DOMESTIC HOMICIDE REVIEW

Newham

Case of Avani

Report Author: Althea Cribb

Date Completed: February 2016 **(amended September 2016)**

1. Executive Summary

1.1 Outline of the incident

1.1.1 On the date of the homicide in 2013 Avani was found at home having been stabbed. Her husband Riaz pleaded guilty to her murder and was sentenced to life imprisonment serving a minimum of 16 years.

1.2 Domestic Homicide Reviews

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.2.2 The purpose of these reviews is to:

(a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

1.2.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

1.3 Terms of Reference

1.3.1 The full terms of reference are included at **Appendix 1.** The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 The first meeting of the Review Panel was held on 2 June 2015. The Review Panel were asked to review events from 1 January 2005 up to the homicide.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. A review was started immediately after the homicide occurred, however it did not progress satisfactorily and the Chair was decommissioned by the Community Safety Partnership. Newham Community Safety Partnership agreed to start a new review. This Review did not commence until almost two years after the homicide. Once this review

commenced in June 2015 it was completed within eight months, in February 2016.

1.4 Independence

1.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Newham Community Safety Partnership or any of the agencies involved in this case.

1.5 Parallel Reviews

1.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

1.6 Methodology

1.6.1 As a previous review had been started, at the first Panel meeting it was discussed and agreed that this review process would start again, with requests for chronologies and Individual Management Reviews (or confirmation of no contact) sent to all relevant organisations.

1.6.2 Individual Management Reviews (IMRs) were therefore sought for all organisations and agencies that had contact with Avani and/or Riaz and/or the children. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved: specifically Aanchal and Nia for their domestic abuse expertise.

1.6.3 The children were included in the review to the extent that their contact with agencies could support learning around those agencies' responses to Avani and/or Riaz; therefore only minimal information is provided in this report about the children, to protect their confidentiality.

1.6.4 All IMRs included chronologies of each agency's contacts with the victim and/or perpetrator. IMRs were received from:

(a) Barts Health NHS Trust

(b) East London NHS Foundation Trust (ELFT) Health Visiting Service

(c) Guy's and St Thomas' NHS Foundation Trust

(d) Newham Clinical Commissioning Group, on behalf of the General Practitioners for the victim, perpetrator and children

(e) School for the older child

1.6.5 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Agnes Adentan, East London NHS Foundation Trust

(c) Allison Buchanan, London Borough of Newham Community Safety

(d) Anne Morgan, Newham Clinical Commissioning Group

(e) Chris Brown, Metropolitan Police Service, Critical Incident Advisory Team

(f) Debbie Saunders, Guy's & St Thomas' NHS Foundation Trust

(g) Jane Callaghan, Barts Health NHS Trust

(h) Karen Ingala-Smith, Nia (Independent Domestic and Sexual Violence Advocacy, IDSVA, service provider)

(i) Representative, School[1]

(j) Su Bhuhi, Aanchal (Newham One Stop Shop)

(k) Tony Pape, London Borough of Newham Adult Services

1.6.6 Aanchal, in addition to contributing to the Review as a substantive member, also acted as specialist experts in relation to domestic abuse victims from minority ethnic backgrounds.

1.6.7 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.7 Contact with the family

1.7.1 The independent Chair attempted to make contact with family members of Avani. Letters were sent to Avani's family, the children's child-minder, a friend of Avani's and the employers of Avani.

1.7.2 For Avani's family in India and the children's child-minder, contact was made by London Borough of Newham Children's Social Care, as they had previously been in contact with them following Avani's homicide and as a result were considered by the DHR Panel to be the most appropriate route. Letters were posted directly to Avani's friend and employer. No answers were received.

1.7.3 The independent Chair also contacted Riaz in the prison in which he is held. He was interviewed in November 2015.

[1] Details of the school have been kept anonymous to protect the confidentiality of the children

1.8 Summary of the case

1.8.1 Avani was aged 27 at the time of her death. She was originally from India, and had moved to the UK in approximately 2004. She was employed as a secretary and also worked in a café.

1.8.2 Riaz was aged 40 at the time of the homicide and worked as a chauffeur.

1.8.3 Avani and Riaz had been married[2] since approximately 2005, and had two children. Prior to, or at the time of, marrying Riaz, Avani converted from Sikhism to Islam.

1.8.4 The police investigation revealed that Avani had reported to work colleagues that she was unhappy in her marriage, and also that Riaz was controlling and critical of her clothing and had assaulted her in the past. None of this was reported to the police or any other agency.

1.8.5 Avani, Riaz and/or their children had contact with: General Practitioners (GPs); Guy's and St Thomas' NHS Foundation Trust (GSTT); Barts Health NHS Trust; East London NHS Foundation Trust (ELFT); and the older child's school. These are summarised below.

1.8.6 In addition to referrals for midwifery care in 2006 and 2011, Avani attended her GP on a number of occasions in 2006, 2009 and 2011 for contraception.

1.8.7 All of Avani's contact with GSTT and ELFT was in relation to her two pregnancies and children. She was referred for, and attended, antenatal and postnatal routine health appointments with GSTT in 2006 and 2011, and following on from each birth for health visiting service appointments with both GSTT (2006 to 2011) and ELFT (2011). None of these appointments raised any concerns at the time; the Individual Management Reviews, and Panel, noted the following:

(a) At different times during her contact with GSTT and ELFT, Avani gave addresses in Southwark and East London. Minimal exploration was done in relation to her appearing to move between the boroughs. This would have been particularly relevant on two occasions (September 2006 and March 2009) when Avani stated that she was "separated" or "living separately" from Riaz.

(b) Avani was not asked the routine domestic abuse enquiry question during her first contact with GSTT midwifery service in 2006; the procedure had been introduced the year before and was not thoroughly embedded.

[2] The Review was unable to establish whether this was a religious or legal marriage or both.

(c) Routine enquiry in relation to domestic abuse was carried out by GSTT with Avani in 2011, and she answered “no”.

(d) ELFT did not follow its procedures in relation to the ‘transfer-in’ of Avani’s younger child when they were transferred from GSTT to ELFT.

(e) Although routine enquiry is now mandatory for ELFT Health Visitors to carry out, it is not possible to identify if it was carried out with Avani.

(f) When the Health Visitor from ELFT attended the family home in August 2011 for a ‘new birth visit’, Avani and Riaz were recorded as being “evasive” about their living arrangements and Avani stated that she would be moving back to Southwark shortly. Further exploration in relation to this, or the fact that Avani apparently then stayed in East London with Riaz, was not done.

1.8.8 Barts Health had contact with the two children, none with Avani and limited contact with Riaz. The two children were each brought twice to the Emergency Department; no concerns were noted at the time. (The older child in August 2006, September 2009 and January 2013 with minor injuries; the younger child in April 2013 with a minor injury and July 2013 with sickness.)

