STANDING together
against domestic violence

DOMESTIC HOMICIDE REVIEW

London Borough of Newham

Case of Adult ZA

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September 2016

Contents

Please note, the Executive Summary is a standalone document to this report.

1. Introduction

1.1 Details of the incident

1.1.1 In July 2013 a 999 emergency call was made to the police from an address in Newham. On arrival at the house, the door was answered by the children of ZA and they were joined by WX, her husband. The children said that they had heard their mother screaming earlier. Her husband stated that she was not home. The police officers went into the house and found ZA unconscious; she had been strangled. Her husband was arrested. ZA was taken to hospital where she was pronounced dead. A homicide investigation commenced.

1.2 The review

1.2.1 These events led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the London Borough of Newham Community Safety Partnership (CSP). The initial meeting was held on 2nd August 2013, and there have been four subsequent meetings of the DHR panel to consider the circumstances of this death.

1.2.2 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2.3 The purpose of the review 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 victims and their children through improved intra and inter-agency working.

1.2.4 This review process does not take the place of the criminal or coroners courts proceedings nor does it take the form of any disciplinary process.

1.3 Terms of Reference

1.3.1 The full terms of reference are included in 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. Agencies were asked to review all contact between January 2011 and July 2013 and to summarise contact before that date. This time period was set in order to gather and analyse contact between agencies and the subjects of this review that may have had an effect on the family. Those agencies who had contact were required to complete Individual Management Reviews (IMRs) for submission to the panel.

1.4 Parallel and related processes

1.4.1 The progress of this case has been severely affected by a parallel disciplinary process. On initial examination of the circumstances of the case the Metropolitan Police Service (MPS) decided to refer the matter to the Independent Police Complaints Commission (IPCC). A total of nine misconduct notices were served on officers from MPS and Hertfordshire Constabulary in October 2013. It was apparent that the MPS Individual Management Review (IMR) would require officers involved in investigating reported domestic abuse to be interviewed as part of the DHR process. The IPCC made representations to the panel that any interview by IMR authors could compromise the disciplinary investigation. It was agreed by the panel that the IPCC would take primacy with interviews and that this DHR could use the content of the published IPCC report to inform this overview report. The IPCC initially estimated that their report would be published at the start of 2014. The report was eventually released to the panel in the summer of 2015. A recommendation around unsatisfactory performance and learning lessons was made for select officers. At the time of writing, the final IPCC report had still not been published.

1.4.2 The East London Foundation Trust (ELFT) conducted a serious incident review into this case before submission of their IMR.

1.5 Panel membership

1.5.1 The members of the review panel included:

a. Aanchal Women's Aid – Chair of DV Forum

b. East London Foundation Trust (ELFT) – Mental Health Services

c. Essex Police

d. Hertfordshire Police

e. London Borough of Newham Domestic and Sexual Violence Commissioner

f. London Borough of Newham – Children's Social Care

g. London Borough of Newham Safeguarding Adults

h. London Borough of Newham – Strategic Commissioner for Mental Health

i. London Community Rehabilitation Company

j. London Probation Trust Newham

k. Metropolitan Police Service (MPS) – Critical Incident Advisory Team (CIAT)

l. Metropolitan Police Service Newham Borough

m. National Probation Service

n. Newham Action Against Domestic Violence (NAADV)

o. Newham Clinical Commissioning Group (NCCG)

p. NHS England

q. Standing Together Against Domestic Violence (Independent Chair and minutes)

(Full details of the panel members are recorded in Appendix 2.)

1.6 Independent Chair

1.6.1 The Independent Chair of the DHR is Mark Yexley, an ex-Detective Chief Inspector in the Metropolitan Police Service with 32 years' experience of dealing with sexual violence and domestic abuse. Mark was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, the head of cold case rape investigation unit and partnership head for sexual violence in London. He was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Mark was a member of the Department of Health National Support Team and London lead on National ACPO and HMIC Reference Groups. Since retiring from the police service he has been employed as a lay Chair for NHS Health Education Services in London, Kent, Surrey and Sussex. This work involves independent review of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

1.6.2 Mark has no connection with the London Borough of Newham. Mark retired from the MPS in January 2011. Although he worked in the department investigating sexual violence, his role was in a Pan London Unit dealing with Cold Case Investigation and Sexual Assault Referral Centres. There have been structural changes to the MPS since he left the service and Mark has no connection with the teams involved in this case. He has no personal or professional connections with the police officers involved in the case and has never held any line management responsibilities for the police teams. Mark's experience was discussed with the CSP commissioner at Newham before the review commenced and it was decided that is knowledge would be valuable in this review process.

1.7 Methodology

1.7.1 The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with WX or ZA, and her 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. Details of those agencies providing IMRs or summaries of information held are outlined in the terms of reference.

1.7.2 Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored.

1.8 Contact with family and friends

1.8.1 The family of ZA reside in the UK but had disowned her and cut all contact with her before the homicide took place. It is believed the severing of contact was due to opposition to her marriage to a Muslim man. ZA's family were invited to take part in this review and were made aware of the process. They have chosen not to participate in the police investigation and do not wish to assist any other enquiries.

1.8.2 The panel gave consideration as to whether ZA's children should be involved in the review. This was kept under review during the DHR process. The Chair discussed the review with the family social worker and she spoke with ZA's eldest child about the process. She did not want to take part in the review as she considered it to be too painful. It was thought not to be in the best interests of the younger children to pursue this further with them. A copy of this report will be attached to the Children's Social Care records and will be available to them in the future.

1.8.3 After the final panel meeting, the Chair made an attempt to approach the brother of the victim independently of any police processes. There was no response to the letter sent by the Chair.

1.8.4 The police were able to provide the Chair with telephone contact details of ZA's work colleagues and friends. The Chair made direct contact and conducted interviews by telephone without any police involvement. They were able to provide information to the review and this proved valuable to the process.

1.9 Equalities

1.9.1 The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The victim in this case was female and

born in Britain to a South Asian family. The panel do not know what ZA's religion was prior to her marriage to WX, however they married through an Islamic wedding, including a Sharia marriage.

1.9.2 In forming the panel for the review, consideration was given to the involvement of specific local services that could support this process with expertise. This would include expertise on domestic abuse through Newham Action Against Domestic Violence and also cultural specific services through Aanchal Women's Aid. Consideration has been given to the impact of this homicide on the children within the family. The panel considered the involvement of Children's Social Care and links to education would be appropriate to consider the interests of children.

2. The Facts

2.1 Death of ZA

2.1.1 The victim was born in West Bromwich in 1975. She had been previously been married to a man from India. During this marriage ZA had sponsored her husband's spousal application for residence in the UK between 2003 and 2008. In 2007, ZA and her husband were arrested for facilitating an illegal immigrant's entry to the UK. No further action was taken against ZA. Her husband was found guilty of mortgage fraud and possessing false passports. He was sentenced to 34 months imprisonment and his application for residence was refused as a result of the conviction. It is believed that they separated on his conviction and the couple were divorced in March 2013. Her ex-husband was deported to India on his release from prison and has not returned to the UK. He is not subject to this report.

2.1.2 ZA had three children during this relationship. Her daughter, FV, was born in 1998. ZA also had two sons, BV born in 2000 and EV born in 2005. The children were aged fifteen, thirteen and eight years old at the time of their mother's death. The children went to local schools and ZA was employed in an administrative role in an NHS GP practice in Ilford. ZA was also known to have worked as a model. She was considered by her children's school and her work colleagues as a lone parent. There were concerns expressed by work colleagues that ZA had started an online relationship with a man in the Middle East. This has not been confirmed.

2.1.3 It is not known how ZA met WX. It is known that ZA had been in a relationship with WX since November 2012 and, within six months, on 27th April 2013, they had undertaken an Islamic Sharia marriage.

2.1.4 On 14th June 2013, ZA went to her solicitor in Hertfordshire and reported that her husband, WX, was abusive. She made a sworn statement. In this statement, ZA expressed that she was in fear of her life. On 17th June 2013, ZA attended Watford County Court and a non-molestation order, together with an occupancy order was granted by the judge in favour of ZA. Copies were served on MPS officers in the London Borough of Newham

2.1.5 After papers were served ZA sent texts to her solicitor indicating that she had difficulties getting WX to leave her home in Newham. On 19th June 2013, ZA and WX appeared at the solicitor's office in Hertfordshire asking for the orders to be revoked. ZA then spoke to the solicitor alone. She then disclosed that she had been taken to the solicitor's office against her will by WX. WX had told her to revoke the orders or she would not see her son again. It was not known which son this refers to. Although acting under duress, ZA still wanted the orders revoked. The solicitor reported the matter to Hertfordshire (Herts) Police.

2.1.6 Herts Police attended the solicitor's office and arrested WX. When the police saw ZA she later disclosed that she had been raped by WX the previous night. This statement was captured on police body worn video camera. A copy of ZA's statement to the County Court was handed to the police. This statement also outlined rape perpetrated by WX. WX was also arrested for rape. It transpired that the initial kidnap and sexual offences took place in London. Herts Police reported the matter to the Metropolitan Police Service (MPS). The MPS Sapphire (sexual offences) Team took responsibility for the investigation. The Detective

Inspector in charge of the unit sent a Sexual Offences Investigative Techniques (SOIT or Specially Trained) officer with a supporting officer to see ZA. The MPS officers took approximately four hours to arrive at Watford. During this period there was no offer of medical help or SARC services. The SOIT officer spoke to ZA and she retracted her allegations. The MPS did not send an investigating officer to Hertfordshire. WX was not interviewed and was released without charge. The matter was recorded by the MPS as a Crime Related Incident (CRI).

2.1.7 On 27th June 2013, ZA called police to her home in Newham. She reported that WX was outside her house and there was an injunction in existence. Before police arrival, ZA phoned the police back stating her husband had left the area. MPS officers decided to continue to respond to the call and went to ZA's home, finding WX there. He was not arrested. The police officers made a record of the attendance as a domestic incident and completed a risk assessment. They assessed the risk as 'standard' and recorded that an injunction was not in existence.

2.1.8 During this period, WX disclosed to work colleagues that he believed his wife was having an affair. On 5th June 2013, WX told the same work colleague that he was going to kill his wife. This was not known to anyone else and was not reported to Police at the time.

2.1.9 In the early hours of 7th July 2013, the MPS received a call from a mobile phone. The call was cut off by the caller. The police operator called the phone back. It was answered by ZA's eldest daughter, who said her brother had been playing with the phone. The original call was traced by the police and found to be registered to ZA's address. Police computer systems revealed the previous domestic incident and officers were sent to ZA's home.

