DOMESTIC HOMICIDE REVIEW

Executive Summary

Into the death of Adult A

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Independent Chair and Author
17th November 2015

Section One: Introduction

1.1 Background to the Domestic Homicide Review (DHR)

On the morning of the 20th October 2014, the police received a 999 telephone call from Adult C saying he had found his sister in her kitchen. The police arrived and found Adult A seriously injured. She was taken to Wexham Park Hospital where she was pronounced dead.

Adult B was arrested and charged with the murder of Adult A. Adult B pleaded guilty of murder on 18th March 2015 and sentenced to life imprisonment to serve a minimum of 14 years and 9 months.

1.2 Subjects of the Review

Adult A
Asian British female
Deceased was the wife of Adult B

Adult B
Asian British male
Perpetrator and husband of Adult A

Child A
Asian British female

Child B
Asian British female

Child C
Asian British male

Child D
Asian British female

Adult C
Asian British male
Brother of Adult A

Adult D
Pakistani
Cousin of Adult A

1.3 Terms of Reference

Scoping of the Review:

1. The Review will examine events and agency involvement, where relevant, with Adult A, Adult B and any dependent children from 1st January 2013 to

20th October 2014; however this may vary depending on information received during the DHR process.

Confidentiality and Anonymity:

2. All documents will remain confidential and distributed either through secure email and/or password protected. Individual names will be anonymised.

Methodology:

3. Each agency will secure all records and protect against loss or interference
4. To commission, review and analyse agency reports or summary of information
5. To seek involvement of the family members, employers, colleagues, friends and religious elders, where relevant, to ensure that a robust analysis takes place of the full circumstances surrounding the homicide.

The following areas will be addressed in the Overview Report:

6. Examine the events leading up to the incident, including a chronology of the events in question
7. Consider which agencies did not come into contact with the Adult A or Adult B but might have been expected to do so, and what could have been done to maximise the opportunity for engagement and/or disclosure
8. Consider which agencies were in contact with Adult A and Adult B where there was no reporting of a disclosure or signs of domestic violence/abuse and what could have been done to maximise the opportunity for disclosure or recognising domestic violence/abuse.
9. Consider how local awareness raising and literature encourages confidence in members of black and minority ethnic groups to come forward and seek support for domestic abuse and or honour based violence; either as a victim, family member, friend or a perpetrator
10. Form a view on practice and procedural issues that emerge in considering the circumstances of this case and any lessons from this engagement that can be applied to other situations where domestic violence/abuse is known of or suspected.
11. Seek the views of family, friends, colleagues, employers, religious elders and neighbours on how agencies could improve identifying and raising awareness of the risks associated with domestic violence/abuse, provide effective interventions and access to support.
12. Seek the views of family, friends and colleagues on how they could have been better supported when they had been made aware of the domestic abuse
13. Examine whether the employers of Adult A and Adult B were aware of or may have recognised any abuse in the relationship and what policies and procedures were in place to support them to effectively manage any risk
14. What impact, if any, did the 'honour' code have on any violence?
15. To determine if there were any missed opportunities for agency intervention in relation to Adult A, Adult B and dependent children
16. Any other matters that the review considers arise out of the matters above

Family Involvement:

17. To involve the family, friends, and work colleagues of Adult A and Adult B to give them the opportunity to participate in and inform the Review

Equality and Diversity:

18. The Review will give due regard and consideration to any equality and diversity issues that are relevant to Adult A and Adult B and dependent children, for example age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation[1]
19. To seek independent expert advice if the Review Panel is agreed that such a contribution to the DHR is necessary

1.4 Confidentiality

The Review was conducted in private. All documents and information used to inform the Review are confidential. The Overview Report and Executive Summary will be anonymised.

This report will consider whether access to services was prohibited because of Adult A's and Adult B's ethnic heritage. The Review Panel considered the ethnicity of the membership and was joined by a specialist support worker with the same cultural background as the family concerned in this DHR.

1.5 Methodology

The Home Office was informed of the intention to conduct a DHR on 26th November 2014. The Review Panel selected the Independent Chair. The Review Panel meetings were held on:

- 29th January 2015 – introduction to the case and developing ToR
- 12th May 2015 - review of reports, facts of case and interviewing family, colleagues and friends
- 13th August 2015 - discussion of the draft Overview Report

The scoping of statutory and voluntary agencies following the homicide found no prior engagement with either Adult A or Adult B that could assist in the DHR.

There was a nil return from local statutory and voluntary agencies. Reports were requested from the GP and the children's schools. Three schools had no information to relay. Child C's school did report a very brief disclosure which was delayed due to the summer holidays. All other information in this Report was obtained from Thames Valley Police and the Judge's summing up of the case before handing down the sentence for Adult B.