1.8.9 The Barts Health IMR highlights that more in depth exploration should have taken place in one instance of the younger child being brought in by Avani. In addition, it notes that Avani and Riaz interpreted for the older child during one attendance, and that this practice should not be in place. Recommendations are made in the IMR to address this.

1.8.10 The older child’s school contributed to the review but no concerns had been noted in their contact with Avani.

1.9 Issues raised by the review

1.9.1 Avani’s homicide was not preventable in the immediate time before it occurred. No agency had any indication, or concerns, that could have led to actions that may have prevented the incident. Unfortunately the review did not hear from Avani’s family or employers, who may have been able to provide more information on Avani and Riaz’s relationship (a recommendation, 8, is added to ensure employers develop domestic abuse policies in order to support staff). When interviewed, Riaz denied that he had killed Avani, calling it an accident.

1.9.2 However, there were a number of opportunities for agencies to explore with Avani her relationship with Riaz, which could have led to support and potentially to safety for Avani. These were mainly following the birth of her first child, when she stated on one occasion that she and Riaz were separated (September 2006), and on another that they were living separately (March 2009). It should be noted that when asked directly about domestic abuse by GSTT midwifery services, Avani denied it was an issue for her and never made a disclosure.

1.9.3 *Opportunities for asking about domestic abuse/violence*

Avani's General Practitioner (GP) had opportunities to ask about her relationship and home life in response to her – at times frequent – requests for contraception, including emergency contraception. It is expected this situation will improve with the roll out of training for GPs, and a recommendation (2) is made for this to be scrutinised and evaluated. A recommendation is also added (3) to raise awareness of these types of opportunities for asking women about their relationships.

The GSTT and ELFT Health Visiting service also had opportunities to explore with Avani both her living arrangements and relationship with Riaz: specifically in response to her statement that they were separated (September 2006) and on occasions when they did not appear to be living together.

1.9.4 *Living arrangements*

Between January 2006 and January 2012 Avani frequently provided different – and at times contradictory – explanations for her living arrangements. There was a lack of scrutiny and enquiry about this; which could also have led to exploration with her about her relationship with Riaz.

Both GSTT and ELFT did not follow 'transfer' procedures in relation to records being transferred from GSTT to ELFT, and for ELFT in relation to appropriate appointments being made for the family. While this would not have had a bearing on this case, as there were no concerns to be shared, the Panel discussed the issue and felt that there is a need to address the procedures in relation to transfers, and a recommendation (4) is therefore made in this report. A recommendation is also made (5) regarding responses to transient families, in light of this learning.

1.9.5 *Ethnicity / Race / Religion*

The Panel discussed the potential impact on Avani of the fact that she had moved to the UK from India, and that she did not have family here; in particular that this may have increased her isolation, and been a barrier to her seeking help in relation to her relationship with Riaz. Avani's transience was perceived by agencies at times as 'normal' for someone of her background or culture, and it may be that this prevented further probing and questioning of her living situation. A recommendation is made (6) to address this.

The Panel were aware that Avani had converted to Islam at the time of, or prior to, marrying Riaz; this was felt to have potentially resulted in her being cut off from her family, increasing her isolation. A recommendation (7) is made to raise awareness around this learning with mosques.

1.10 Recommendations

1.10.1 Recommendation 1

The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress for IMR and Overview Report recommendations should be made to the Newham Community Safety Partnership within six months of the Review being approved by the Partnership.

1.10.2 Recommendation 2

The Clinical Commissioning Group to report to the Community Safety Partnership on the roll out of training to General Practices in the borough. Report to include number of GPs trained and an assessment of the impact on identification of domestic violence/abuse and referrals to specialist support services.

1.10.3 Recommendation 3

The Clinical Commissioning Group and London Borough of Newham to raise awareness with providers of patients seeking contraception as an appropriate opportunity to ask women about their relationships, with the aim of increasing opportunities for women to disclose domestic abuse. Awareness to be raised with General Practices (as part of Recommendation 2), Pharmacies, Sexual Health Clinics and other relevant providers.

1.10.4 Recommendation 4

East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to audit their current procedures to ensure existing transfer in/out policies and procedures are adequately followed, referencing the learning from this Review.

1.10.5 Recommendation 5

East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to share the learning from this review and reflect on responses to transient families and those moving between boroughs. Reflection through existing supervision, training, team meetings and case file reviews as appropriate.

1.10.6 Recommendation 6

The Community Safety Partnership to share with all partner agencies the learning from this review regarding the assumptions made by many professionals in relation to Avani's ethnicity and culture that prevented proper enquiry and follow up, and the need to make appropriate enquiries about relationships and living arrangements and women who travel to Newham for marriage.

1.10.7 Recommendation 7

The Domestic and Sexual Violence Strategic Board to develop and implement an awareness raising programme with mosques in the borough, with particular reference to support provided to people when they convert from their religion, if there is a particular risk of isolation from their friends and community, including the learning in this and other relevant Domestic Homicide Reviews.

1.10.8 Recommendation 8

The Domestic and Sexual Violence Strategic Board to develop and implement a domestic abuse awareness raising programme with employers in the borough, including the need for employer's domestic abuse policies for staff.

2. DHR Newham, Avani

Overview Report

Introduction

2.1 Outline of the incident

2.1.1 On the date of the homicide in 2013 Avani was found at home having been stabbed. Her husband Riaz pleaded guilty to her murder and was sentenced to life imprisonment serving a minimum of 16 years.

2.2 Domestic Homicide Reviews

2.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

2.2.2 The purpose of these reviews is to:

(a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

2.2.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

2.3 Terms of Reference

2.3.1 The full terms of reference are included at **Appendix 1**. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

2.3.2 The first meeting of the DHR Panel was held on 2 June 2015. The DHR Panel were asked to review events from 1 January 2005 up to the homicide. Agencies were asked to summarise any contact they had had with Avani or Riaz prior to 1 January 2005.

2.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. A review was started immediately after the homicide occurred, however it did not progress satisfactorily and the Chair was decommissioned by the Community Safety Partnership. Newham Community Safety Partnership agreed to start a new review. This review did not commence until almost two years after the homicide. Once this review commenced in June 2015 it was completed within seven months, in January 2016.

2.4 Independence

2.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the Newham Community Safety Partnership or any of the agencies involved in this case.

2.5 Parallel Reviews

2.5.1 There were no reviews conducted contemporaneously that impacted upon this review.

2.6 Methodology

2.6.1 The first Panel meeting sought to understand how far the previous Domestic Homicide Review process had progressed. It became apparent that there had been at least two meetings, and some agencies had checked records and completed chronologies. However, given the delay since then, and the need to be as thorough as possible, the Panel agreed that the review process would start again, with requests for chronologies and Individual Management Reviews (or confirmation of no contact) sent to all relevant organisations.

