or exploited for sexual or criminal reasons? Consider the relationship of the person accompanying the adult.

SELF-NEGLECT: Evidence of poor hygiene, unkempt in appearance, untreated injuries, pressure damage, malnutrition, housing issues, withdrawn or avoiding eye contact and housing issues. Consider these as part of your assessment.

ASSAULT: Has the person been assaulted, sexually or raped?

DOMESTIC VIOLENCE/ABUSE: This question must be asked irrespective of gender.

Is there any disclosure or do you suspect domestic violence/abuse in the family, or have you observed signs of controlling/coercive behaviour? Consider risks to other family members including children.

DOMESTIC VIOLENCE/ABUSE INFORMATION: Have you discussed support available and given out information on how to stay safe and confidential contact details?

FAMILY: Is there anyone in the same household/home who may be at risk (consider children at home – if at risk you may need to complete a Children Social Care Referral)

16.4.4 Since April 2014 Domestic Abuse policies and pathways have been reviewed, updated, and were circulated to all Trust staff. The Domestic Abuse policy was last updated in January 2024. The Trust delivers regular Safeguarding training to the entire staff where there are varying levels of training for adults and children. Domestic Abuse is explored at a deeper level through both Safeguarding Children and Safeguarding Adults Level 3, every three years, as per the Intercollegiate Document (2019). In addition, Clinical Group ad-hoc briefing sessions and supervision sessions are also provided. During these multidisciplinary sessions, healthcare professionals are encouraged to apply the Think Family approach, to think of the unthinkable, and consider that while DA may very well be experienced by the adult, it also puts children at serious risk too.

16.4.5 The panel were encouraged to see that BHRUT have a Harmful Practices Safeguarding Advisor who has been in post since January 2020. Upon her appointment Trust posters were designed and disseminated around both sites (Queen's and King George's). These posters were updated in December 2023 and signpost victims of DA and Sexual Assault to national helpline numbers for women and men. These posters are displayed in patient and staff toilets to encourage disclosures from both patients and staff. In the last 2 years DA awareness days have been reinstated within the hospital canteens. Initially they were only available for staff due to COVID-19 restrictions, however the canteens are now open to the public. The local IDVA's and the Havering Community Safety Officer have helped support these events. The panel recognised this as an area of good practice and multi-agency working.

16.4.6 Learning from safeguarding cases is shared via the Trust quarterly dashboards, case studies and monthly Bulletins, and DA has featured 6 times within the Bulletins between 2020 and 2024. These cases are also often taken to Patient Summits. Case studies are introduced and discussed at the quarterly Safeguarding Operational meeting which is open to internal and external stakeholders and agencies, including NELFT and the ICB. These case studies are then turned into Bulletins which are shared widely with the entire organisation. Bulletins are issued monthly, on occasion more frequently with Special Editions.

16.4.7 The panel noted that, as an organisation and a key employer of a very diverse community, BHRUT acknowledge that within the UK context, although DA occurs in all cultures and races, some culture may be impacted more than others, including ethnic minorities. In March 2022 BHRUT launched the 'Better Together' campaign. It emphasised that they believe hospitals are better places to work and receive care when all feel included, respected, and welcome.

16.4.8 In February 2023 "See ME First" was launched a staff-led initiative to promote Equality, Diversity and Inclusivity and commitment to having zero tolerance for any form of discrimination. Staff who are subjected to such behaviour are supported to speak up. Staff members are given a badge to wear following making a pledge.

16.4.9 The six-colour badge aims to represents the differing levels of melanin in skin tones. The badge reflects the famous ideology at the heart of the Dr Martin Luther King's "I have a dream" speech: *"that people should not be judged by the colour of their skin but by the content of their character*" (August 1963). "See ME First" is not simply a badge. Any member of staff who wishes to wear the badge is encouraged to make a personalised pledge to uphold the values that the badge symbolises.

See ME First pledge

The Trust Board pledge is *"Our Trust will take action to become a fairer place to work and be cared for, celebrating the diversity of our people and actively challenging racism and other forms of discrimination."*

16.4.10 As an organisation BHRUT plan to continue to focus on DA and how staff and patients can be encouraged to share their concerns of DA. They plan to:

1. Continue to produce regular bulletins and case studies on safeguarding topical issues to include Domestic Abuse and information on how to seek confidential help.