2.1.10 Police arrived at the address and WX, together with ZA's daughter, came to the door. After denying knowledge of the phone, WX said that his wife was not home. FV then told police that she had heard her mother screaming earlier. The police officers went into the house and found ZA unconscious and could not revive her. She was taken to hospital where she was pronounced dead.

2.1.11 WX was arrested and admitted killing ZA. He refused to be interviewed. WX was charged with murder and remanded in custody.

2.2 Sentencing of WX

2.2.1 WX appeared at the Central Criminal Court on 6th May 2014 and pleaded guilty to murdering his wife. On 27th May 2014 he was sentenced to life imprisonment with a minimum term of seventeen years to be served.

2.3 The perpetrator

2.3.1 The perpetrator was of Islamic faith born in Bangladesh. He was known by the police to have had three previous partners before meeting ZA.

2.3.2 His first known partner, GS, reported domestic incidents to the police in Newham and Essex. His second known partner, HT, reported incidents to police in Essex and his third partner, SK, reported an incident in Hackney.

2.3.3 WX had three children with GS and the family lived in Essex. As a result of his first marriage, WX was granted UK naturalised status in 2006. Very little is known about WX's second wife HT. From police reports it appears that WX commenced an Islamic marriage with his second wife in the summer of 2011. This marriage ended in July 2012. WX is known to have had a relationship with SK before he met ZA. In November 2012, WX met ZA. The couple entered into an Islamic marriage on 27th April 2013. WX worked as a Cross Rail security officer at the time of his arrest for homicide. WX was known to the police through previous incidents of domestic abuse. These are recorded within the report.

2.3.4 A request has been made to the prison authorities to interview WX as part of this review. The request was approved by the prison governor. When the formal approach was made to interview WX to assist the DHR process he refused to be interviewed and cooperate with the review.

2.4 Police

2.4.1 This review identified police contact with WX and ZA within three police service areas. Essex Constabulary had dealt with matters of domestic abuse concerning the perpetrator. These Essex incidents had occurred between 2006 and 2009 and involved WX's first wife, GS. The Metropolitan Police Service (MPS) had had dealings with the perpetrator since 2011 and investigated the domestic homicide. In July 2013, ZA reported a rape and abduction to Hertfordshire Constabulary. It transpired that this offence took place in London and the MPS took over the investigation. All three police force areas were represented in the DHR process.

2.4.2 The incidents involving Essex police fell outside the terms of reference for this review, however they are included to provide a picture of WX's previous behaviour.

2.4.3 In 2006, Essex Police dealt with a call to a domestic incident between WX and his wife, GS. There was no violence reported at the time, but GS reported that WX had been violent in the past. The matter was recorded and no further action was taken. The decision not to charge was taken by police.

2.4.4 In June 2007, WX was arrested by Essex Police for assaulting GS by kicking her and causing bruising. GS declined to make a statement. She was referred to appropriate support agencies and Basildon Children's Social Care (CSC) were notified. WX refused to answer questions in interview and was released without being charged.

2.4.5 In April 2008, WX was arrested by Essex Police for assault on GS. The assault involved WX banging GS's head against a wall; two children were in the house

but did not directly witness the incident. WX was arrested. He denied the offence. A police inspector made a decision not to prosecute as the case did not pass the threshold test. The matter was reported to Children's Social Care. At this point, WX was reported to have left GS to live with another woman. In June 2008, police were called to an argument between WX and GS that amounted to a dispute over ownership of furnishings and property. The incident was recorded and no action was taken. A supervisor completed a risk assessment and classified the risk as 'standard'.

2.4.6 In July 2008, Essex Police received a call from another woman, HT, reporting concerns with her 'ex-partner', WX. She reported that he had been at her home and refused to leave. He was no longer present when police arrived. The matter was recorded and HT was provided with security advice and support from the police Domestic Abuse and Safeguarding Team (DAST). WX was also arrested for making unauthorised use of a credit card belonging to HT. No charges were brought against WX.

2.4.7 WX's dealings with Essex police were considered to have been historic by the review panel. The way in which domestic abuse is now managed has completely change in the county, with full adoption of MARACs and the Domestic Abuse, Stalking and Honour based violence (DASH) Risk Indicator Checklist. The incidents are not subject to further analysis in this review. Discussions with Essex Police's representative on the DHR panel revealed that they now conduct DASH risk assessments in each case of domestic abuse when a report is withdrawn or retracted. This was considered as good practice.

2.4.8 On 8th June 2011, WX came to the attention of the MPS when he was reported to have assaulted GS again. She was now living at an address in Newham. After an argument concerning leaving a light switched on, WX assaulted her by head butting her and strangling her, causing her to lose her breath. WX threatened to kill his ex-wife if she reported him to the police. A Child Coming to Notice of Police (MERLIN) report was shared with Newham Children's Social Care on 12th July 2011. There is no record of GS being referred to a MARAC.

2.4.9 WX was arrested on 12th July 2011. He denied that any assault or threats had taken place and was granted conditional bail. GS chose not to support a criminal prosecution and there was no medical evidence. The assault was apparently witnessed by their children, but their mother chose not to allow them to be interviewed. GS did apply for a non-molestation order. The order was applied for in September 2011 at Bow Magistrates Court and served on WX in October 2011. Whilst on bail for this investigation, WX committed a further assault on GS.

2.4.10 On 26th July 201,1 GS reported that her ex-husband attended her home in order to obtain food from her. She attempted to phone the police and WX put his hand over her mouth to stop her. He then left. This offence amounted to a common assault and was a breach of bail conditions imposed for the previous assault. The police could not initially locate WX. He was later arrested on 27th September 2011. Advice was sought from the CPS and WX was charged on 2nd November 2011 with common assault on GS. On 16th January 2012, WX was convicted of the assault at Stratford Magistrates Court. WX successfully appealed this verdict

and this was varied to Not Guilty at Crown Court on 30th July 2012. The day after this appeal a new partner of WX, KP, reported domestic abuse by him.

2.4.11 It transpired that in the summer of 2011 WX had married a new partner, HT, under Islamic law. KP subsequently discovered that WX had been having an affair. KP found out that WX had an ex-wife, GS. KP was then made aware, by GS, of the existing non-molestation order. On discovery of these facts, KP decided to contact the MPS to report incidents of abuse.

2.4.12 On 31st July 2012, KP reported to police that WX had abused her in May and late June or early July 2012. During an argument in May 2012, WX told KP that he would 'break her face'. Over a month later, during another argument, WX injured KP's hand as he had pulled on computer cable. The incident was reviewed by a Detective Sergeant in the Community Safety Unit in Hackney who assessed the injury to the hand as being accidental. No further action was taken. There are no records of KP being referred to a MARAC.

2.4.13 There were no further reports to the police for the next eleven months. In this time, WX had established a new relationship with ZA and her children. During this time, ZA had reported to her solicitor that she was being abused by WX. ZA's solicitor was based in Watford, Hertfordshire. ZA contacted her solicitor on 14th June 2013 to formally deal with the matter.

2.4.14 On 17th June 2013, ZA appeared before Watford County Court and made an ex-parte application for non-molestation and non-occupation orders against WX. In her sworn affidavit, ZA stated that she met WX in November 2012 and had been in a controlling and abusive relationship. She felt pressured into an Islamic marriage which took place on 27th April 2013. She said 'In Islam I was now married to someone who would become my tormentor'. She said that she was not allowed to question WX's actions and, if she were to do so, it would place ZA and her children 'at risk of physical harm'. ZA also reported that her daughter was receiving psychiatric treatment, due to stress caused by WX. In her affidavit, she stated that WX forced her to have sex. The last occasion that non-consensual sex took place was on 17th June 2013. She was also pregnant, carrying their child.

2.4.15 The court order sought to prohibit WX from threatening, assaulting, and molesting ZA; communication was only allowed through ZA's solicitor. The order was granted, along with an occupation order.

2.4.16 On 17th June 2013, the orders and a copy of ZA's statement were served on WX at the home he shared with ZA. The order required WX to vacate the address within forty-eight hours. That day, the process server delivered copies of the court orders to Forest Gate Police Station where they were handed over to police staff for inclusion on the Police National Computer (PNC) database. It is now apparent that the MPS did not enter a record of the civil non-molestation and non-occupation orders on the PNC.

2.4.17 Between 18th and 19th June 2013, ZA's solicitor received text messages from her expressing concerns that WX would not leave the house. ZA was preparing the children to leave the house in case the police were required to attend.

2.4.18 On 19th June 2013, ZA attended her solicitor's office in Watford with WX. ZA spoke to her solicitor in private and disclosed to him that she had just been abducted by WX. WX had taken her against her will in his car to Epping Forest where he told her she would have to revoke the order or he would kill her. ZA was in a distraught state, begging her solicitor to revoke the order. The solicitor's office informed Hertfordshire police, without alerting WX.

2.4.19 Herts police officers arrived at the solicitor's office within eight minutes of the call being received. One of the officers was wearing a body camera, which recorded the events. ZA told the officers that WX had taken the children to school in his car and was giving her a lift to work. He then kept her in his car for two to three hours and threatened to kill her and threatening that he had a weapon in the car. She was taken against her will to the solicitor's office to withdraw the court order. ZA was described by the officers as being 'frantic, crying and very scared'. The account given by ZA was repeated in front of the police officer wearing the body worn video camera.

2.4.20 WX was arrested and searched. The police did not find any weapons. He was taken to Watford Police Station.

2.4.21 ZA was also taken to the police station. During this time, she disclosed to the officer wearing the body worn video camera that she had been raped by WX. This disclosure was recorded.

2.4.22 It was established by the Herts officers that rape, abduction and initial breach of the non-molestation order had taken place in London. Under Home Office Crime recording standards, the recording of those offences would ultimately be in London. It was decided to contact the MPS. As the most serious offence reported was rape, the investigation would fall to the MPS Sapphire Team. The Herts officers continued to support ZA and noted comments that she made concerning the abuse. The notes of comments made by ZA and a copy of the body worn video camera footage were later handed over to the MPS.

2.4.23 Hertfordshire Police contacted the MPS to take over the investigation. Hertfordshire Police informed the MPS that WX had been arrested at a solicitor's office in Watford in breach of a non-molestation order granted the previous day. The MPS were also informed that ZA had disclosed that she had been raped the previous day by WX. The matter was brought to the attention of the Sapphire Detective Inspector (DI) responsible for offences in Newham. Two SOIT officers were sent to Watford Police Station. It was the role of the SOIT officer to provide care and support, secure the confidence of the victim, gather information from the victim in a manner that preserves the integrity of the investigation and to ensure that information on support agencies was provided and that referrals were made to the Sexual Assault Referral Centre (SARC) or the Havens. The SOIT officer role is separate from the investigating officer. The MPS did not send an investigating officer to Watford.