2.6.2 Individual Management Reviews (IMRs) were therefore sought for all organisations and agencies that had contact with Avani and/or Riaz and/or the children. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved: specifically Aanchal and Nia for their domestic abuse expertise.

2.6.3 The children were included in the review to the extent that their contact with agencies could support learning around those agencies' responses to Avani and/or Riaz; therefore only minimal information is provided in this report about the children, to protect their confidentiality.

2.6.4 The Metropolitan Police Service, the London Borough of Newham, Victim Support, drug and alcohol services and East London NHS Foundation Trust mental health services reviewed their files and notified the DHR Review Panel that they had no involvement with Avani or Riaz and therefore had no information for an IMR.

2.6.5 During the review it was discovered that Avani had lived in Southwark before moving to Newham; therefore agencies in Southwark were contacted, and involved in the review where they had had contact.

2.6.6 All IMRs included chronologies of each agency's contacts with the victim and/or perpetrator. On the whole, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete were comprehensive and high quality. IMRs were received from:

(a) Barts Health NHS Trust

(b) East London NHS Foundation Trust (ELFT) Health Visiting Service

(c) Guy's and St Thomas' NHS Foundation Trust

(d) Newham Clinical Commissioning Group, on behalf of the General Practitioners for the victim, perpetrator and children

(e) School for the older child

2.6.7 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

2.6.8 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Agnes Adentan, East London NHS Foundation Trust

(c) Allison Buchanan, London Borough of Newham Community Safety

(d) Anne Morgan, Newham Clinical Commissioning Group

(e) Chris Brown, Metropolitan Police Service, Critical Incident Advisory Team

(f) Debbie Saunders, Guy's & St Thomas' NHS Foundation Trust

(g) Jane Callaghan, Barts Health NHS Trust

(h) Karen Ingala-Smith, Nia (Independent Domestic and Sexual Violence Advocacy, IDSVA, service provider)

(i) Representative, School[3]

(j) Su Bhuhi, Aanchal (Newham One Stop Shop)

(k) Tony Pape, London Borough of Newham Adult Services

2.6.9 Aanchal, in addition to contributing to the review as a substantive member, also acted as specialist experts in relation to domestic abuse victims from minority ethnic backgrounds, and contributed expertise and knowledge in relation to Avani's possible experiences.

2.6.10 Aanchal was first established in 1984 (then known as Apna Ghar) with a mission to alleviate the suffering of women and children from domestic abuse, supporting them to rebuild positive healthy lives. The current services provided in Newham are: 24-Hour Helpline with out-of-hours advocacy support linking with police and legal partners; managing the One Stop Shop and delivering counselling, empowerment programmes; low and medium risk IDVA support; co-located IDVA provision at the police station; working with other partners to signpost towards a holistic wrap around service. Aanchal support No Recourse to Public Funds cases, and supporting people affected by Honour Based Violence and Forced Marriage. Aanchal deliver training and awareness raising to GPs. The services include a diverse range of language provisions for South Asian communities.

2.6.11 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

2.7 Contact with the family

2.7.1 The independent Chair attempted to make contact with family members of Avani. Letters were sent to Avani's family, the children's child-minder, a friend of Avani's and the employers of Avani.

2.7.2 For Avani's family in India and the children's child-minder, contact was made by London Borough of Newham Children's Social Care, as they had previously been in contact with them following Avani's homicide and as a result were considered by the DHR Panel to be the most appropriate route. Letters were posted directly to Avani's friend and employer. No answers were received.

2.7.3 The review was made aware that Riaz had another family in a different borough. The previous Chair had written to them to invite them to be part of the review, and this invitation was declined. The Panel agreed that they would not be within the remit of this review, however they were written to by the independent Chair to invite them again to participate. No response was received.

[3] Details of the school have been kept anonymous to protect the confidentiality of the children

2.7.4 The independent Chair also attempted contact with Riaz via the prison in which he is held. He responded that he would be willing to be interviewed. This meeting was held in November 2015, and the information has been incorporated into the report.

3. The Facts

3.1 Outline

3.1.1 On the date of the homicide in 2013 Avani was found at home having been stabbed. Her husband Riaz pleaded guilty to her murder and was sentenced to life imprisonment serving a minimum of 16 years.

3.2 Information relating to Avani

3.2.1 Avani was aged 27 at the time of her death. She was originally from India, and had come to the UK in approximately 2004.

3.2.2 It is believed her relationship with Riaz had already started, on a previous (brief) trip to London, and they were married after she moved to London permanently. She converted from Sikhism to Islam at some point after moving to the UK and prior to marrying Riaz. They had two children together.

3.2.3 Avani worked as a secretary in an office, and also in a café.

3.2.4 The police investigation revealed that Avani had reported to work colleagues that she was unhappy in her marriage, and also that Riaz was controlling and critical of her clothing and had assaulted her in the past. None of this was reported to the police or any other agency.

3.2.5 From 2005 to approximately October 2011 Avani gave agencies an address in Southwark, then one in Newham. Medical records suggest that her living arrangements were not always clear: at times she reported to Guy's and St Thomas' NHS Foundation Trust that she was living in East London but keeping a Southwark address in order not to have to change GP (see below). In his interview, Riaz stated that Avani had been living in East London with him throughout their relationship, but using a friend's address in Southwark for the purposes of registering with a GP.

3.3 Newham Clinical Commissioning Group: General Practice for Avani

3.3.1 Avani first registered with a GP in west London, and then transferred to a GP in Southwark in January 2006. She was immediately referred to antenatal care at Guy's and St Thomas' NHS Foundation Trust, as she was pregnant (see below). The next record was for the birth of that baby.

3.3.2 In October and November 2006 Avani attended her GP for contraception.

3.3.3 Her next attendance was almost three years later, in March and then April 2009, again regarding contraception.

3.3.4 In May 2011, Avani attended pregnant, and was referred for antenatal care (again to Guy's and St Thomas' NHS Foundation Trust). The next record was for the birth of that baby.

3.3.5 In October 2011, Avani attended for contraception and a routine post-natal check in which no concerns were noted.

3.3.6 Avani changed her GP to East London shortly after that appointment, and a new patient registration was noted in October 2011. It was recorded for her that "main spoken language [is] Hindi". She was again prescribed contraception.

3.3.7 In January 2012, Avani requested a home visit regarding "back pain" and "numbness in one leg". The notes indicated that advice was given; it is not clear whether Avani was visited. On the same day there is a record of "attendance for minor ailments", this is assumed to be related to the previous record. This was Avani's last recorded contact with her GP.