2. Ensure staff are compliant with their Level 3 training as per Trust KPIs.

3. Actively promote the non-mandatory DA training for staff.

4. To continue Trust wide sharing of leaflets and posters on DA to raise awareness and ensure they are displayed in confidential areas (such as toilets (both genders), staff rooms etc.) to encourage safe disclosures.

5. To continue DA awareness days within the main hospital atriums/canteens for staff and patients to access.

16.4.11 The panel are content that Debbie's interactions with BHRUT were appropriate.

Learning Consideration: BHRUT provide an IDVA to be available across the Trust.

16.5 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

16.5.1 Debbie was referred to the Musculoskeletal Services and, in December 2019, she did not attend her first appointment. The trust followed up the missed appointment with a telephone call which was not answered, and they were not able to leave a message. As a result, a new appointment was arranged for the 24th February 2020 and a letter posted. A few days prior to that new appointment Debbie called the trust to advise she no longer required the service. It is unclear whether a notification was sent to Debbie's GP notifying that she no longer required the service. There wasn't any reason to suspect that there was any concern, and she was subsequently discharged. There is no record that Debbie had accessed psychological services provided by NELFT.

16.5.2 The panel understand that appointments of this nature will be cancelled on a regular basis for a whole host of reasons. We know that, in this case, Debbie had decided to seek private treatment, and the panel are content with the response from NELFT, however it would have been considered best practice to inform the GP of non-attendance.

16.6 LONDON AMBULANCE SERVICE (LAS)

16.6.1 The only interaction related to the LAS is on 13th July 2021 when Debbie called NHS 111to report palpitations and jaw pain when chewing. She was advised to visit an Urgent Treatment Centre for further assessment. We know Debbie did this the following day when she presented at BHRUT.

16.6.2 The panel are content with the interactions with LAS and have no recommendations in relation to LAS.

16.7 GENERAL PRACTICE (GP)

16.7.1 Both Debbie and Manny were patients at the same practice and had been for many years. The IMR author has reviewed the practice's interactions with Manny and been supported in this by the ICB Adult safeguarding lead. The panel have been reassured that there was nothing in this review in relation to Manny that would involve a DA question or further analysis.

16.7.2 The IMR stated that there was nothing in the medical notes of relevance to suggest an opportunity to prevent or anticipate the death. It stated there was no mention of discord, aggression, mental health problems and no observations of behavioural problems or unexplained injuries which would be associated with abuse. Both Lisa and Manny had a not-atypical number of ongoing medical problems. It also stated that notes/consultations and records indicated standard levels of positive engagement, attendance and no high rate of non-attendance.

16.7.3 The practice was not aware of any opportunity for improvement for themselves. However, they are in the process of exploring how they can engage in local IRIS training to help optimise the team's skills.

16.7.4 The panel expressed concerns around aspects of the practice's response to this review. However, the panel acknowledge that very often reviews of this nature are new to a GP practice and feel this review is an opportunity to evaluate their practices related to current training and responses to domestic abuse. The panel are encouraged that IRIS training is to commence and feel that this would enhance the wider understanding within the practice.

16.7.5 The panel have seen no evidence of any DA questioning of any sought. The panel discussed clinical and routine enquiries and recognise that some health environments undertake routine enquiry of domestic abuse in all female patients. Whilst it does ensure all female patients are asked about domestic abuse, it can make asking the question routinised and therefore inattentive, which can in turn discourage victims/survivors from disclosing.

16.7.6 Gene Feder, a GP in Bristol and Professor of Primary Care at University of Bristol who Chaired NICE guidelines on domestic abuse explains: "We, clinicians, have to ask [about domestic abuse] but it has to be in the context of really wanting to know and it has to be triggered by what the patient is presenting. Your asking is triggered by someone being for example anxious, depressed, chronic pain, maybe difficulty sleeping- a whole range of symptoms we know are associated with abuse." NICE guidelines state that there is insufficient evidence to recommend screening or routine enquiry in most healthcare settings. Therefore, GPs are recommended to practice clinical enquiry, which sets the threshold for asking low and uses the information from the interaction with the patient to make an assessment.

16.7.7 SafeLives guidance[19] for GP's recognises that some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should always be asked about abuse. In addition, in heterosexual relationships abusive perpetrators often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination.

16.7.8 The panel agree that clinical enquiries are its preferred methodology. It is very clear, given Debbie's presentations, that she would have fulfilled the clinical threshold and should have been asked about DA.