2.4.24 On arrival at Watford, the MPS SOIT officers were briefed by the Herts officers and provided with the evidence gathered by them. At this point the Herts officers state that ZA was still distressed. The evidence handed over included a copy of

the non-molestation order, non-occupancy order, sworn statement from the civil proceedings and a copy of the body worn video camera footage. The statement included clear accounts of coercive control and rape, with the victim expressing fear for her life and safety of her children. The camera footage contained a report of rape.

2.4.25 The MPS SOIT officers met with ZA. Following her engagement with the MPS officers, ZA provided a retraction statement. A retraction statement is recorded when the initial allegation is untrue or unjustified. In her statement she explained that her solicitor had taken her account out of context, she had not been kidnapped or falsely imprisoned and her relationship with WX was misrepresented.

2.4.26 There is no record of any medical help being offered to ZA. The CRIS report for a reported rape includes a section where the SOIT officer should indicate or 'flag' whether the victim was offered the services of a SARC/Haven. The report was flagged as 'Haven Services Not Applicable'. In the body of the report this was justified as 'No rape'. The SOIT officer recorded that on arrival they explained the SOIT role, the investigation procedure and the need for an ABE (achieving best evidence) statement and 'possibly Haven'.

2.4.27 After completing her retraction statement, ZA was taken home. WX was not interviewed by MPS officers and was released from Watford Police Station without charge.

2.4.28 A crime record of the initial report of rape was not made by Herts officers. The MPS created a crime report the next day, 20th June 2013. The report comprised a sole entry by the Sapphire DI. The report was recorded as a Crime Related Incident and not classified as rape. The report was supervised by the Sapphire DI with no further action being taken.

2.4.29 MPS officers completed a Book 124D Domestic Violence Report Form. ZA provided positive responses for three heightened risk factors, these included separation from her partner, escalation in arguments and controlling behaviour in relation to her clothing. There was no reference to the sworn statement in possession of the MPS. The statement included the fact that ZA was pregnant. A DASH risk assessment was conducted and recorded the risk to ZA as 'standard'. There were no details of ZA's three children in the CRIS report or the Book 124D. There were no 'Child Coming to Notice'/MERLIN forms completed to alert Children's Social Care. There was no referral to an Independent Domestic Violence Advisor (IDVA).

2.4.30 Herts police did make a record of WX's arrest on the PNC.

2.4.31 Details of the non-molestation order and non-occupation order were not recorded on the PNC. Again, ZA was to bring the existence of the orders to the attention of the police.

2.4.32 On 27th June 2013, ZA called 999 and asked the police to come to her home in Newham. During the telephone call she said that she had taken out an 'occupational injunction' against her partner, due to his anger and aggression.

She said the injunction was in force until 17th December 2013 and she was with her children next door taking refuge from him. ZA also telephoned WX on his mobile phone and he later left the house. ZA returned home with her children. ZA called the police again and said that WX had now left and the police were no longer required and she could see them the next day.

2.4.33 Police staff conducted intelligence checks at the time and identified the reported rape of 19th June 2013. The information was logged on the Computer Aided Despatch (CAD) system. The officers who attended the call were not informed of this information. The information would have been available on the mobile terminal in the vehicle of the officers attending. The operator did try to contact ZA again but was unsuccessful. The police operator decided to still send officers to the address. The call was graded as requiring a 'standard' response by the police control room. The officers despatched to the call reviewed the nature of the call and decided to respond immediately, rather than the 'standard' response originally allocated to the call.

2.4.34 WX then returned to ZA's house thirty minutes later. The two police officers arrived, finding him there. One of the attending police officers recounted that, on arrival, ZA denied making the call to police; this was in front of WX. When ZA was in private with one of the officers she whispered to him that she had actually called the police. The officer states that he spoke with ZA in private and she told him that she had separated and did not want WX in the house. She said there was no court order. WX was asked by police to return his key; he said that he did not have one. The officer states that he conducted PNC checks and was not informed of any arrests or breaches by WX. The officer states that checks of the PNC satisfied him that there was no order in existence. They allowed WX to collect belongings from the house.

2.4.35 The police officers completed a Book 124D and recorded that ZA did not wish to be referred to any domestic violence support agency. Although the initial call to police referred to an injunction there was no mention made of this in the Book 124D. A risk assessment was completed with a recorded level of 'standard'. The only heightened risk factor shown was 'separation'. The officers took no further action and recorded the dealings with ZA and WX as a Domestic Incident on a CRIS report. The CRIS report contained an incorrect spelling of ZA's surname. There was no reference in the CRIS report to the abduction and rape reported eight days earlier. Intelligence checks were not recorded as having been conducted. The original 999 call to police by ZA referred to her children. However, no 'Child Coming to Notice'/ MERLIN report was completed to alert Children's Social Care.

2.4.36 A secondary investigation of this incident did take place within the Community Safety Unit (CSU) at Newham. The CSU investigating officer did not identify any recorded domestic incidents involving both parties. The incorrect spelling of ZA's surname by the reporting officer on the CRIS report stopped the investigating officer making the link with the rape reported on 19th June 2013. The investigating officer did not conduct a check on the address of ZA. An address check would have revealed the previous reported rape. A check of the PNC did

reveal that WX was known for breach of non-molestation order, assault and dishonesty offences. The breach of non-molestation order referred to the incident in Watford on 19th June 2013, however no further enquires were made into this. Details of the original non-molestation order and non-occupancy order handed over to police were still not recorded on the PNC. The investigating officer contacted the victim and asked her if she wished to be referred to support agencies. When calling ZA he referred to her by the incorrect name, she did not correct him. On 4th July 2013, the investigating officer updated the CRIS report recording that ZA did not wish to be referred to the IDVA Service, Newham Action Against Domestic Violence (NAADV). There was no risk assessment on ZA's children and no MERLIN report completed. The risk assessment was reviewed on 6th July 2013 and remained as 'standard'. The report was closed.

2.4.37 On the next day, WX murdered ZA.

2.5 East London Foundation Trust

2.5.1 The records of the East London Mental Health Trust have been checked. Neither WX nor ZA are known to them as patients.

2.5.2 ZA's eldest daughter, FV, was known to the Child and Adolescent Mental Health Services (CAMHS). Dealings with CAMHS originated from a surgical referral for FV and they are recorded under the 'Health' section of this report. The Trust provided two services to the family; community child health services and CAMHS.

2.6 General Practice (GP) / Health

2.6.1 WX was registered to a different General Practice to ZA. WX's medical records were checked and there was nothing found in WX's GP records that could be considered relevant to this enquiry.

2.6.2 ZA and her children were registered within a single GP practice. ZA and her children's contact with health services are considered together. There were a number of contacts between health services and the family. During some of these contacts, ZA would make reference to her own and her family's health. WX was present for a number of appointments for the children, where he acted in the role of providing parental consent.

2.6.3 The first indication of ZA's relationship with WX came through contact with their GP. On 6th December 2012, ZA visited her GP concerning contraception. This appears to have been at the start of her relationship with WX. She told her GP that she wanted to start a family with her new partner.

2.6.4 On 15th January 2013, FV was taken to Accident and Emergency (A&E) with severe abdominal pains. She had her appendix removed, although this was found to be healthy. FV later reported bleeding and infection at the wound site for her appendix operation; the site was found to be healing well.

2.6.5 On 22 February 2013, FV reported to her GP that she was too unwell to attend school as a result of chest pain and constipation. She was admitted to Newham University Hospital. The staff were concerned about her low body weight and recent weight loss. She had reported abdominal pain since January 2013 and no organic cause had been found. She had had an appendectomy and the appendix was normal. There was thought to be a psychological element to FV's illness and she was referred to the Child and Adolescent Mental Health Service (CAMHS) by the hospital.

2.6.6 At this point WX gave consent for the CAMHS referral. WX did not have parental responsibility for FV. Hospital notes show that ZA was initially reluctant for the referral and it appears that the hospital were not aware of family dynamics and relationships or the fact that WX did not have parental responsibility.

2.6.7 FV's referral to CAHMS identified that her pain started when WX moved into the family home in January 2013. At this stage, FV shared a bed with her mother and WX had a separate room.

2.6.8 The psychiatric assessment took place on the day of referral by the duty psychiatrist. The provisional formulation was of Pain Disorder with related psychological factors. Appropriate referrals were made to psychotherapy with the School Nurse being informed. There were no questions asked about the possibility of domestic abuse. There is no evidence of CAHMS and the School Nurse liaising on how to work with the family in the future.

2.6.9 During the period of January to March 2013, ZA had seen her GP and out-of-hours service for treatment of a urinary infection and a Sexually Transmitted Infection (STI). Diagnosis and prescribing took place with the out-of-hours services. In dealing with the out-of-hours, only the presenting features would be discussed. This did not provide ZA with an opportunity to discuss her domestic circumstances. She was advised to attend a Genitourinary Clinic (GU) for more complicated symptoms, which she did on 13th February 2013. The opportunity to discuss ZA's domestic circumstances was not taken by the GP or the GU service.

2.6.10 ZA cancelled a planned CAMHS meeting on 5th March 2013 due to her own poor health. On 8th March 2013, FV was taken to her GP by WX with a throat infection. WX spoke in private with the GP and said that FV had psychiatric problems. WX had no parental responsibility. FV was not seen alone by the GP.

2.6.11 There was further contact with the GP when ZA requested a sick certificate from her GP to cover an absence from work between the 18th to 24th March 2013 due to a facial infection. She asked for this to be extended without seeing her GP on 21st March 2013. She continued with treatment for infections into April 2013.

2.6.12 FV eventually attended her CAMHS appointment on 19th March 2013 with ZA and WX. The family found it difficult to explain who WX was. FV was seen on her own; she did not say anything adverse about WX, saying he was kind. She did say that her biological father kept phoning and asking questions about WX. The outcome of this meeting was for CAMHS to follow up with Paediatrics due to low weight, obtain background information from the GP, discuss with consultant and

refer to Paediatric Liaison team at Children's Social Care, discuss attendance with school and then offer FV another appointment when the actions had been completed.