3.3.8 In addition, to the above there were sporadic attendances for the two children, all minor except for the following:

(a) January 2013 an entry noting the older child's emergency hospital admission (Barts Health) for fracture right distal femur

(b) April 2013 an entry noting the younger child's emergency hospital admission with a cut to the head (Barts Health)

3.3.9 Both of these were logged on the GP system; there was no evidence of follow up.

3.4 School

3.4.1 Avani and Riaz's oldest child started at the primary school in January 2011, and attended until the end of the summer term in 2013.

3.4.2 Avani dropped the child off and collected them from school each day. The only events of note from the school were as follows:

(a) Reception year (2011): the child's teeth were noted to be "dirty" and the child said they "had spiders on [their] teeth".

(b) Year one (2011/12): the child did not often do their homework.

(c) Year two (2012/13): the SAT (Standard Assessment Tests, routinely done at the end of year two) results showed the child was not "reaching [their] age related expectations" in one area, and would have received support for this in the next academic year.

(d) There is a record on the school system stating the child was away from school due to an appointment in January 2013 for an injury (see Barts Health records below).

3.5 Barts Health NHS Trust

3.5.1 Barts had no involvement with Avani.

3.5.2 On three occasions the older child was brought in to the Emergency Department with accidental injuries: in August 2006, September 2009 and January 2013. The child was treated, and following extensive discussion with Avani and Riaz, the clinicians recorded no concerns. The child was recorded as not speaking English, with Avani and Riaz translating.

3.5.3 The younger child was brought to the Emergency Department by Avani in April 2013 with an accidental injury (cut) to their head for which they were treated.

3.5.4 Avani brought the younger child to the Emergency Department in July 2013 as the child had been vomiting; they were discharged to primary care.

3.6 Guy's and St Thomas' NHS Foundation Trust (GSTT)

3.6.1 GSTT was responsible for midwifery care for Avani. Health Visiting service information is presented in this section however it should be noted that GSTT were not responsible for the management of that service at the time as it was part of NHS Southwark (the former Primary Care Trust). Health Visiting services were integrated into the Trust in April 2011.

3.6.2 Avani was referred by her GP to GSTT in January 2006 for a maternity booking appointment. This appointment took place in March 2006, in which a history was taken. Avani was recorded as having come to the UK in 2003 and was unemployed. Her English was noted as good, and she did not need an interpreter. The pregnancy was unplanned but Avani was noted to be happy.

3.6.3 Avani had routine antenatal appointments in March, June and July 2006. The midwife noted that Avani was going to a temporary address for a few days upon discharge following the birth of the baby. It was noted that Riaz was concerned that some building work was due to commence over the next few days so Avani and the child were to stay at his father's address.

3.6.4 GSTT made a record in September 2006 that the local Health Visiting service (Tower Hamlets) had visited Avani and the child at home at the address she was discharged to in East London. No concerns were noted.

3.6.5 In September 2006 Avani attended a baby clinic in Southwark, and stated that she had stayed temporarily in East London but was now back in Southwark. She stated that she lived separately from her partner and that she was staying with family, who were "supportive". There was no record of exploration with regard to Avani's mention of separation from her partner.

3.6.6 A developmental review of the child was conducted in June 2007 at which no concerns were noted. Avani's primary address was noted as East London.

3.6.7 The next contact recorded is when the Health Visitor saw Avani and the child at the clinic in February 2008. Avani informed the Health Visitor that she was living in East London but keeping an address in Southwark because she did not want to change her GP. The Health Visitor advised Avani on the disadvantages of having a non-local GP, and noted a plan for Avani to register with a GP in East London.

3.6.8 The Health Visitor saw Avani and the child in February 2008 for the routine 18-month review of the child.

3.6.9 In September 2008 the Health Visitor saw Avani, Riaz and the child at home (Southwark) for a routine development check of the child. Some concerns were noted with the child's speech development, and a referral to Speech and Language Therapy was made. Avani and Riaz stated that they would be moving to Newham in the next few months.

3.6.10 In early 2009 the Speech and Language Therapy service made a number of attempts to contact Avani to make an appointment. Avani made contact in March 2009 and stated she had not responded as she had been away.

3.6.11 The assessment was carried out at home (Southwark) in March 2009. It was noted that Avani and the child were living with the child's uncle, aunt and their four children; and that she had regular contact with her father. At home the family were recorded as speaking English and Hindi (Avani) and Bengali (Riaz); it was noted that they attended some playgroups in East London.

3.6.12 In October 2009, the Health Visiting service received a notification from the Hospital (Barts) of the child's attendance in the Emergency Department in September. Under the concerns category "none" was listed; no details were provided on the presentation or the reported mechanism of injury.

3.6.13 The Health Visitor attempted to contact Avani and Riaz, following receipt of this notification, in October 2009. The phone numbers were not recognised and so the Health Visitor wrote to the family asking them to make contact.

3.6.14 Avani called the Health Visitor in November 2009 in response to this letter; she stated that the child had fallen down the stairs, that the cast had now been removed and a follow up x-ray was due to be taken that day. Home safety leaflets were sent.

3.6.15 Avani cancelled the scheduled Speech and Language Therapy appointment in December 2009, and did not attend the rescheduled appointment or respond to a follow up letter. The child was therefore discharged from the service.

3.6.16 Avani was referred to GSTT maternity services by her GP in January 2011. The maternity booking appointment took place that month; Avani gave negative responses to routine enquiry around depression, and around domestic violence. Her address was in Southwark. Avani gave her marital status as single, with Riaz

listed as her partner. Her religion was recorded as Muslim. The pregnancy was noted to have been a planned one.

3.6.17 Avani had routine antenatal appointments in March, May, June and July 2011.

3.6.18 In June 2011, the Health Visitor attended Avani's home to make a routine home visit prior to the child being born. Avani was not at home; a "family friend" was present and told the Health Visitor that Avani lived with her child at the address with him, his wife and their child. The friend gave the Health Visitor a number to contact Avani on; the Health Visitor was unable to contact Avani on that number.

3.6.19 When the child was born and Avani was discharged by the midwifery service the discharge summary was sent to Newham community midwifery team as the mother gave a discharge address for this area. They saw Avani and the child in August 2011.

3.6.20 The GSTT Health Visiting service made contact with Avani in August 2011; Avani stated that she had been unable to reach the Newham Health Visiting service (ELFT) to arrange a new birth visit. She stated that she was planning to register the child with a GP in Newham shortly; and that she had seen a midwife in the area. She also stated that she was being supported by her husband. The Health Visitor spoke with the Health Visiting service in Newham; a birth notification and movers out report was faxed to the service and receipt was confirmed. Health records were sent to the service regarding the younger child (not the older child).

3.7 Community Health Newham, East London NHS Foundation Trust (ELFT) (Health Visiting and School Nursing services)

3.7.1 The service was first aware of the family on receipt of a new birth notification from GSTT in August 2011, following the birth of Avani and Riaz's second child.