Learning Consideration: The GP practice is to embed IRIS training and ensure that clinical DA enquires are utilised at appropriate presentations.

KEY LINES OF ENQUIRY

16.8 Dynamics of gender in a relationship

16.8.1 The panel recognise the research in chapter 11 in relation to gender and acknowledge that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse. There is no direct evidence that gender alone influenced this review; however, the panel notes that gender was one of several intersecting factors evident in Debbie's case.

16.9 Dynamics of the Age of the victim Debbie

16.9.1 The panel recognise the research in chapter 11 in relation to Age, in particular that on average, older victims experience abuse for twice as long before seeking help as those aged under 61. Also, that older victims' experiences are often exacerbated by social, cultural and physical factors that require a tailored response. The Insights dataset shows that clients over 60 are less likely to have attempted to leave than those under (17% vs 29%). There is no direct evidence that age alone influenced this review; however, the panel notes that age was one of several intersecting factors evident in Debbie's case.

16.10 Was identity, faith and/or culture a barrier.

16.10.1 The panel recognise the research in chapter 11 in relation to faith and culture. The panel acknowledges the expert input from both Ashiana and Sikh Women's Aid. The panel acknowledges the input of Debbie's daughters in this review. They state after Debbie was subjected to DA she was taken to her own family in the West Midlands as a form of humiliation. The panel conclude that there is direct evidence that faith and culture were a barrier for Debbie

[19] Pathfinder GP practice briefing.pdf (safelives.org.uk)

which along with other intersectional factors placed her at a significant disadvantage in feeling able to disclose to agencies the abuse she was a victim of for the majority of her life.

16.10.2 The panel have been advised and recognise the normalisation of violence against women, as well as the significant influence of patriarchy in silencing women and fostering fear in reporting such incidents. Factors such as tolerance, collusion, issues of shame, and concepts of 'honour' contribute to this dynamic. Consequently, remaining in an abusive relationship or marriage may appear to be the only viable option for some individuals, driven by acceptance and the fear of not being believed. All these things likely prevented Debbie from seeking any help. One of the key principles of Sikhism is equality between men and women but the cultural practice can be very different. The intersectional lens is vital. The outcome may have been different if Debbie had accessed a 'by and for' specialist organisation where she would not be judged and feel safe to disclose the abuse. She would have been offered options and appropriate risk assessments would have been conducted. Had there been awareness raising/education programmes delivered by specialist services within the Sikh community, it might have offered another opportunity to disclose.

16.10.3 The Chair has considered whether Sikh women are proportionality represented in the local area in terms of request for services. The Chair suggested an audit to identify how many Sikh women are identified as service users. From discussions at panel, it is clear that such data collection at a local and national level is not a requirement and therefore is not available. The panel believe this is a gap and current criteria are too broad, resulting in agencies lacking a clear understanding of different ethnic groups and faiths.

16.10.4 The family raised a question in relation to "Was the cultural identity of any professionals involved a barrier to disclosure or support". Manny and Debbie were both registered at the same practice. From a 'Think Family' point of view, it is helpful to have all family members at the same practice which can help with knowledge around the whole family, especially when there are children. This is often referred to as `the old days' when one GP knew all the family. There are, of course, difficulties with all members being at the same practice (in this case Debbie and Manny), such as fear of being seen going to the practice and fear that information might be shared.

16.10.5 Regarding the cultural identity of professionals, one perspective is that it may be advantageous to communicate with someone from your own community. However, another consideration is that this might have the opposite effect. Specifically, there could be a perception that the practitioner's community ties are stronger than their adherence to professional codes of conduct, such as the medical code of practice. These are additional factors that Debbie would have needed to navigate.

Learning Consideration: Collection of specific data on ethnicity and faith to be captured for service users.

17. CONCLUSIONS

17.1 Debbie's death was a tragedy, and her children are affected deeply by the loss of their dear mother.

17.2 In approaching learning and recommendations, the Review Panel has sought to do two things. Firstly, to try and understand what happened and consider the issues in Debbie's life that might help explain the circumstances of her death. Secondly, to use this case to consider a wider range of issues locally, including provision for victims of domestic abuse.

17.3 The Review Panel would like to extend their sympathies to all those affected by Debbie's death.

LESSONS TO BE LEARNT

17.4 The review identified several learning points that build upon agency IMRs. However, if an agency has already introduced the learning into their practices because of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary.