2.6.13 CAMHS did establish that FV felt safe at home.

2.6.14 It was noted at CAMHS that School Nursing were aware of Children's Social Care involvement with the family. The CAMHS doctor had discussions with the consultant Paediatrician on 25th March 2013, the Inclusion Officer from the school on 26th March 2013 and the Head of House on 27th March 2013.

2.6.15 On 3rd and 4th April 2013, FV was seen by the GP, reporting abdominal pain. She was accompanied by her mother and WX. WX was referred to as 'Dad'. ZA was also seen for asthma. FV was also seen by the out-of-hours services on 9th April 2013.

2.6.16 All three children attended out-of-hours GP services with WX and his parental status was not questioned. On 20th April 2013, FV was seen as her appendix wound was not healed. On 23rd April 2013, FV was jointly assessed by the Consultant Paediatrician, Consultant Psychiatrist and Senior Psychiatric Trainee from CAMHS. FV attended the CAMHS appointment with WX, as her mother was working. FV reported that her scar was bleeding. The scar was examined and found to be healing well, with no evidence of bleeding. FV admitted that her pain could be linked to how she felt. FV was referred for individual psychology sessions. FV was on the waiting list for individual psychology sessions at the time of her mother's death.

2.6.17 On 24th April 2013, out-of-hours GP services were contacted and informed that FV's wound was bleeding. This contact was within GP surgery time. It was advised that FV attend the emergency department. FV later attended with her mother. There was blood on her dressing but the wound was healing. A full examination for self-harm was conducted and FV was seen in the absence of her mother. FV did not report problems at home. She was referred back to CAHMS. FV attended hospital the next day, after a fall down stairs. She had no injuries and was discharged.

2.6.18 Between 29th and 30th April 2013, the GP and CAHMS attempted to contact ZA by phone concerning FV's hospital attendances. They could not contact ZA and the GP wrote to her, asking ZA to attend the clinic with her daughter.

2.6.19 On 2nd May 2013, health services made a referral to Children's Social Care in relation to FV. The exact origin of the referral is unclear from health records. It was described as a referral for universal services and may be connected to bullying. The lead was allocated to the School Nurse who tried to contact ZA by phone. There was no reference made to the existing work with CAHMS and the GP.

2.6.20 On 3rd May 2013, ZA spoke with her GP concerning causes for urinary tract infections (UTI). It is not known whether the GP would have made the link between ZA being the mother of FV and the previous request for them to visit the practice.

2.6.21 On 9th May 2013, FV visited the GP with ZA. It is not known if this was as a result of the letter sent by the GP. A physical and social history was taken and both were present. ZA spoke of stresses at home but no detail of the nature was recorded. CAMHS was discussed and ZA was advised to bring FV to the surgery if there were any problems with her daughter's abdominal pain, mood or appetite. FV went on to see surgical outpatients two days later, her wound was healing well. She had tenderness at the scar site, however when she was distracted the tenderness was not present. She was referred to paediatrics and CAHMS.

2.6.22 On 14th May 2013, ZA contacted her GP. She spoke to her GP about FV's health, suspecting gastro-enteritis, and was given advice. ZA also informed her GP that she was pregnant. She requested a termination as her partner was not keen for her to continue with the pregnancy. ZA was referred to the Pregnancy Advisory Service and not seen in person by her GP.

2.6.23 On 15th May 2013, there is a record of discussion between a Children's Physiotherapist and Children's Social Care.

2.6.24 On 20th May 2013, FV was seen by the out-of-hours service, accompanied by WX. On this occasion, it was for a thickening of one of her nails.

2.6.25 On 21st May 2013, FV was seen by the physiotherapy service with her mother and 'uncle'. This may have been WX but this was not confirmed. She was found not to have a full range of motion and had muscle weakness due to inactivity. The physio service was not aware that FV had been relatively fit a month before, and on work experience in a nursery.

2.6.26 On 24th May 2013, ZA was seen in the pregnancy advisory clinic. She had had an unplanned pregnancy of about six weeks. She was given her first dose of medication to begin the termination. She was given the second dose on 1st June 2013. ZA was not seen by the counsellor. No time was taken to discuss the potential for domestic abuse and coercion by her partner.

2.6.27 On 3rd June 2013, ZA contacted her GP stating that she had been feeling unwell since she had taken the medication and she was concerned that the pregnancy had not been terminated. She was advised to visit the Termination of Pregnancy Clinic (TOP). ZA also reported that her daughter's hair had been falling out for four days. She was advised to bring FV into the surgery but there was no discussion on potential stress and links to CAHMS.

2.6.28 On 12th June 2013, the School Nurse attempted to contact ZA concerning FV, as there had been an out-of-hours attendance by FV for tonsillitis. The School Nurse could not contact ZA and did not follow up the case with the family, school or GP.

2.6.29 On 27th June 2013, ZA contacted her GP and informed them that she believed she was still pregnant. She was advised to conduct a urine test. ZA also informed her GP of more problems with FV's throat infection.

2.6.30 On 3rd July 2013, the GP contacted ZA by phone. ZA confirmed that she had done two pregnancy tests and they were both positive. If the previous

termination was unsuccessful then ZA would have been twelve weeks pregnant at this time. ZA said that she was under a lot of stress and was going on holiday at the end of the month. An appointment was made for a scan on 5th July 2013. The scan showed a viable pregnancy and an appointment was made for a pre-surgery meeting on 10th July 2013, followed by a surgical termination on 12th July 2013.

2.7 Education and Children's Social Care (CSC)

2.7.1 At the outset of this review CSC took responsibility for liaising with schools and examining records of ZA's three children. The panel did not request information concerning the children of WX from previous relationships. It was felt that this was outside the terms of reference and would interfere with the privacy of parties not subject of the review.

2.7.2 CSC had sporadic contact with ZA's family and there was no long term engagement in the review period for this DHR. An examination of social care records shows that ZA and her children were known to social care agencies dating back to 1998. This case was closed in 2004 and falls outside the terms of reference with no apparent bearing on the circumstances of the homicide. Social care also had some contact between 2005 and 2006, when the children's biological father made threats towards his children when he had problems with his immigration status. The contact between ZA's children and CSC was triggered through FV's admissions to hospital in 2013.

2.7.3 The CSC Safeguarding Education Lead (SEL) took the lead on meeting schools and reviewing education records.

2.7.4 ZA's youngest son, BV, was eight years old at the time of his mother's death. BV's attainment and achievement at primary school was reported to have been inhibited by unspecific minor illnesses. There was also an emerging pattern of him being absent on Fridays. The impression of staff was that he was not enthusiastically interested in learning. There were no behaviour concerns identified and he was popular with her peers. Concerns about BV's poor attendance were to be escalated to formal meetings. ZA was seen to be engaged with her son's school staff and helped on a school trip. The staff at BV's school were under the impression that ZA was a lone parent.

2.7.5 ZA's second child, BV, was thirteen years old and her daughter, FV, was fifteen years old at the time of their mother's death. They both attended the same secondary academy school.

2.7.6 On BV's admission to the school in 201,1 his school records showed contact details for his mother and no father. ZA's neighbours were nominated as her emergency contacts. There were no significant concerns recorded regarding BV. BV did have a low attendance record, averaging 86%. His absences were attributed by his mother to minor illnesses. There was reference to his mother being a single parent in the school records.

2.7.7 It was a different case with ZA's daughter. FV's school attendance record had been of on-going concern. During the academic year of 2012/13 her attendance was measured as being 45%.

2.7.8 The poor attendance record started with sporadic absences, attributed to FV being unwell and unable to attend school. ZA reported her daughter as having fever, stomach pains and other non-specific symptoms. The school Attendance Officer became involved with the family and requested that ZA provide medical evidence on each occasion FV was unable to attend through illness.

2.7.9 The Attendance Officer met with ZA on several occasions and considered that she had a good working relationship with her. She offered support to ZA. The focus of the meetings was on FV's health. ZA gave no indication of there being any other reason keeping her daughter from attending school. The Attendance Officer expressed concern to ZA that her daughter's illnesses were not sufficiently serious to keep her off school. She offered support from the school counsellor; this was not taken up. A referral to CAMHS was also discussed with ZA and she did not want a referral.

2.7.10 FV's absences increased in November and December 2012 and culminated in a prolonged absence when FV was admitted to hospital in January 2013. FV had her appendix removed and remained absent from school until the half-term break. This hospital admission resulted in FV being referred to Children's Social Care (CSC) by the hospital on 25th February 2013.

2.7.11 The reason for the referral to CSC was due to FV reporting pain, with no medical cause being found. FV's relationship with her mother was considered to be good. There was speculation that FV could have been subject to bullying at school. This was due to her body language when questioned about bullying. Her case was referred for CSC triage. It was decided that there was no evidence of safeguarding concerns or need for support. The School Nurse was informed and school contacted regarding potential bullying. There were no other concerns reported at school.

2.7.12 On four occasions at the start of May 2013, FV signed out of school as being unwell. On these occasions it was WX who gave permission for her to return home.

2.7.13 There were no other incidents of concern or contact with school and CSC until the day of ZA's death. Since that time, CSC have taken responsibility for the care and welfare of the children.

2.7.14 Staff from the schools believed they knew the children well but they had no knowledge or understanding of the reasons for the children's absences from school apart from those provided by ZA. These were generally health-related.

2.7.15 The attendance record of FV was an obvious concern for the school. The school use a strategy of requiring a parent to supply medical evidence to support absence for minor illness to focus a parent's attention. This would usually result in an improved attendance record. The staff did address their concerns with ZA but felt that their 'hands were tied' when she supplied medical evidence to

support FV's absences. It appeared to the school that the health reasons became more serious, culminating with FV's hospital admission. The school staff appeared to lessen their concerns that there was an emotional cause when she was admitted to hospital for surgery. The school's view that there were no emotional concerns could have been supported by ZA turning down the referral to counselling and CAMHS.

2.7.16 It was found that there had been no case recording at the meetings between the Attendance Officer and ZA. There were no leaflets or publicity materials on local DV support agencies or services in the Attendance Officer's office or general reception. The Safeguarding Education Lead was told that no leaflets or posters were allowed to be displayed in the school.

2.8 London Probation Trust – WX

2.8.1 The Probation Service had contact with WX over an eight-month period between December 2011 and July 2012. WX was allocated to the service for pre-sentence reports, risk assessment and unpaid work.

2.8.2 On 11th December 2011, WX was interviewed for a pre-sentence report. This referral related to the common assault on GS on 26th July 2011. The first significant contact came when WX had been found guilty of the offence on 19th December 2011. The probation service obtained copies of CPS documents, witness statements and previous convictions before the meeting. At this time, the victim of the assault was living in London and WX was living in Ilford, Essex.