3.7.2 At that same time Avani contacted the service to find out when a Health Visitor would be visiting her, and was advised that someone would visit in the next few days.

3.7.3 The Health Visitor carried out a new birth visit in August 2011 with Avani and Riaz present. The Health Visitor recorded that Avani was staying with her partner at his address in Newham but had a flat in South London and Avani and children registered with a GP in Southwark. The notes stated: "At present parents are quite evasive as to their living arrangement, not sure how long Avani and her two children will stay in Newham." Avani stated that they would be attending Health Visiting service in South London and already had an appointment with a Health Visitor in South London in two weeks' time. Avani was informed that unless the Health Visiting team in Newham was told that Avani had moved to Southwark, appointments would be sent to the Newham address.

3.7.4 An appointment was later made in Newham; Avani did not attend and instead was recorded has having taken the baby to see a GP in South London.

3.7.5 There is no record of the older child's records being requested.

3.7.6 Although routine enquiry is now mandatory for ELFT Health Visitors to carry out, it is not possible to identify if it was carried out with Avani.

3.7.7 Avani's maternity discharge summary was received by the service from GSTT in September 2011; the transfer-in records were also received in September (for the younger child only).

3.7.8 Avani brought the child to the clinic in September for a routine check and again in November 2011 and January 2012.

3.7.9 In November 2011, the School Nursing service recorded that routine Parent and Teacher questionnaires were sent to the older child's school. This was completed and returned by Avani in December 2011 with no concerns noted.

3.7.10 The Health Visiting service recorded the receipt of the notification from Barts Emergency Department following the older child's attendance in January 2013. ELFT did not have access to the full records to establish what action may have been taken in response.

3.8 Information from Avani's Family

3.8.1 No information was received from Avani's family (please see paragraph 2.7 above for details of what attempts were made).

3.9 Information relating to Riaz

3.9.1 Riaz was aged 40 at the time of the homicide, and was employed as a chauffeur. Riaz had previously been married, and had children in that relationship. They were not made part of this review.

3.10 Newham Clinical Commissioning Group: General Practice for Riaz

3.10.1 Riaz registered with a GP in October 2011, and had an appointment for a minor ailment.

3.10.2 The only other attendance was in February 2013 when Riaz attended with low back pain from an injury sustained shortly before. The nature of the injury was not recorded.

3.11 Barts Health NHS Trust

3.11.1 In April 2007 Riaz was referred (by his GP[4]), and in November 2007 he attended, orthopaedic outpatients for assessment and a repeat x-ray. The record states that Riaz was offered "removal of metal work from right leg" and that Riaz preferred to "wait and see". The record noted that Riaz had broken his leg in

[4] GP records unavailable for this.

2004 after “jumping from a 20ft bridge to escape a gang of people who were pursuing him” but had not attended follow up appointments and therefore his GP had referred him again.

3.11.2 In June 2008, Riaz attended orthopaedic outpatients for assessment and repeat x-ray; the notes stated that there would be a review after three months and that Riaz was referred for physiotherapy; there were no further records.

3.11.3 In February 2013, Riaz attended the Emergency Department having been referred by the Urgent Care Centre. The record stated that he had fallen over when playing with his child that morning and broken his arm. There were limited notes for this attendance and no evidence of a hospital admission.

3.12 Information from the Perpetrator

3.12.1 The perpetrator replied to the letter from the independent chair indicating he was willing to be interviewed. This meeting took place in November 2015.

3.12.2 When interviewed, Riaz denied that he had murdered Avani. He stated that they had struggled over a knife, that he had pushed Avani and then left; and was not aware that the knife had “fallen” into her until he returned to the flat two hours late.

3.12.3 Riaz denied any abuse or violence towards Avani. His interview responses suggested that he was using controlling behaviours: taking her to and from work; checking her phone bills; trying to change what she wore; going through her papers. However he denied that he was controlling her and stated that his checking up on her was to protect her and keep her safe.

3.12.4 Riaz made a number of significant and serious allegations about Avani in the interview. The review is unable to check the veracity of these; Avani, obviously, has no right to reply, and unfortunately her family and friends have not responded to requests to participate in the review. In light of this, and Riaz’s denial of the homicide, these statements have not been included in the review.

4. Analysis

4.1 Domestic Abuse/Violence Definition

4.1.1 The government definition of domestic violence and abuse is:

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

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

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

4.1.2 It transpired after her death Avani reported to work colleagues that she was unhappy in her marriage; that Riaz was controlling and had assaulted her in the past. Avani did not speak of this to any agency with which she was in contact. A recommendation is made (8) for Newham to raise awareness with employers of domestic abuse and the need for employer policies.

4.1.3 There were opportunities for agencies to explore with Avani the nature of her relationship (and living arrangements), however these occurred some time before her death.

4.2 Newham Clinical Commissioning Group: General Practices

4.2.1 Avani's attendances, other than those related to her two pregnancies and children, consisted of requests for contraception. The IMR recognises that these contacts presented opportunities to ask Avani about her relationship, as there were also references to unprotected sex. A recommendation (3) is made for awareness to be raised around this.

4.2.2 The IMR author notes that the lack of contact by Avani with her GP is unusual due to Avani's possible lack of local connections or support (having come to the country alone), although we cannot know what local support she had. It was also unusual in light of her two small children: GPs often find that families with small children attend their General Practice more frequently.

4.2.3 Avani did access medical services for her children through Health Visiting and the Hospital (routine immunisations and routine developmental reviews and attendances at the Emergency Department) however not through the GP. Her lack of contact, though unusual, would not have been seen as a concern.

4.2.4 The IMR outlines that the GP surgeries were up to date with safeguarding training at the time, and this training included information about domestic abuse.

4.2.5 The Panel discussed the availability of leaflets and posters to GP surgeries. It was noted that the Domestic Abuse Forum have circulated these to GPs (as well as other partner agencies), but the review panel could not establish whether these have been fully utilised. A recommendation has been included in the CCG IMR for this to be audited to ensure GPs are displaying the relevant domestic abuse information.

4.2.6 A number of Newham GPs are currently receiving training from local domestic abuse specialist agency, Aanchal. This training aims to improve the response of GPs to domestic abuse by ensuring they are aware of the signs and triggers that should lead to them proactively asking patients about domestic abuse. They are also provided with contact details for local specialist agencies in order for referrals to be made. A recommendation (2) is made in this report for this approach to improving GP responses to be monitored and evaluated.

4.3 School

4.3.1 Although there were concerns noted by the school in relation to the child's teeth and homework not being completed, during Panel discussion it became clear that these issues were not unusual at the school, in fact being very common amongst pupils in those year groups. As a result, the school took no action.