The Overview Report has been written by the Independent Chair in discussion with the Review Panel. The Chair is independent of Safer Slough Partnership, of the

[1] Equality Act 2010

local service providers, the commissioners and has had no prior contact with Adult A or Adult B or their family and friends.

1.6 Involvement of Family and Friends

The family were represented by Adult C and were informed of the DHR through their Family Liaison Officers (FLOs). Following the completion of the criminal justice process the family representative was contacted again. After careful consideration the family did not feel able to engage with the DHR at this time.

Friends and colleagues of Adult A and Adult B were also contacted but they did not wish to engage with the DHR.

Section Two: Domestic Homicide Review Panel Report

2.1 The Facts

Adult A and Adult B were first cousins and married in 1997. They moved to England and between 1999 and 2004 had four children. They appeared to have a happy marriage until 2013 when Adult A's contact with her younger male cousin, Adult D, increased. Adult B accused Adult A of having an affair, which she strongly denied. The relationship deteriorated over the next year. Adult B became controlling and violent.

On the morning of the 20th October 2014 Adult A and Adult B had an argument. Adult B took the children to school and returned home. Adult A had been to visit her sister-in-law and then came home. Another argument began which ended with Adult B cut her neck with a knife.

Adult B went to work. Later that day Adult C was contacted by a friend of Adult A's to say she thought the house had been broken into. Adult C entered the house and found Adult A on the floor in the kitchen. The police were called. Adult B was also contacted and he came home. He was later arrested and charged with the murder of Adult A.

On 18th March 2015 Adult B pleaded guilty to murder and sentenced on 5th May 2015. Adult B was given a life sentence with a tariff of 17 years however due to time on remand and credit for pleading guilty the Judge ordered he serve a minimum of 14 years and 9 months.

2.2 Chronology

1997 – Adult A and Adult B marry and move to England

1999-2004 – Adult A and Adult B had 4 children, 3 girls and a boy.

2013 – Adult A's contact with her male younger cousin who lived in Pakistan increased. Adult B became increasingly jealous of this relationship although Adult A denied any wrong doing.

2014

February – Adult A visits her family in Pakistan.

April – the whole family go on a holiday to Pakistan. Whilst in Pakistan Adult B argues with Adult A and he accuses her of having an affair, assaults her with a bottle and a shoe. He tells her she can have a divorce if she wants one. The children and other members of the family were present. Adult B also calls Adult C and says that Adult A can now be free, an implication that they would get divorced.

April – Adult B accuses Adult A of having an affair in front of her mother. According to a friend of Adult A's, she told her that there was a violent incident where Adult B banged her head against a wall.

April – on their return from Pakistan they do not share a bedroom but instead each adult shares a bedroom with a child.

April – Child C tells his teacher that his father had hit his mother with a shoe when they were on holiday.

May 9th – Adult A attends her GP surgery due to recurring headaches and associated visual symptoms. The GP ordered blood tests which came back normal.

May 19th – Adult A returns to her GP surgery with ongoing headaches and dizziness.

May 22nd - Adult A had a brief telephone consultation with her GP regarding the headaches.

June 16th – Adult A returns to the GP with the ongoing headaches and mentions in a general way that she is stressed.

July 18th – Adult A went to A&E and was diagnosed with tension headaches and advised to see her GP.

July 23rd – Adult B attends the GP surgery where he says that he is stressed about the diabetes control and changes to his life. The GP signposts him to Talking Therapies. There is no record of Adult B following this up.

August 6th – Adult A contacted her GP regarding the A&E attendance and was offered an appointment for the following day, which she refused.

October 20th – Adult B killed Adult A.

2.3 Analysis of Involvement

There is no evidence of either Adult A or Adult B accessing support through any agency either voluntary or statutory for problems within their marriage. They chose to talk to family and friends. The family, friends and colleagues felt unable to participate in the DHR.

2.3.1 General Practitioner

Adult A and Adult B were registered at the same surgery in their local area. Adult B had increasing medical conditions, including heart problems and diabetes, which made him feel depressed. He did not disclose any problems in his marriage and the GP had no cause to consider this.

Between May and August 2014 Adult A had four face to face consultations and two telephone consultations with her GP and a visit to A&E regarding the reoccurring headaches. There appeared to be no physical reason for them except tension. Adult A did report feeling stressed. The GP did not enquire further about the causes of the stress. There was nothing in Adult A's history that indicated domestic abuse therefore it would not have been in the forefront of the GP's mind. The GP report stated that both Adult A and Adult B were 'very well regarded' by the staff at the surgery and the events were 'totally unexpected'.

All GPs in the surgery have access to details of local Domestic Abuse Services on their shared drive and literature is available in the Reception area. The Review Panel recommend this as good practice.