17.5 The review highlights several important themes related to Debbie's death. These themes have been thoroughly examined, and the resulting learning points and recommendations aim to assist victims and survivors facing similar challenges. The Review Panel has focused on understanding what happened and identifying key issues in Debbie's life.

The themes identified are:

Lack of understanding of Sikh culture and impact on victims of DA.

Lack of bespoke services for Sikh victims of DA.

Lack of clinical DA questions by GP's.

18. RECOMMENDATIONS

BHRUT

Recommendation 1: BHRUT provide an IDVA to be available across the Trust.

ICB

Recommendation 2: The GP practice is to embed IRIS training and ensure that clinical DA enquires are utilised at appropriate presentations.

Recommendation 3: GP'S to seek support from the ICB when completing safeguarding referrals.

All

Recommendation 4: Collection of specific data on ethnicity and faith to be captured for service users.

Recommendation 5: All agencies to review their current provision of DA awareness training, to ensure that such training is delivered as a standalone program and incorporates cultural nuances.

CSP

Recommendation 6: VAWG strategic group to review community engagement programme assess what is being providing to marginalised communities and implement a women's group for community development.

Recommendation 7: The CSP to Lobby MOPAC and local councils for the provision of bespoke services for Sikh women regarding Domestic Abuse and support "by and for" groups.

National

National Recommendation 1: The Home Office to ensure collection of specific data on ethnicity and faith is a mandatory requirement to be captured for service users.

APPENDIX 1
Terms of Reference

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The Chair of the Havering Community Safety Partnership has commissioned this review, following notification of the death of Debbie.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel.

1.3 The resources required for completing this review will be secured by the independent Chair commissioned by the Havering Community Safety Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of Debbie.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.

- the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review.
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by ⋯ acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent Chair.

4 Scope of the review

4.1 To review events up to this domestic abuse related death of Debbie. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies from 5 years before the date of death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough

between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews (including those in Havering) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

5 Key Lines of Enquiry

5.1 The following themes have been prepared by the Chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

- Dynamics of gender within relationships
- Was identity, faith and/or culture a barrier?
- Was age a factor.

6 Role of the Independent Chair

- Convene and Chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).
- Convene and Chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

The above was confirmed at the first DHR Review Panel Meeting held on…

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at:)

8 Liaison with Media

8.1 Havering Community Safety Partnership will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 Confidentiality

All panel members are bound by the agreed confidentiality agreement.

APPENDIX 2
Family Contact

When	By whom	Who to	Method
8/12/23	Chair	VS	Email
13/12/23	Chair	VS	Tel call and letter for family
28/12/23	Chair	Sarah	In person meeting with VS.
5/1/24	Chair	Sarah	Email
11/1/24	Sarah	Chair	Pictures of Debbie for panel
15/1/24	Chair	Sarah /VS	Email panel update
8/2/24	Chair	Sarah/VS	Email
29/2/24	Chair	Sarah/Lisa/VS	Meeting in person
7/3/24	Chair	Sarah /VS	Re panel in person dates
19/4/24	Sarah	Chair	RE SWA contact
25/4/24	Chair	VS/Sarah	Email
31/05/24	SWA	Sarah	Email re contact

05/06/24	Chair	VS	Email re attendance at panel
17/6/24	Chair	VS	Email progression updates
25/7/24	Chair	VS	Email re meeting with perpetrator
30/7/24	Chair	Sarah Lisa Mark	Virtual call at family request re meeting with perpetrator
25/9/24	Chair	VS	Email including draft overview
17/10/24	Chair	Sarah Lisa	Virtual call re draft overview feedback
24/10/24	Chair	Sarah	Email re draft overview
6/12/24	Chair	Sarah Lisa	Virtual call to discuss submission to HO, any further questions and agree tribute will follow.

APPENDIX 3

Glossary of Terms

Advocacy After fatal Domestic Abuse	AAFDA
Barking Havering Redbridge University NHS Trust	BHRUT
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
Domestic Abuse Stalking & Harassment	DASH
North East London Foundation Trust	NELFT
General Practitioner	GP
Individual Management Reviews	IMR
Integrated Care Board	ICB

London Ambulance Service	LAS
Metropolitan Police	MPS
Multi-Agency Risk Assessment Conference	MARAC
Victim Support	VS