4.3.2 The school were planning to take action in relation to the need for improvement in one area evidenced through the SAT results; however again, it was not unusual for children to need some level of support in at least one area at that age.

4.3.3 The school display leaflets and posters from Aanchal, and offer a great deal of support in the school for parents and families. While it was noted that Avani did not pursue any of these school activities (we cannot know if she saw / picked up a leaflet), this would not have raised concerns.

4.3.4 Therefore no recommendations are made for the school.

4.4 Barts Health NHS Trust

4.4.1 Barts' involvement was with the two children; they had no contact directly with Avani and minimal with Riaz.

4.4.2 Following the two attendances for the older child, in September 2009 and January 2013, the IMR notes that the clinicians had extensive conversations with

Avani and Riaz and were satisfied that there were no safeguarding concerns (specifically that the injuries were accidental).

4.4.3 This same level of enquiry was not recorded for the younger child's attendance with injury in April 2013. While the IMR and this review do not suggest that the injury was non-accidental, it is best practice for health staff to show professional curiosity and fully explore with parents how injuries to children occurred.

4.4.4 In addition, the Panel noted that the staff should not have allowed Avani and Riaz to translate for the older child when she attended. This would not be normal practice for adults attending and a recommendation is included in the IMR to ensure that this practice has changed in relation to children, and take action if it has not.

4.4.5 This review also notes that the triage process in the Emergency Department now routinely asks about Children's Social Care involvement. Notifications were sent to Health Visiting and this is seen as an effective failsafe in case of safeguarding concerns that may not be picked up at the Hospital.

4.5 Guy's and St Thomas' NHS Foundation Trust (GSTT)

4.5.1 GSTT Midwifery and Health Visiting services' involvement with Avani, Riaz and the children was routine and no concerns were noted. It is not clear whether Avani was asked the domestic abuse/violence routine enquiry question in relation to domestic violence in 2006 (the policy had been introduced in 2005 and was still being rolled out); she was definitely asked in 2011 and answered no.

4.5.2 There was no evidence that the Health Visiting service carried out routine enquiry with Avani following the birth of her first child; however, the IMR notes that such enquiry was not mandatory at the time. It has been mandatory since 2011.

4.5.3 The IMR author outlines the extensive services in place within the Trust for domestic violence/abuse victims, to which Avani would have been referred if she had disclosed domestic abuse or that there was any indication of abuse from Riaz in 2011. Midwifery staff receive mandatory training on asking about and responding to domestic violence/abuse. There are two services offered within the Trust or in partnership by the Trust and the voluntary sector, and training and care pathways are firmly embedded within the midwifery service.

4.5.4 GSTT also outlined that routine enquiry in midwifery services is not seen as a 'yes/no' question or just a tick box. Training and ongoing practice encourages midwives to cover the subject of domestic abuse/violence as part of conversations with women, for example around family, relationships or any stressors. Staff are also trained and encouraged to revisit the subject at other

times following the initial enquiry at the first appointment, allowing for women to disclose at a later point once more of a relationship has been developed.

4.5.5 Both Midwifery and Health Visiting were aware of Avani moving between South and East London; this did not lead to any concerns, and Aanchal noted that it was known that some mothers of Asian descent or background move to be with family after the birth of a baby. This perhaps led to a lack of curiosity or enquiry on the part of health professionals as to Avani and Riaz's relationship and Avani's living arrangements.

4.5.6 An expectation would have been for the Health Visiting service to have done more exploration with Avani about her living arrangements, and in connection with that her relationship with Riaz – in particular when Avani stated (September 2006) that she was separated from her partner.

4.5.7 The Health Visitor had received notification from Barts about the injury to the child in 2009; however, this notification lacked detail of the nature of the presentation. The IMR author notes that it would have been prudent for the Health Visitor to contact the Hospital following the notification of the older child's attendance in September 2009 to ascertain further information prior to speaking to Avani. However, it was good practice for the Health Visitor to follow up on the attendance by speaking with Avani.

4.5.8 The Health Visitor was right in encouraging the mother to register with a local GP and not move about between services. Having a GP in a different area to where she was living was not optimal and could lead to fragmented care and service provision.

4.5.9 When, in 2011, Avani was recorded as having moved permanently to East London, the younger child's (Health Visitor) records were transferred to ELFT; the older child's (school nurse) records were not (in fact they were not transferred until after the homicide, when the first Domestic Homicide Review was established).

4.5.10 This is addressed further in section five.

4.6 Community Health Newham, East London NHS Foundation Trust (ELFT) (Health Visiting and School Nursing services)

4.6.1 The IMR from ELFT relied on records that were sent from the area in which the children now reside; all records had been transferred over when they moved, and had to be requested for this review. As a result, the records available to the IMR author were not always complete.

4.6.2 The IMR author highlighted the following learning in relation to their contact with Avani and the children:

(a) The 'transfer-in' process was not followed when Avani started accessing the service having moved from Southwark in August 2011.

(b) Not all routine developmental check appointments were carried out.

(c) The lack of information from Southwark on the older child was not identified at the time the family moved but should have been picked up when the Health Visitor visited the family and records requested.

4.6.3 The IMR therefore recommends a review of the current system for administrative staff to notify Health Visitors of developmental reviews that are due for children; and that the Early Help model should be audited for its effectiveness.

4.6.4 Domestic violence is a mandatory question for Health Visitors to carry out as part of both new birth and transfer-in visits since 2009. It is not possible to identify if it was carried out with Avani.

4.7 Diversity

4.7.1 *Gender*

Being female is a risk factor for being a victim of domestic abuse/violence, making this characteristic relevant for this case, Avani having reported to colleagues that she was a victim of domestic abuse from Riaz. This factor – in particular the recognition of heightened domestic abuse risk in pregnancy – was recognised by GSTT in their implementation of routine enquiry for women in midwifery services, and Avani was asked about domestic violence/abuse in 2011 (although not in 2006, the policy was still being rolled out at that point).

Both GSTT and ELFT require Health Visitors to routinely ask all mothers about domestic abuse, and this is a positive step in recognition of the risk women, and pregnant / postnatal women face from abusive partners.

4.7.2 *Race*

Race and/or national or ethnic background are not risk factors for experiencing domestic abuse/violence, but they are potentially aggravating factors in both the type of abuse experienced and the help seeking patterns/perceptions of services for victims. In particular for Avani, she had left her family and country of origin – as well as her religion – in order to be with Riaz. While we do not know what impact this had on Avani's experience of abuse/violence, or help-seeking, research does suggest that women of Avani's background can experience specific forms of abuse/violence:

"Women … experienced: isolation from family and friends … [women with] immigration issues reported threats of deportation from the perpetrator …

women … were also subject to pressures of a religious or cultural nature as part of the violence"[5]

Many of the perceived issues presented in IMRs were explained in terms of "this is common" for families and individuals of Avani's ethnic background and community. While this may be true, it appears to have led in some cases to a lack of enquiry or exploration with Avani about her circumstances, for example in relation to where she was living (see more below). A recommendation (6) is made in relation to this.