2.3.2 Child C's School

The only disclosure of the situation at home was by Child C to classmates and his teacher during the lunch period following the holiday in April 2014. A conversation arose about holidays and Child C said that his father had hit his mum with a shoe. The teacher spoke to him further but concluded he was not at any risk and therefore did not escalate it to the Designated Child Protection Officer (DCPO). The School has a policy whereby any disclosure of domestic abuse should be taken to the DCPO who would then contact Social Care to discuss if a Multi-Agency Referral Form (MARF) needs to be completed and which agency is in the best position to talk to the parents. This has been reinforced to all staff by the Head Teacher.

Child A, B and D did not make any disclosure to anyone at their school and the teachers reported they did not see any change in their behaviour or in their school work prior to 20th October. They had no cause to be concerned.

2.3.3 Escalating Domestic Abuse/Violence

There is no evidence that there was abuse or violence in the marriage prior to 2013/14 when Adult A's contact with her cousin, who lived in Pakistan, increased. Both parents took responsibility for bringing up the children and led an unremarkable life. However from the information provided abuse and violence became a factor in their marriage when Adult B became increasingly jealous as he believed their relationship was more than platonic. Adult A insisted that the relationship with her cousin was more of a maternal one. The family did discuss contacting the police but decided not to at this time.

There was nothing to suggest that the murder was premeditated but happened on the spur of the moment. In a brief conversation with the Independent Chair Adult C

said that the family did not anticipate the murder the worst case scenario they expected was a divorce.

Section Three – Conclusions

3.1 Conclusions

3.1.1 The Review Panel have concluded that this homicide could not have been predicted. With the information available and the brief conversations with Adult C and a friend of Adult A, the worst outcome in their view would have been a divorce. There was no evidence of premeditation by Adult B on the 20th October and the Judge acknowledged that it happened on the spur of the moment but accepted that he meant to kill her.

3.1.2 There was a missed opportunity by Adult A's GP for agency inquiry which may have led to appropriate intervention. The Review Panel believed that he could have shown more curiosity by asking her what she was stressed about, especially as the headaches were reoccurring over a number of months. However it is speculative to say she would have disclosed the on-going problems at home had the GP asked further questions, but she may have.

3.1.3 The only disclosure of domestic abuse was by Child C to his school friends and teacher. Although it was a passing comment, the teacher did speak further to Child C and assessed there was no risk to him. There was nothing to suggest either parent would have spoken of the escalating abuse at home even if the teacher had escalated the concern. This was a missed opportunity for agency inquiry.

3.1.4 It is understood that Adult B became very jealous of the relationship between Adult A and her cousin, Adult D; despite Adult A saying it was more maternal than anything else, and no evidence it was anything other than platonic. Adult B had not been abusive or violent for the majority of his marriage to Adult A. They had discussed divorce and were sleeping in separate bedrooms following their return from Pakistan in April 2014. Research has shown that the risk of violence starts or increases during separation (Bergman et al 1998; Hester & Radford 1996; Kurz 1996; Hearn1998; Kantor & Jasinski 1998) and it is a high risk factor.[2]

3.1.5 The Review Panel was informed by the police that the family had discussed reporting the increase in abuse/violence within the marriage but made the decision not to at that point. There is no documented evidence or suggestion that Adult B killed Adult A to preserve the 'honour' code of the family, but there was a verbal suggestion the family did not report because of the shame it may bring on them. The Review Panel felt it appropriate to consider this as a general area of concern. Encouragement to come forward and access appropriate support is essential to prevent further violence.

3.1.6 Within the Slough borough there are two specialist support services for victims of domestic abuse and honour based violence. They provide a number of

[2] CAADA – DASH (Domestic Abuse, Stalking & Harassment and Honour Based Violence) Risk Identification Checklist (RIC); Q. 6

interventions for female and male victims; outreach; Independent Domestic Violence Advocates (IDVAs); support groups; access and resettlement workers; refuge provision and a Multi-Agency Risk Assessment Conference (MARAC). These are underpinned with risk assessment and management and safety planning. There is a community based programme for men who are abusive and are motivated to change their behaviour. Domestic abuse is a strategic priority for Safer Slough Partnership and the Slough DASP DA Strategy includes honour based violence.

Section Four: Recommendations

The following recommendations are agreed by the Review Panel. Details of the implementation are recorded in the action plan attached to the Overview Report.

1. The Slough Local Safeguarding Children's Board, Slough Safeguarding Adults Partnership Board and statutory bodies provide reassurance to the SSP that they have assessed the effectiveness of domestic abuse and/or safeguarding policies, training and have quality assurance processes in place

2. A domestic abuse campaign aimed at the public. In addition to general awareness and how to access local services for the victim, family, friends or perpetrator, it highlights the increase in risk when there is a separation

3. Slough DASP work with local domestic abuse services and BME communities to assess the effectiveness of engagement with local communities and agencies, in addition to current DA training, put in place further specialist training and awareness material on honour based violence to encourage reporting and support prevention of domestic violence and honour based violence. It is proposed these findings are incorporated into the Slough DA Strategic Plan