2.8.3 The probation officer completed a comprehensive report, supported by an Offender Assessment System (OASys) risk assessment. It was noted that WX had no previous convictions for violence. His victim's statement indicated that there had been previous incidents of violence over the ten years of their marriage. At the time of the offence, July 2011, they were separated and WX had been denied access to his three young children. There was no evidence of contributory factors such as mental health, drugs or alcohol. The probation officer did identify distorted thinking, attitudes and controlling behaviour as fundamental factors in his offending. WX was assessed as taking no responsibility and having little insight into his behaviour. He showed no remorse and was dismissive of the victim and in denial of the offence. WX stated his intention to appeal, as the offence did not happen.

2.8.4 The probation report to the court assessed that violence in a domestic setting would be an aspect of his future offending. It was recommended that a programme for perpetrators of domestic violence would be the most suitable sentencing option. Due to WX's complete denial and intention to appeal he was considered unsuitable for the programme. The probation service considered any other sentencing option as not relevant. WX was sentenced on 16th January

2012 to a Community Order of 100 hours' unpaid work. There was further contact with probation in the management of this order.

2.8.5 WX did not attend his first appointment due to a train breakdown. He attended his induction on 2nd February 2012. During this meeting he explained the events leading up to his conviction and was very upset at not being able to see his children as he missed them. WX successfully completed his order on 25th May 2012. Records show that he finished the order without any unacceptable absences.

2.8.6 Probation records show that WX appeared at Snaresbrook Crown Court where his appeal against conviction was allowed. The Judge said "I cannot be sure the alleged offence took place". The court was told that an injunction was still in existence.

2.9 Other agencies

2.9.1 The panel considered the involvement of other agencies, third sector and statutory, that ZA may have sought help or support from.

2.9.2 The London of Borough of Newham commissioned an Independent Domestic and Sexual Violence Advisor (IDSVA) service delivered by NAADV from 2011 until June 2015. Following June 2015, the contract was awarded the Nia Project.

2.9.3 Aanchal Women's Aid and Newham Action Against Domestic Violence conducted a search of their records and could find no trace of either party or children being referred or accessing services.

2.9.4 The Borough has a Victim Support Service (VSS). A check was made of Victim Support records in relation to ZA and WX. Neither party was known.

2.9.5 At the time of the reported rape, SARC services in London would have offered confidential healthcare for victims of sexual violence with the option of forensic examination retention of samples and police referral. These services would have included sensitive management and treatment of STIs. The Havens service could also provide supportive service to any termination of pregnancy. In addition to this there was an Asian Development Worker who could provide services with understanding of the cultural needs of women with South Asian heritage. The panel requested that The Havens records be checked. There was no record of the victim being referred to The Havens by police or attending the service by self-referring.

2.10 Contact and relationship with family/friends

2.10.1 The family of ZA had cut off all contact with her before the homicide took place. It is believed that this break of contact was due to her marital relationships. This cannot be confirmed as the family have chosen not to participate in assisting the police homicide investigation and they have disowned ZA. Due to this lack of

involvement, the family have not been asked whether they would prefer a pseudonym to be used to represent ZA in this report.

2.10.2 The children of ZA are in the care of the local authority and are settling into long term placements. The panel thought it important for the children to be informed of the review and asked if they wanted to contribute.

2.10.3 ZA's eldest child, FV, was spoken to by her social worker about the DHR process. FV chose not to be involved in the review as she felt it would be too painful for her. FV also felt that her younger brothers would not want to be involved. The Chair and the family social worker are thankful for FV's consideration, understand this decision and respect her expertise in knowing what is in their best interests at this time.

2.10.4 The Chair was able to speak to ZA's work colleagues and friends. One friend and colleague who had known ZA for two years said that she was not initially aware of problems between ZA and WX.

2.10.5 Work colleagues were aware that ZA was having internet contact with another man from abroad, not WX, at some stage. They were concerned about her as they believed she would be going to the Middle East to marry the man. ZA told friends that the man in the Middle East had requested that ZA send him pictures of her daughter in her hospital bed. It should be noted that the police investigation reviewed communication between ZA and her friend. Nothing of concern was revealed in relation to safeguarding.

2.10.6 ZA never talked much of WX until about 2 months before her death. She started wearing a hijab to work and WX started to pick her up from work. Colleagues stated that ZA had always dressed conservatively before. Her colleagues remembered 'her hair and nails were always lovely'. She stopped wearing makeup and was described as looking sad in her hijab and it felt like 'her personality was being squashed'. WX was described as very domineering by ZA's colleagues – it is not known if this was ZA's description. Colleagues believed that ZA's daughter, FV, did not like WX.

2.10.7 Work colleagues were told about the kidnap that was reported in Hertfordshire. On the day of the kidnap, ZA's manager received a text from her phone; it later transpired that this had been sent by WX. Later, her manager was phoned by Herts police to inform her that she was safe. The next day, ZA told her colleagues that WX had taken her to Epping Forest and told her that he had hammer in the boot. ZA made no mention of any sexual violence being investigated by police.

2.10.8 There was a further incident revealed that was not known to the DHR. This was reported by a colleague of ZA; there was no way to corroborate this information. After the kidnap, ZA was apparently grabbed by WX in Stratford Station car park. An off duty police officer stepped in and protected ZA. The officer took ZA to her place of work, six miles from the station, to make sure she was safe. It should also be noted that a search of MPS police systems have not identified this incident. Although this matter took place in London, it is possible that this was a

police officer outside their police force area or someone purporting to be a police officer.

3. Analysis

3.1 Relationship between victim and perpetrator – controlling behaviour

3.1.1 In the period before meeting WX, ZA was a lone parent with three children and a husband who was in prison and later deported. She was in employment and, whilst working, cared for her children. It is not known whether she had any extended family support at this time. All of her children had experienced problems with attendance at school.

3.1.2 WX had been violent in previous relationships. This had been to the extent that he had been prosecuted for domestic assault on one occasion. It is appreciated that WX was later acquitted on appeal for this offence, although in his dealings with probation services he was assessed as demonstrating distorted thinking and controlling behaviour. A course to address WX's behaviour had been considered but he was not willing to address the issues. This review has seen that there was a clear pattern of controlling and coercive behaviour across many intimate relationships that pointed to a need for robust intervention to disrupt and divert WX.

3.1.3 When WX and ZA formed a relationship at the end of 2012, he was able to quickly exert his controlling behaviour on her and her children.

3.1.4 ZA's work colleagues noticed a change in her. Apart from the obvious change in dress to wearing a hijab, she stopped wearing makeup and taking care of her appearance as she had previously done. She was described as 'sad'. WX would often take ZA to work and pick her up. This was not seen by her colleagues as a good thing, and was considered to be controlling.

3.1.5 Evidence of the way WX exerted his control can be seen in the way that he took parental responsibility in dealings with the children, where he had no such legal position. He suggested to health professionals that FV's eldest child had a mental illness. He authorised the children's absences from school.

3.1.6 The most extreme level of control is in the manner in which he kidnapped ZA, then took her to her solicitor's office to ensure that she withdrew the civil case. Having held ZA in his car under threat to her family's lives, he was able to calmly wait outside her solicitor's office whilst ZA was disclosing to her solicitor.

3.1.7 In spite of WX's controlling and coercive behaviour, ZA still took positive steps to get help.

3.2 ZA's efforts to get help from the police

3.2.1 It is clear that ZA made efforts to get help for herself and her children despite WX's attempts to control her behaviour. These were made through formal lodging of court orders with the police, reporting abduction and rape, and a call to police stating that WX was at her home in breach of an injunction.

3.2.2 ZA made a direct approach to a solicitor in order to seek a legal means of protecting her children and herself. This process required the completion of a sworn statement and attendance at court with legal representatives. On 17th June 2013, a Judge at Watford County Court was satisfied that there was sufficient evidence to justify the service of a non-molestation order and the exclusion of the perpetrator from his then marital home. The occupation order was served on WX at approximately 16:00 on 17th June 2013 and he was required to leave the matrimonial home within forty-eight hours of service.

3.2.3 The importance of this step and the contents of the statement cannot be overemphasised. At this point in her life, ZA had made a clear effort to protect herself and family and her grave fears were at the heart of her evidence. Her decision to disclose the physical threat to the court and the repeated sexual violence by WX showed immense courage.

3.2.4 At this point, ZA also disclosed the psychological effect that WX was having on her and on the wellbeing of her children. In particular, this was affecting her daughter.

3.2.5 The service of the non-molestation and non-occupation order on the MPS would have provided the police service with legal powers to more effectively hold WX to account for his abusive behaviour against ZA in times of crisis. ZA's solicitor took immediate steps to ensure that the orders were served on WX and Newham Police. Had the details of the orders been correctly entered into the police intelligence databases at this stage, this would have provided an effective legal method for managing the protection of ZA and her children. Having taken the step to obtain court orders and have her solicitor serve them on police, it would have been reasonable for ZA to expect any future police dealings with her to be supported by this information.

3.2.6 On 19th June 2013, when ZA was abducted and forcibly taken to her solicitor's office to withdraw the order, she again showed that she was able to seek help. ZA disclosed the serious offence of abduction to her solicitor in private. At this point, her abuser was in the same building and she was still able to provide sufficient grounds for her solicitor to call the police to protect her. Her solicitor was able to support ZA by again providing police with a copy of her court orders and a copy of a statement evidencing the levels of abuse, including rape.

3.2.7 When police were called to the solicitor's office, ZA was provided with support and protection by the Herts officers. She was afraid and distraught. ZA provided further disclosure of rape to a Herts Police Constable and this was recorded on video. At this point, ZA had been the victim of a recent rape, was pregnant with

her abuser's child after a failed termination and was emotionally distressed. She should have been provided with an Early Evidence Kit and medical help by Herts officers. ZA should also have been provided with support from MPS specialists. This was not forthcoming. At this point, there was no need to interview ZA any further. Police focus should have been to ensure that she was healthy and safe. Whilst MPS spoke with ZA, they took no steps to interview WX.

3.2.8 In her sworn statement from the non-molestation proceedings and her statement to Herts officers captured on video, ZA would have provided sufficient evidence to justify a 'high' level of risk in any assessment. This was not recorded by the MPS. Under Home Office counting rules for recorded crime, the initial report of rape made to Hertfordshire Police should have been formally recorded and then transferred to the MPS. The record of the events of 19th June 2013 were not entered onto the MPS CRIS system until 20th June 2013 and the details of the non-molestation order and non-occupancy order were never entered on National and MPS Intelligence Systems. Hertfordshire Officers did record the arrest of WX on the PNC system.

