SAFER SANDWELL PARTNERSHIP

Executive Summary of

Overview Report

Domestic Homicide Review

Independent Author

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December 2014

Introduction

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

In July 2011 the perpetrator attended his local Police station stating that he had killed his girlfriend, the Victim. Officers attended the address to find the body of the Victim therein. She had been strangled.

A Police investigation commenced and the perpetrator was charged with the Victim's murder. He appeared before the Crown Court for a trial in June 2013, and he was convicted of murder and sentenced to Life imprisonment, with a recommendation that he served a minimum of 12 years. H.M. Coroner opened the inquest into the death of the Victim and subsequent to the criminal trial of the perpetrator; the Coroner recorded an unlawful killing verdict.

A Domestic Homicide review was commissioned by Safer Sandwell Partnership.

Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section a "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

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

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

In compliance with Home Office Guidance[2], West Midlands Police notified the circumstances of the death in writing to Sandwell Community Safety Partnership.

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

[2] Home Office Guidance Page 8

These reviews are known as Domestic Homicide Reviews.

The Domestic Homicide Review Panel

The Review was carried out by a Domestic Homicide Review Panel made up of representatives of the agencies who were involved delivering services to the family of THE VICTIM. It included Senior Officers of agencies that were involved. The professional designations of the Panel members were:

- A Detective Chief Inspector from West Midlands Police
- Head of Adult Safeguarding Quality Assurance, Community Directorate, Wolverhampton City Council
- Head of Sandwell Probation, Staffordshire and West Midlands Probation Trust
- Designated Nurse, Safeguarding Children, Head of Service, Sandwell PCT (now Sandwell and West Birmingham Clinical Commissioning Group
- Social Care Director Black Country Partnership Foundation Trust
- Community Safety and Domestic Violence Manager Sandwell MBC
- Safeguarding Adults Board Manager Sandwell MBC

The Panel Chair and the Overview Report Author was Mr Malcolm Ross, a retired Senior Detective from West Midlands Police who is independent of any agency involved in this case. He has many years' experience in conducting case reviews for Local Authorities all over the United Kingdom.

Purpose and Terms of Reference

The purpose of the review is defined in Home Office Guidance as:

- 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;

- 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

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

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

The generic questions are as follows:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators Domestic Abuse, Stalking and Harassment (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a Multi Agency Risk Assessment Conference (MARAC)?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols?

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

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

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

West Midlands Police

1. Do the circumstances of this case raise any concerns in respect of the current risk assessment framework for incidents of domestic abuse?

1.2 Was the Victim fully advised of options available to her and were appropriate referrals made to other organisations that could provide support?

1.3 Were there any specific barriers for the Victim reporting to the Police?

GP

1. Was the Victim fully advised of options available to her and were appropriate referrals made to other organisations that could provide support?

1.2 What are the care pathways for victims of domestic abuse in Wolverhampton and were they followed?

1.3 Was the GP aware of adult safeguarding responsibilities and were they followed?

UK Border Agency

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

The Haven, Wolverhampton

1. What is your role?
1.2 What provision do you have for different groups within the community?
1.3 How was the risk to the Victim assessed?
1.4 What happened in the initial contact?
1.5 Did you put any specific support or signposting in place?
1.6 Is there a link with Crisis Point? If so, please explain further.
1.7 What other information does the Haven have about this case?
1.8 What are the Haven's links to MARAC and Sexual Assault Referral Centre (SARC)?

Crisis Point

1. What is your role?
1.2 What provision do you have for different groups within the community?
1.3 How was the risk to the Victim assessed?
1.4 What happened in the initial contact?
1.5 Did you put any specific support or signposting in place?
1.6 Is there a link with the Haven, Wolverhampton? If so, please explain further.
1.7 What other information does Crisis Point have about this case?
1.8 What are the Crisis Point's links to Wolverhampton MARAC and the West Midlands Sexual Assault Referral Centre (SARC)?

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

Individual Management Reviews

The Panel requested the following agencies to carry out Individual Management Reviews of their agencies' involvement and produce Reports. The aim of reviews was to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, how those changes will be brought about.

The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out Individual Management Reviews and produce Reports (IMR reports)

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

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

- Wolverhampton Homes
- West Midlands Ambulance Service

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

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

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

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

Guidance[3] determines that the aim of an IMR is to:

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

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

[3] Home Office Guidance Page 17

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

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

Independent Overview Report

Government guidance requires that an Overview Report of the Domestic Homicide Review should be written by a person involved from an early stage with appropriate qualifications, knowledge and experience. The Overview Report brings together and analyses the findings of the various reports from agencies and others, and makes recommendations for future action.

As stated above, the author of the Overview Report for this Serious Case Review was Mr Malcolm Ross. He had no involvement directly or indirectly with any members of the family or the delivery or management of services by any of the agencies.