4.7.3 *Religion and Belief*

Avani converted from Sikhism to Islam prior to, or at the time of, marrying Riaz. The Panel discussed this as a potentially significant turning point for Avani. Research suggests that many families disown someone when they convert; if this had happened to Avani then she could have been left with no family support in relation to her relationship with Riaz, leading to her potentially becoming more dependent upon him, a risk factor in domestic violence/abuse (recognised in question four of the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Model[6] on isolation and dependency).

Avani would not automatically have received support in a mosque, as conversion can take place at home; and the Panel were made aware that even where conversion (or marriage) does take place in a mosque, support around relationships or domestic violence/abuse may not follow.

A recommendation is made in relation to this (7). The Panel were aware of another DHR in the borough in which this was an issue, and reference should be made to that in implementing the recommendation.

4.7.4 *Age; disability; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*

No information was presented within the review to indicate these were issues.

[5] Thiara, R. & Roy, S. 2012 *Vital Statistics 2: Key Findings Report on Black, Minority Ethnic and Refugee Women's and Children's Experiences of Gender-Based Violence* Imkaan

[6] http://www.dashriskchecklist.co.uk

5. Conclusions and Recommendations

5.1 Preventability

5.1.1 Avani's homicide was not preventable in the immediate time before it occurred. No agency had any indication, or concerns, that could have led to actions that may have prevented the incident. Unfortunately the review did not hear from Avani's family or employers, who may have been able to provide more information on Avani and Riaz's relationship. When interviewed, Riaz denied that he had killed Avani, calling it an accident.

5.1.2 However, there were a number of opportunities for agencies to explore with Avani her relationship with Riaz, which could have led to support and potentially to safety for Avani. These were mainly following the birth of her first child, when she stated on one occasion that she and Riaz were separated (September 2006), and on another that they were living separately (March 2009). It should be noted that when asked directly about domestic abuse by GSTT midwifery services, Avani denied it was an issue for her and never made a disclosure.

5.2 Issues raised by the review

5.2.1 *Opportunities for asking about domestic abuse/violence*

Avani's General Practitioner (GP) had opportunities to ask about her relationship and home life in response to her – at times frequent – requests for contraception, including emergency contraception. It is expected this situation will improve with the roll out of training for GPs, and a recommendation (2) is made for this to be scrutinised and evaluated. In addition a recommendation (3) has been made to raise awareness amongst other providers of this learning.

The GSTT and ELFT Health Visiting service also had opportunities to explore with Avani both her living arrangements and relationship with Riaz: specifically in response to her statement that they were separated (September 2006) and on occasions when they did not appear to be living together.

5.2.2 *Living arrangements*

Between January 2006 and January 2012 Avani frequently provided different – and at times contradictory – explanations for her living arrangements. The following was recorded by the different agencies in contact with Avani:

(a) January and March 2006: SE1 address noted.

(b) August 2006: Avani and child discharged from midwifery to E3 address (noted to be temporary).

(c) June 2007: address in E7 noted by GSTT Health Visiting following routine developmental appointment for child.

(d) February 2008: Avani attended the GSTT Health Visiting clinic in Southwark but stated she lived in East London.

(e) September 2008: Avani seen “at home” in Southwark by GSTT Health Visiting with Riaz and child; stated they were due to move to East London.

(f) March 2009: GSTT Speech and Language Team assessment conducted “at home” in Southwark; child noted to be living with Avani, uncle and aunt and their four children; and to have “regular contact” with Riaz. It was also noted that they attended playgroups in East London.

(g) September 2009: GSTT Health Visitor attempted to call Avani and none of the numbers were recognised.

(h) January 2011: Avani referred to GSTT midwifery services from Southwark GP; at the booking appointment an SE1 address was given.

(i) June 2011: GSTT Health Visitor attempted home visit to Avani, met with “family friend” who stated Avani and child living with them and family.

(j) August 2011: GSTT discharged Avani following birth of child to E7.

(k) August 2011: during contact with ELFT Health Visiting, Avani was noted as only living in E7 for the next month.

(l) August 2011: ELFT Health Visiting new birth visit with Avani and Riaz present; recorded that Avani was staying with her partner at his address in Newham but had a flat in South London and Avani and children registered with a GP in Southwark. “At present parents are quite evasive as to their living arrangement, not sure how long Avani and her two children will stay in Newham.” Avani stated that they would be attending Health Visiting service in South London.

(m) September 2011 to January 2012: Avani attended ELFT Health Visiting clinics in Newham.

There was a lack of scrutiny and enquiry about Avani’s living arrangements; which could also have led to exploration with her about her relationship with Riaz.

Both GSTT and ELFT did not follow ‘transfer’ procedures in relation to records being transferred from GSTT to ELFT, and for ELFT in relation to appropriate appointments being made for the family. While this would not have had a bearing on this case, as there were no concerns to be shared, the Panel discussed the issue and felt that there is a need to address the procedures in relation to transfers, and a recommendation (4) is therefore made in this report. A

recommendation (5) is also made for these agencies to look at their response to transient families.

5.3 Recommendations

5.3.1 Recommendation 1

The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress for IMR and Overview Report recommendations should be made to the Newham Community Safety Partnership within six months of the Review being approved by the Partnership.

5.3.2 Recommendation 2

The Clinical Commissioning Group to report to the Community Safety Partnership on the roll out of training to General Practices in the borough. Report to include number of GPs trained and an assessment of the impact on identification of domestic violence/abuse and referrals to specialist support services.

5.3.3 Recommendation 3

The Clinical Commissioning Group and London Borough of Newham to raise awareness with providers of patients seeking contraception as an appropriate opportunity to ask women about their relationships, with the aim of increasing opportunities for women to disclose domestic abuse. Awareness to be raised with General Practices (as part of Recommendation 2), Pharmacies, Sexual Health Clinics and other relevant providers.

5.3.4 Recommendation 4

East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to audit their current procedures to ensure existing transfer in/out policies and procedures are adequately followed, referencing the learning from this Review.

5.3.5 Recommendation 5

East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to share the learning from this review and reflect on responses to transient families and those moving between boroughs. Reflection through existing supervision, training, team meetings and case file reviews as appropriate.

5.3.6 Recommendation 6

The Community Safety Partnership to share with all partner agencies the learning from this review regarding the assumptions made by many professionals in relation to Avani's ethnicity and culture that prevented proper enquiry and follow up, and the need to make appropriate enquiries about relationships and living arrangements and women who travel to Newham for marriage.