3.2.9 In her sworn statement supplied to police by her solicitor, ZA disclosed her fears for her children. There was no mention made of the children on the MPS CRIS record and no entry was made on the MERLIN system. Therefore, no referral was made to Children's Social Care. At this point, ZA had disclosed to the police, through her supplied county court statement, her views on the cause of her daughter's frequent medical problems and the link to her abusive partner. If this information was passed to CSC and Health services, it would have provided the evidence to support concerns on FV's emotional well-being and would have provided grounds to consider the protection of all of her children.

3.2.10 On 27th June 2013, ZA again sought help from the police. In her call to the MPS, she told them that her husband was at her home, an injunction existed, and the expiry date. At this stage, ZA would have known that her non-molestation order would have been brought to the attention of police on two previous occasions and WX had previously been arrested for breaching the order. It is clear that she was in fear of WX knowing that she had made the initial phone call to police. She had also told the police operator of the existence of the court orders and expiry date. Had the orders been entered on to police intelligence systems after initial service or when the rape was reported, WX would have been liable for arrest. Before the police officers attended ZA's home an intelligence search had established a link with the reported rape investigated by the Sapphire Officers. This information was not brought to the attention of the officers who dealt with ZA and WX. This was another missed opportunity to link all of the incidents and to bring WX before a court and protect ZA and her family.

3.2.11 The reporting of this final incident provided the police with a further opportunity to accurately assess risk and consider the welfare of ZA's children. The original call made reference to ZA being at a neighbour's house with her children. There was no MERLIN report completed and the actions of the officers attending ZA's home were not supervised to ensure this was done. The secondary investigation was hampered by the incorrect recording of ZA's surname on the CRIS report. If an

intelligence check had been made on the home address it would have revealed the rape investigation. This was another occasion where links could have been made with Children's Social Care, had a MERLIN entry been made.

3.3 Health Care Contact

3.3.1 ZA and her children were known to universal healthcare services, including GP, GP out-of-hours, health visiting and school health services. They were also known to secondary services including Barts Health and CAMHS. WX was known to a different GP. It is apparent that a male, believed to be WX, features in FV's medical contact as attending appointments with her. There is nothing in WX's records to suggest he was known to be a perpetrator of domestic violence and no entry that would suggest an opportunity was created to discuss domestic abuse.

3.3.2 It appeared from ZA's contact with her GP in December 2012 that there were no concerns around her relationship with WX. When she spoke with her GP, she said that she wanted to start a family with her new partner.

3.3.3 Within a month, ZA's daughter was presenting to the Hospital Emergency Department (ED) with abdominal pain. This resulted in the unnecessary removal of an appendix which was found to be healthy.

3.3.4 When FV was admitted to hospital in February 2013 with chest pain and constipation there was considered to a psychological component to the symptoms and she was referred to CAMHS. At this point, WX provided consent for the CAMHS referral, even though ZA was initially unhappy with this. The decision taken by WX undermined ZA's responsibility for her own daughter. This shows that the hospital staff had no understanding of the family dynamics. They did not take into account that FV could have provided consent herself, if considered to be Fraser competent. In this case, the position of ZA and her daughter were undermined by WX providing the consent when he had no authority to do so. This reflected poor practice in relation to a family history being undertaken by Barts Health.

3.3.5 The assessment made by CAMHS suggested a link between psychosomatic illness experienced by FV and the start of her mother's relationship with WX. There was also suggestion that this could be linked to the relationship between FV and her absent biological father. There was a good assessment by CAMHS in making the link for future work with school health services. However, the suggestion of domestic abuse or child sexual abuse was not considered. Both are known to be a cause of emotional distress in children and it is not known why this was not discussed.

3.3.6 In March 2013, WX took FV to the GP with an inflamed throat. The GP spoke in private with WX who was described in records as 'Dad'. WX asserted that FV had psychiatric problems. This discussion about FV would be wholly inappropriate as WX had no parental responsibility. The lay person's view of FV's emotional problems as 'psychiatric' by WX was attributing her poor health to a

medical cause rather than emanating from her emotional distress. WX appeared again to be attempting to control the healthcare response to ZA's child. It would have been far more appropriate for the GP to have spoken to FV on her own.

3.3.7 It appears that WX continued to take the lead on healthcare appointments for the children. His parental responsibility was never questioned. It is not known if WX was being supportive of ZA or manipulative.

3.3.8 When FV attended her CAMHS appointment on 19th March 2013 she was accompanied by ZA and WX. On this occasion, FV was seen on her own and asked if she felt safe at home. She was also asked about her mother's new partner. It is appreciated that FV did not make any disclosures. This enquiry should be considered as good practice.

3.3.9 ZA had also seen the GP and out-of-hours services about her own healthcare concerns. She had presented with persistent gynaecological problems and an STI. It appears that ZA may have avoided direct personal contact with her GP. This was a missed opportunity for the GP to discuss ZA's sexual health and intimate partners. This would also have been an opportunity to discuss relationships and family dynamics in private. Sometimes, it is difficult for GP services to make the link between the health problems of two members of the same family, unless a patient's record is flagged. Had a link been made between ZA and FV then it may have been appropriate to discuss at a practice meeting.

3.3.10 It does not appear that the GU clinic took the opportunity to ask about domestic abuse. As there can be a high association between sexual abuse as part of domestic abuse, this could be considered as a missed opportunity.

3.3.11 The request by ZA for a termination of pregnancy was another lost opportunity for discussion of domestic issues. ZA informed her GP that she wanted a termination because her partner was not keen for her to continue with the pregnancy. Although she was originally referred to the Pregnancy Advisory Service, ZA saw her GP in person shortly after the request for termination. ZA had her daughter with her and no steps were taken to have a discussion in private. This lack of discussion was compounded when ZA visited the Pregnancy Advisory Service as the counsellor was on leave. It was established that domestic abuse was not routinely discussed with patients referred to the service.

3.4 Children's Social Care and Education

3.4.1 The school attendance records of all three children was not good. Steps were taken to provide supportive strategies for ZA's sons to improve attendance and there were no perceived underlying issues. FV was seen to have health concerns that kept her off school.

3.4.2 Whilst FV had previously been absent due to minor health issues, the school's concerns reduced when she had surgery at the start of 2013. While the school believed that FV's absence was justified through her appendix operation and slow recovery, health professionals were concerned that there was a psychosomatic element to FV's illness.

3.4.3 There should have been better liaison between the School Nurse and the school; a key area of communication was missing. Health Services and Children's Social Care made the link to the School Nurse but there appears to have been no communication between the School Nurse and the Attendance Officer. Communication at this stage would have alerted the Attendance Officer and allowed the concerns to be raised with ZA. This would have provided an opportunity for domestic abuse to be discussed.

3.5 What might have helped?

3.5.1 There are a number of policies in place within the police service which should have ensured that ZA and her family were kept safe. However, for policies to work, they need to be enforced, monitored and supervised.

3.5.2 In relation to healthcare and education, the issue of domestic abuse needs to be considered as routine enquiry.

3.5.3 Neither the MPS IMR nor the IPCC enquiry has established what happened to the civil court orders after they were served on the MPS. Electronic transfer of civil court orders directly to the Police National Computer (PNC) should be considered as this would have ensured that officers checking the PNC would have access to accurate information when dealing with calls to support victims who have lodged injunctions. This would remove part of the current process that can cause delay and increase risk to victims.

3.5.4 In police dealings with ZA, her medical welfare should have been considered as paramount. ZA had reported a rape that had occurred the previous day. The full details of that reported rape were not known and the medical treatment and gathering of forensic evidence should have been prioritised. The timeframe for the recovery of DNA evidence will vary based on the nature of penetration. A delay of four hours whilst waiting for the MPS could have hindered the gathering of evidence. It should be standard practice for an Early Evidence Kit (EEK) to be used by the initial investigating officers. This would have allowed the gathering of DNA from the mouth and urine samples. There should have been immediate steps taken to obtain the services of a SARC. This could have been within Hertfordshire or London. MPS instructions for the treatment of victims of rape state that health, wellbeing and welfare should take precedence over the investigative issues. In this case, it would have helped if ZA was taken to a SARC rather than being interviewed by the SOIT officers.

3.5.5 There were no reasons to interview ZA at the time in Hertfordshire and any interview should have been conducted under guidelines for interviews to achieve best evidence (ABE). It should also be considered that ZA would have been concerned about collecting her children from school and this would have resulted in additional pressure and stress. If police had focussed on victim care, all of ZA's medical issues could have been dealt with at the SARC. She would have been spoken with by an independent crisis worker, offered examination by a doctor and treated for any STIs. In addition to this, her termination could have been supported and managed forensically if required. In cases where pregnancy

is believed to have resulted from rape, SARC services are able to liaise with the medical team caring for the victim. The SARC then can work with the police to establish paternity through DNA analysis. The SARC also had an Asian Development Worker who would be able to discuss sexual violence and cultural issues that may have affected ZA.

3.5.6 At this point in time, there were locally commissioned IDVA services co-located within the Community Safety Unit at Newham. Referral to this service would have given ZA the opportunity for further specialist domestic violence and sexual violence support.

3.5.7 In considering the overall rape investigation, it would have helped if CRIS records had been reviewed by local commissioned domestic violence and sexual violence specialist. At the time of the report, East London Rape Crisis provided the locally commissioned ISVA service. The involvement of an 'independent eye' on retraction of rape would add an extra level of audit. In this case, the DI took on the role of investigator, supervisor and manager. It would also have helped if there was another level of supervision of the investigation.

3.5.8 In reviewing medical records, the CCG reviewer was of the opinion that the involvement of services for ZA and FV were far greater than would be expected. These were often for trivial problems. The contact was often by telephone and they were seen by a number of different professionals. There were opportunities when ZA could have been asked about her relationship and the issue of domestic abuse.

3.5.9 A key opportunity for discussion around domestic abuse arose when ZA was being treated for a sexually transmitted infection and her planned termination. A consultation could have considered ZA's relationships and intimate partners and also talked about domestic abuse. The issue of intimate relationships and domestic abuse needs to become routine enquiry within general practice and in particular when STIs and unwanted pregnancies are discussed.

3.6 Good practice

3.6.1 This review has identified some areas of good practice.

3.6.2 In reviewing the current practice of police forces it was established that Essex Police conduct a new risk assessment on retraction of reported domestic abuse.

3.6.3 The Hertfordshire Police routinely use body worn video cameras which, in this case, provided valuable evidence of ZA's complaint of rape. Whilst this practice is good, it is only useful when the video recordings are then reviewed by investigators.

3.6.4 The CAMHS appointments were focused on the safety of FV as well as her health. She was asked if she felt safe at home. The routine consideration of the possibility of abusive relationships should be encouraged.

3.6.5 In dealing with FV's recovery after surgery, hospital staff were considerate of the possibilities of psychosomatic symptoms. They carried out a full assessment and made an appropriate referral to paediatrics and CAMHS to follow up concerns.

4. Conclusions and Recommendations

4.1 Preventability

4.1.1 In this case it should be remembered that only one person, WX, is responsible for taking the life of ZA. However, in this review it is the opinion of the panel that adherence to procedures and communication between agencies, in particular the police services, may well have prevented the death of ZA.

4.1.2 This review has highlighted some occasions when ZA and her children came into contact with statutory Health services and the possibility of domestic abuse could have been raised. There was a concern that ZA's daughter was experiencing bullying; it was not disclosed where that bullying was taking place. It is likely that the view was taken that the bullying was a school problem and not related to domestic abuse. At the time, there were concerns about the emotional causes of FV's problems as her school absences were increasing. The school mistakenly felt that the amount of time spent at hospital justified these absences because of the initial presentation of a surgical problem. CAMHS and CSC communicated concerns to the School Nurse but these do not appear to have been passed on to the Attendance Officer.

4.1.3 There should have been a co-ordinated multi-disciplinary response to FV's care including CAMHS, Acute Paediatrics and Education. Whilst it may not have ultimately revealed the existence of domestic abuse it would have been a valuable opportunity to share information and protect the family. This process may then have revealed the role of WX and caused questions to be asked about his identity and role within the family. It should be noted that WX was providing consent for health procedures and school absences without any legal authority – this was unchecked.

4.1.4 Better communication between health and education (School Nurse and Attendance Officer) may have revealed the nature of the domestic relationship. A multi-disciplinary approach when ZA was experiencing medical problems would have shown that WX had been abusive in two previous relationships. This would have been before ZA informed her solicitor of the abusive relationship.

4.1.5 The main concern is the failure of the police service to deal with processing and administration in relation to the service of court orders and reports of domestic and sexual violence.

4.1.6 The IPCC investigation has focused on the failings of individual police officers. It would be simple to focus on the officers and state that they did not follow policies and procedures. However, an organisation cannot create policies around domestic abuse and simply rely upon the policy to protect. An organisation must establish processes to audit and monitor supervision and compliance with those policies to ensure that they take effect. In this case, ZA informed the police that she was experiencing domestic abuse on three occasions and she was not protected. There was a lack of adherence to policy at several points of contact with the police. The correct supervision of policies, intelligence checks and communication with statutory partners at any point of police contact could have synthesised information and led to a different outcome for ZA.

4.1.7 Over a period of ten days, the following took place: ZA's solicitor served a copy of a non-molestation order and a non-occupancy orders on her local police; ZA

reported abduction, rape and breaches of the orders; and ZA reported a second breach of the orders. Despite this contact with police, no action was taken to protect ZA and her children, or to bring WX before the courts.

4.1.8 ZA presented to the police in a traumatised state, still pregnant from a failed termination, reporting a recent rape and was not given any medical care or referred appropriately. She provided written evidence of the trauma suffered by her daughter, FV, and told the police that she was seeking refuge with her children, yet this did not result in notification to Children's Social Care. The supervisory processes of the police did not identify these failings. This case demonstrates a complete police systems failure in providing protection for ZA and her family.

4.1.9 In dealing with serious sexual violence between intimate partners, there needs to be an understanding that victims need the highest level of service and support. Unless police use all available measures to secure a victim's safety, a perpetrator can use their controlling influence to deter a victim from engaging with police. This requires involvement in a full coordinated community partnership response to provide effective support. This will also allow prosecuting authorities to gather evidence from all available bodies and widen the options for criminal justice outcomes. In this case, the use of civil orders (already obtained by the victim) would have provided protection and supported a full and thorough response to ZA's needs.

4.1.10 The police service has dedicated resources to dealing with domestic abuse and serious sexual offences. The Community Safety Unit sits within the Borough structure with established links to IDVAs, local support services and local authorities. The Sapphire teams sit outside that structure. It appears that some of the most serious sexual abuse investigations are not structurally linked to the essential community based services. In order to overcome this, there needs to be established joint working practice on all serious sexual offences between intimate partners. Sapphire teams need to work with police experts on domestic abuse and their established local support services. This cannot be through a 'tick box' or flagging process; domestic abuse specialists need to demonstrate an active role in the investigation.

4.1.11 It is noteworthy that, when the police came to ZA's house on 7th July 2013 her young children stood up to WX. They had originally made the call that brought police to the home and then, when WX tried to send the police away, they challenged him. The importance of that intervention by the children cannot be overemphasised. Given the danger represented by WX, it is not unreasonable to suggest that the call to the police may have saved the lives of the three children who were the witnesses in the house where their mother lay dying. It was important that at that time that they received a response from the police, that the response was appropriate, and that they were believed.

4.2 Recommendations

4.2.1 The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations that mirror these. It is suggested that the single agency action plans should be subject of review via the action plan, hence the first recommendation.

4.2.2 Recommendation 1: That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.

4.2.3 Recommendation 2: That the London Borough of Newham and Newham CCG should ensure that all Schools, GPs, Sexual Health Services, gynaecology services and Pregnancy Advisory Services are routinely enquiring about domestic violence and sexual violence and are aware of clear pathways for referral to domestic abuse support services and MARAC. This should be monitored by regular audit and reporting performance on MARAC and Domestic and Sexual Violence referrals to the Domestic and Sexual Violence Board.

4.2.4 Recommendation 3: That the London Borough of Newham, Newham CCG and Education provide publicity and information leaflets for public facing health services on domestic abuse. Priority should be given to encouraging family and friends to make third party referrals and to emphasising that no religion accepts domestic violence.

4.2.5 Recommendation 4: That the London Borough of Newham and the MPS conduct a review of the MPS Sapphire Team involvement in the MARAC process.

4.2.6 Recommendation 5: That the MPS Sapphire Team considers processes that will actively involve Borough Community Safety Teams in the investigation of serious sexual violence between intimate partners.

4.2.7 Recommendation 6: That the MPS implement processes that will monitor, supervise and audit the quality of investigations of serious sexual violence offences between intimate partners. These processes should include a level of independence from the police service and a link to community based domestic abuse services.

4.2.8 Recommendation 7: That the MPS implement training for all staff to ensure awareness and understanding of civil orders in domestic abuse cases and the police service role. A system should be developed to ensure that, when police become aware of a civil order, there is a process of receipt, a generation of a new specified investigation (treated like a new allegation/incident), an instigation of contact with a victim, and a referral to IDVA services locally, as well as consideration of a MARAC referral.

4.2.9 Recommendation 8: That the Home Office work with the Ministry of Justice to implement a system whereby Non-Molestation Orders and Non-Occupancy Orders can be input directly to the Police National Computer.

Appendix 1: Domestic Homicide Review Terms of Reference for ZA

This Domestic Homicide Review is being completed to consider agency involvement with ZA and her partner WX, following her death on 07.07.2013. 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 (DHRs) 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 ZA and WX and their children during the relevant period of time: 01.01.2011 – 07.07.2013.

3. To summarise agency involvement prior to July 2013.

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. To commission a suitably experienced and independent person 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.
e. Produce the Action Plan, along with agreement from all Panel members.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Newham CDP.

Membership

9. The following agencies are to be involved:
   a. Aanchal Women's Aid – Chair of DV Forum
   b. East London Foundation Trust (ELFT) – Mental Health Services
   c. Essex Police
   d. Hertfordshire Police
   e. London Borough of Newham Domestic and Sexual Violence Commissioner
   f. London Borough of Newham – Children's Social Care
   g. London Borough of Newham Safeguarding Adults
   h. London Borough of Newham – Strategic Commissioner for Mental Health
   i. London Community Rehabilitation Company
   j. London Probation Trust Newham
   k. Metropolitan Police Service (MPS) – Critical Incident Advisory Team (CIAT)
   l. Metropolitan Police Service Newham Borough
   m. Newham Action Against Domestic Violence (NAADV)
   n. Newham Clinical Commissioning Group (NCCG)
   o. NHS England
   p. Standing Together Against Domestic Violence (Independent Chair and minutes)

10. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the Chair will liaise with and, if appropriate, ask the organisation to join the panel.

11. If there are other investigations or inquests into the death, the panel will agree to either:
    a. Run the review in parallel to the other investigations, or
    b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

12. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secures all relative records.

13. Each agency must provide a chronology of their involvement with ZA and WX during the relevant time period.

14. Each agency is to prepare an Individual Management Review (IMR), which:
    a. Sets out the facts of their involvement with ZA and/or WX;
    b. Critically analyses the service they provide 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.

15. 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 ZA or WX in contact with their agency.

Analysis of findings

16. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a. Analyse the communication, procedures and discussions, which took place 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.

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

17. Sensitively involve the family of ZA in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The

Chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer. This may include interviews with family members.

18. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

19. The Chair will establish a clear action plan from individual management reviews. It will be the responsibility of agencies to ensure implementation as a consequence of any recommendations.

20. The action plan will be incorporated into the Newham Domestic and Sexual Violence Strategic Board action plan, to ensure consistency in implementation and monitoring.

Media handling

21. Any enquiries from the media and family should be forwarded to Newham Communications Team. Panel members are asked not to comment if requested.

22. The CDRP is responsible for the final publication of the report.

Confidentiality

23. 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.

24. 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.

25. 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 can be password protected.