5.3.7 Recommendation 7

The Domestic and Sexual Violence Strategic Board to develop and implement a domestic abuse awareness raising programme with mosques in the borough, with particular reference to support provided to people when they convert from their religion, if there is a particular risk of isolation from their friends and community, including the learning in this and other relevant Domestic Homicide Reviews.

5.3.8 Recommendation 8

The Domestic and Sexual Violence Strategic Board to develop and implement a domestic abuse awareness raising programme with employers in the borough, including the need for employer's domestic abuse policies for staff.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Avani and Riaz following her death. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Avani and Riaz during the relevant period of time: 1 January 2005 to the date of the homicide.

3. To summarise agency involvement prior to 1 January 2005.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. A suitably experienced and independent person has been commissioned to:
   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. This Panel was convened in June 2015; however the homicide occurred in August 2013. An independent Chair was previously commissioned, and a DHR started, however this has not progressed and therefore the DHR process is starting anew. The process will be conducted as swiftly as possible bearing in mind this already lengthy delay.

9. On completion present the full report to the Newham Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives

have knowledge of the matter, the influence to obtain material efficiently and the ability to comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Newham Clinical Commissioning Group
    b) Nia (IDSVA service provider)
    c) Aanchal (Newham One Stop Shop)
    d) London Borough of Newham Adult Services
    e) Barts Health NHS Trust
    f) London Borough of Newham Community Safety
    g) East London NHS Foundation Trust
    h) Metropolitan Police Service, Newham
    i) Metropolitan Police Service, Critical Incident Advisory Team
    j) School for Avani's child
    k) Guy's & St Thomas' NHS Foundation Trust

12. The following agencies will submit a chronology and Individual Management Review (IMR):
    a) Newham Clinical Commissioning Group (for the General Practitioners for the victim and perpetrator)
    b) Barts Health NHS Trust
    c) East London NHS Foundation Trust
    d) School for Avani's child
    e) Guy's & St Thomas' NHS Foundation Trust

13. Aanchal, in addition to contributing to the Review as a substantive member, will also act as specialist experts in relation to domestic abuse victims from a minority ethnic background.

Collating evidence

14. Each agency will search all their records outside the identified time period to ensure no relevant information is omitted, and secure all relevant records.

15. Each relevant agency will provide a chronology of their involvement with Avani and/or Riaz during the relevant time period.

16. Each relevant agency will prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with Avani and/or Riaz;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Avani or Riaz in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review will specifically consider the following points:

a) Analyse the communication, procedures and discussions, which took place within and between agencies.
b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse the training available to the agencies involved on domestic abuse issues.

19. The Review Panel notes that the victim was an Indian immigrant to the UK, and that she had converted to Islam prior to marrying the perpetrator. Therefore, in critically analysing agencies' responses to the family, attention should be paid to the ethnic and national background of the victim, to identify whether there is any specific learning related to this.

Liaison with the victim's and the perpetrator's family

20. The Panel is aware that, with the homicide having occurred in August 2013, and the possibility that contact may have been made by the previous chair, involvement of family, friends and employers will need to be carefully managed.

21. The Panel has been informed that Avani moved to the UK from India, and that her family remains there. We will explore whether it will be possible to sensitively involve the family of Avani in the review, involving Aanchal who have experience of this kind of family liaison.

22. We aim to sensitively involve the childminder of the victim's children in the review, and the victim's two employers.

23. We aim to sensitively involve the perpetrator (via the prison in which he is held), and the perpetrator's family, who may be able to add value to this process.

24. The chair will lead on family engagement with the support of relevant Panel members, including coordination of family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Development of an action plan

25. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Community Safety Partnership: for agencies to report to the CSP on their action plans within six months of the Review being completed.

26. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

27. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

28. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

29. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

30. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

31. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents will all be password protected.

Disclosure

32. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

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Kelly Simmons
Domestic & Sexual Violence Commissioner
Strategic Commissioning & Community
London Borough of Newham
Newham Dockside
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E16 2QU

27 July 2016

Dear Ms Simmons,

Thank you for submitting the Domestic Homicide Review report for Newham AK to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 22 June 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a clear, honest and proportionate review. The Panel felt it was good practice to contact agencies in a different borough. However the Panel also felt that there were a number of missed opportunities to spot signs of domestic abuse that were not fully explored – in particular with respect to the victim's children and health visitor.

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

- The Panel felt the Terms of Reference were good but questioned why they were in the appendices;

- The Panel would like there to be an explanation given as to why the first DHR was stopped and why lines of initial enquiry were not followed;
- The Executive Summary and Overview Report would benefit from being more closely aligned and overall the report would be improved by a thorough proof read, for example, in paragraph 4.7.3 Sikh should be Sikhism;
- The Panel felt recommendation 7 could be more ambitious and cover domestic abuse more broadly;
- The Panel questioned whether all efforts were made to involve family, friends and work colleagues in the DHR as their input can greatly enhance the quality of the review. In future a specialist advocacy organisation should be considered to facilitate this;
- Please consider a recommendation around employer policies to raise awareness of domestic abuse and provide guidance on how employers could respond to disclosures of abuse from victims;

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

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

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

Yours sincerely

Christian Papaleontiou

Appendix 3: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommend ation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendati on?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress for IMR and Overview Report recommendations should be made to the Newham Community Safety Partnership within six months of the Review being approved by the Partnership.						
The Clinical Commissioning Group to report to the Community Safety Partnership on the roll out of training to General Practices in the borough. Report to include number of GPs trained and an assessment of the impact on						

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
identification of domestic violence/abuse and referrals to specialist support services.						
The Clinical Commissioning Group and London Borough of Newham to raise awareness with providers of patients seeking contraception as an appropriate opportunity to ask women about their relationships, with the aim of increasing opportunities for women to disclose domestic abuse. Awareness to be raised with General Practices (as part of Recommendation 2), Pharmacies, Sexual Health Clinics and other relevant providers.						
East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to audit their current procedures to ensure existing transfer in/out policies and procedures are adequately followed, referencing the learning from this Review.						
East London NHS Foundation Trust and Guy's and St Thomas' NHS Trust to share the learning from this review and reflect on responses to transient families and those moving between boroughs. Reflection through existing supervision, training, team meetings and case file reviews as appropriate.						
The Community Safety Partnership to						

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
share with all partner agencies the learning from this review regarding the assumptions made by many professionals in relation to Avani's ethnicity and culture that prevented proper enquiry and follow up, and the need to make appropriate enquiries about relationships and living arrangements and women who travel to Newham for marriage.						
The Domestic and Sexual Violence Strategic Board to develop and implement an awareness raising programme with mosques in the borough, with particular reference to support provided to people when they convert from their religion, if there is a particular risk of isolation from their friends and community, including the learning in this and other relevant Domestic Homicide Reviews.						