Appendix 2: Members of the Panel

Agency represented	Panel members
Aanchal Women's Aid – Chair of DV Forum	Su Bhuhi
East London Foundation Trust (ELFT) – Mental Health Services	Paul James Dr Cathie O'Driscoll John Babalola Jonathan Warren
Essex Police	DI Tracey Martinez
Hertfordshire Police	Alan Postawa Ruth Dodsworth
London Borough of Newham Domestic and Sexual Violence Commissioner	Allison Buchanan Kelly Simmons
London Borough of Newham – Children's Social Care	Jana Reiter Michael Mackay Vivien Lines
London Borough of Newham Safeguarding Adults	Mandy Oliver Tony Pape
London Borough of Newham – Strategic Commissioner for Mental Health	Susan Miller
London Community Rehabilitation Company	Ursula Scheepers
London Probation Trust Newham	Carina Heckroodt Donna Charles-Vincent
Metropolitan Police Service (MPS) – Critical Incident Advisory Team (CIAT)	DS Angie Barton Jack Spratt DI Paul Gardner DS Pam Chisholm
Metropolitan Police Service Newham Borough	DCI Dave Rock John Roch Peter Hopkinson
Newham Action Against Domestic Violence (NAADV)	Jane Ishmael
Newham Clinical Commissioning Group (NCCG)	Anne Morgan Pat Hobson

	Reagender King Roger Cornish
NHS England	Angela Middleton
Standing Together Against Domestic Violence (Independent Chair and minutes)	Mark Yexley

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Kelly Simmons
Domestic & Sexual Violence Commissioner
Strategic Commissioning & Community
London Borough of Newham
Newham Dockside
1000 Dockside Road
London
E16 2QU

15 July 2016

Dear Ms Simmons,

Thank you for submitting the Domestic Homicide Review report for Newham (ZA) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA 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 an honest review with good understanding of domestic abuse and a sensitive appreciation of the victim's position. The Panel also commended the breadth and expertise of the review panel.

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:

- It would be helpful if the independence of chair could be clarified and whether he personally met with the friends and work colleagues of the victim or relied on the use of police statements;
- It was felt that the executive summary would benefit from more clarity on the timescales for implementing the recommendations;
- The Panel suggested that a number of additional recommendations should be considered on:
  - police monitoring of serial perpetrators;
  - the lack of a referral to social care by the children's school;

- identifying sexually transmitted infections and planned terminations as a risk factor in domestic abuse;
- raising awareness of domestic abuse amongst employers and how to respond to disclosures.

- Please proof read to check for spelling and grammatical errors.

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 also 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 Mayor's Office for Policing and Crime for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Appendix 4: Response to Home Office Quality Assurance Panel

Domestic Homicide Review Newham (ZA)

12 September 2016.

Chair of Newham Community Safety Partnership (CSP),

This report is completed for the information of the Newham CSP as a result of a letter received from the Home Office Quality Assurance Panel dated 15 July 2015. The panel considered the Domestic Homicide Review (DHR) on the death of ZA.

The Home Office Quality Assurance Panel approved the DHR overview report, subject to some amendments. The panel also suggested that Newham CSP consider a number of additional recommendations before the report is published. This addendum letter to the original report will consider those recommendations and will make reference to the DHR meeting process and the work of the original panel. The CSP did not seek to reconvene the panel in order to consider the matter further. This report is authored by the chair of the DHR.

The Home Office suggested recommendations are considered in turn.

1. **Police monitoring of serial perpetrators**

In the case of ZA the perpetrator came to the attention of three different police areas: - Essex, Metropolitan and Hertfordshire. Across these areas the perpetrator was involved in repeated reports of domestic abuse. He had been subject to criminal proceedings for domestic abuse, although he was acquitted on appeal. At the time of the homicide the perpetrator was subject to civil orders as a result of his abusive behaviour towards his wife.

Consideration was given as to whether a Borough could have implemented intelligence and enforcement options against a serial perpetrator of abuse. In this case the police have made recommendations at a local level regarding the recording of intelligence. The main issue of this case is the need to consider intelligence across police borders. The analysis of intelligence within a single police borough is not sufficient and this requires a strategic view of the movements of perpetrators across police area boundaries.

The overarching authority over the individual police areas in England and Wales lies with the Home Office. The issue of the actions of domestic violence perpetrators across police areas has already been subject to independent review and resulted in a report to the Home Office by Paladin the National Stalking Advocacy Service in *Paladin Briefing for the Home Office Consultation on Orders for Stalkers (Ref: BR02-16)* of 2016.

http://paladinservice.co.uk/wp-content/uploads/2016/01/Paladin-Briefing-for-Home-Office-on-Register-and-Orders-BR02-16.pdf

The Paladin briefing makes reference to a number of DHRs. A number of recommendations were made to the Home Office. These included monitoring serial offenders at an international level. One specific recommendation to the Home Office was that:

"The Government consider creating a register for serial stalkers and domestic violence perpetrators and incorporating it into the existing framework for sex offenders – ViSOR and MAPPA."

The resources for analysis of the serial perpetrator problem goes far beyond the remit of the Newham CSP. The Chair of this DHR considers that the Paladin report and recommendation to the Home Office more than adequately covers the suggested recommendation from the Home Office to Newham. The chair asks that the Newham CSP fully endorse the work of Paladin to the Home Office.

2. The lack of referral to social care by the children's school.

The representation on the ZA DHR panel for Children's Social Care and Education was provided as a single agency, through the Head of Children's Social Care. The review of the children's schools was undertaken by the Safeguarding Education Lead (SEL) at Newham, reporting to the panel through CSC. On 12 June 2014, the SEL made a number of recommendations to be undertaken within the education department at Newham:

"Senior Designated Leads are reminded again that management oversight of any direct work undertaken with children and their families is necessary in order that all aspects of concern are fully explored.

Senior Designated Leads are reminded again of the link between non-school attendance and safeguarding.

Schools are again encouraged to advertise the services available to parents and children by local and national organisations by the placing of leaflets and posters in strategic places around the school.

Head teachers and Senior Leaders are again advised about the need for operational staff who work in a pastoral capacity to record all conversations, and meetings undertaken with parents and pupils.

The advice contained with the new Statutory Guidance, Keeping Children Safe in Education, issued in April 2014, that particularly relates to the need for school staff to undertake an Early Help Assessment is once again brought to the attention of Head teachers and School Staff.

That the learning from this review is disseminated to all schools."

The report of the SEL was accepted by the DHR panel. All of the recommendations were internal recommendations and were to be actioned by the relevant department immediately. The Overview Report clearly states that all agencies report progress on their internal action plans to the relevant task and finish group of the Newham CSP. Further review of the internal recommendation would suggest that a more specific focused response is required. It is recommended:

Recommendation 9: That Newham Children's Social Care and Education Department conduct an audit on the compliance with policy of referrals between Education and CSC. The results of this audit should be reviewed and changes to policy and training implemented to complete the audit cycle, if required. Progress on this work will be reported to the Newham CSP and Safeguarding Board.

3. Identifying sexually transmitted infections and planned terminations as a risk factor in domestic abuse

In considering STIs, the diagnosis and treatment in STIs is not considered to be a risk factor in itself. When dealing with face to face discussions on sexual health there are opportunities for healthcare professionals to raise the issue of relationships. It may also be an opportunity for a patient to disclose abuse when speaking in a confidential environment. If a diagnosis of an STI is made then there may be potential risk of abuse if

a decision is made to disclose the finding to a current or previous sexual partner of the patient, through "Partner Notification."

When considering termination of pregnancy, it should be noted that the current DASH risk assessment does include pregnancy as a risk factor.

To record termination of pregnancy or STIs in a DASH risk assessment outside services routinely handling such confidential material could also increase risk for victims. Any DASH risk assessment can be subject to disclosure to defence in criminal proceedings. Even if material relating to termination or STI were redacted, it would be apparent that these confidential areas had been withheld from the defence. This could present a substantial breach of patient confidentiality and risk to the victim.

Recommendation 2 of the Overview Report clearly covers the risk arising at a local authority level:

"Recommendation 2: The London Borough of Newham and Newham CCG should ensure that all Schools, GPs, Sexual Health Services, gynaecology services and pregnancy advisory services are routinely enquiring about domestic violence and sexual violence and are aware of clear pathways for referral to domestic abuse support services and MARAC. This should be monitored by regular audit and reporting performance on MARAC and Domestic and Sexual Violence referrals to the Domestic and Sexual Violence Board."

If the CSP consider the Home Office suggestion that STIs and termination of pregnancy being a 'risk factor' is aimed at a higher strategic level, then that matter should be referred back to the Home Office. This can then be considered at a cross-government level with the Home Office, Department of Health and Public Health England.

4. Raising awareness of domestic abuse amongst employers and how to respond to disclosures

In this case the victim did not make any disclosures of domestic abuse to her employers. The employer's policy for dealing with domestic abuse was not subject to the terms of reference of the original review or IMRs. In considering the evidence that was gathered by this review the chair does not consider it appropriate to make specific further recommendation to Newham CSP concerning awareness raising amongst employers.

It is appreciated that in general terms that the role of the employer is not always considered in raising awareness of domestic abuse. Consideration of targeting employers in wider publicity may be appropriate for Newham to consider, but there are not sufficient grounds to make recommendations based on this review alone.

The employer in this case was an NHS GP practice. The matter of domestic abuse within NHS staff has been subject to review of publicity by NHS Employers in 2016. http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/protecting-staff-and-preventing-ill-health/taking-a-targeted-approach/domestic-violence

Mark Yexley
Independent Chair
Standing Together Against Domestic Violence

Appendix 5: 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 recommendation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation ?*	*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?*
1	That all agencies report progress on their internal action plans to the relevant task and finish group of Newham CSP.						
2	That the London Borough of Newham and Newham CCG should ensure that all Schools, GPs, Sexual Health Services, gynaecology services and Pregnancy Advisory Services are routinely enquiring about domestic						

	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
	violence and sexual violence and are aware of clear pathways for referral to domestic abuse support services and MARAC. This should be monitored by regular audit and reporting performance on MARAC and Domestic and Sexual Violence referrals to the Domestic and Sexual Violence Board.						
3	That the London Borough of Newham, Newham CCG and Education provide publicity and information leaflets for public facing health services on domestic abuse. Priority should be given to encouraging family and friends to make third party referrals and to emphasising that no religion accepts domestic violence.						
4	That the London Borough of Newham and the MPS conduct a review of the MPS Sapphire Team involvement in the MARAC process.						

	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
5	MPS Sapphire Team considers processes that will actively involve Borough Community Safety Teams in the investigation of serious sexual violence between intimate partners.						
6	That the MPS implement processes that will monitor, supervise and audit the quality of investigations of serious sexual violence offences between intimate partners. These processes should include a level of independence from the police service and a link to community based domestic abuse services.						
7	That the MPS implement training for all staff to ensure awareness and understanding of civil orders in domestic abuse cases and the police service role. A system should be developed to ensure that, when police become aware of a civil order, there is a process of receipt, a generation of a new specified						

	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
	investigation (treated like a new allegation/incident), an instigation of contact with a victim, and a referral to IDVA services locally, as well as consideration of a MARAC referral.						
8	That the Home Office work with the Ministry of Justice to implement a system whereby Non-Molestation Orders and Non-Occupancy Orders can be input directly to the Police National Computer.						