This document is a Summary of the Overview Report of the Domestic Homicide Review prepared by Mr Ross and accepted by the Safer Sandwell Partnership Board.

The Overview Report comments that the Domestic Homicide Review was conducted thoroughly and actively sought to identify lessons and actions to ensure that better outcomes for vulnerable people are more likely to occur as a result of this Review having been undertaken.

The individual agency reports contain recommendations that concern those agencies that are supported in the Overview Report.

A list of the Recommendations made in the Overview Report is set out at the end of this summary.

Family Involvement

Home Office Guidance[4] requires that:

"members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",

and:

"Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

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

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

Following the conviction of the perpetrator for the murder of the Victim, the report author, assisted by a panel member and an interpreter, again spoke to the Victim's

[4] Home Office Guidance page 15

father in India by telephone. The findings of the report were explained to the Victim's father as were the details of the recommendations made in the review report. The Victim's father expressed his disappointment regarding the sentence imposed on the perpetrator, saying he thought life should mean life imprisonment. He also stated that he thought his daughter should have been told about the services available to her in such circumstances. He appreciated that the systems in the UK were in need of improvement and hoped that if there was an improvement, such events would not happen to anyone else. He wished that the outcome could have been different. Her father stated that he and the rest of the family were aware of the arranged marriage of the victim to H1 and were in favour of that marriage. There is nothing to suggest that this marriage was a forced marriage.

Her father was also aware that her relationship with her husband H1 was at times strained but he said he had advised her that she needed to 'stick at it' and make the marriage work. He was unaware however, that his daughter had been to the police about her problems and wished that she had gone to her family for help. He agreed with the recommendations made regarding the UKBA, saying that he thought that parents in India also had a responsibility to find out more about intended partners of their daughters. He stated that he thought there should be facilities to be able to check intended partners both in India and here in the UK.

Whilst appreciating that the Victim's husband, H1 is a significant witness in the trial of the perpetrator, contact was made by letter explaining the process and expressing an intention to see him in the future after the criminal trial to seek any information that he feels will assist in the review process. Following the trial, two letters were sent to H1's current address. He replied to neither which caused considerable delay in the process. The author made telephone contact with H1, and after several attempts, spoke with him on 4th October 2013. The purpose of the review was explained to him and he was asked if he wanted to contribute any information. He explained that he did and arrangements were made to call him again on Monday 7th October 2013, when he knew where and what hours he would be working. On Monday 7th October 2013, the author again spoke to him. He appeared reluctant to speak and questioned why he was being contacted. He said that he had no idea until he and the Victim were married, that she had been married previously or that she

had a child back in India. He stated that that had caused problems in their relationship. He mentioned that he had 'spent a fortune' getting her to England and once she was settled she 'ran off with another man.' He appeared angry and reluctant to speak further. The author offered to ring again when he knew more details of where he would be working on Thursday 10th October, the only date he was available to speak for a longer period.

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

A month after his conviction, the perpetrator was written to at H.M. Prison explaining the review process and asking if he wished to be seen and contribute. His legal representative and the Prison Governor were also written to with copies of the letter sent to the perpetrator. On 5th August 2013, the Community Safety Partnership received a reply from the perpetrator stating that he had received the letter, the contents had been explained to him and he understood the meaning of the letter, but he declined to partake in the review process.

Summary of background

The Victim was born in India. She married but separated from her husband. There was one child of that marriage, who she has not seen since the leaving her husband. She returned home to her family for a short time, after which she married again in 2007 and came to England in 2009. She was unable to speak English.

Her second husband, H1, had been married before and had children from that relationship. It is known that there had been issues around domestic violence with that previous relationship resulting in court action. He had previously been subject to a Probation Order. There are no children from the relationship between H1 and the Victim. Living in Wolverhampton she was isolated from her family who remained in India.

H1 was a UK national and was 13 years older than the Victim. The Victim initially had problems getting a visa to travel to the UK. Her first application was refused on the basis that the spouse, H1, did not have the financial means to support her. She eventually appealed and her application was granted and she was given leave for an indefinite stay on 14th March 2011.

H1 was known to West Midlands Police through episodes of drunkenness and he was arrested on one occasion under the Section 136 Mental Health Act 1983, which gives Police power to detain someone who they deem to be in need of mental health treatment.

In February 2009 the Victim found employment as a seamstress. H1 was unemployed. The Victim registered with a local GP's practice in March 2009 and between then and June 2009 she had presented at the practice on 10 occasions, mainly for routine treatment.

On 13th June 2009, H1 reported to the hospital emergency department that he was depressed. He was treated and discharged. H1 made numerous applications for housing and on one occasion made an application in his own name saying he didn't intend to move in with anyone, notwithstanding that he was married to the Victim.

In November 2010, the Victim reported to her GP that she was being physically abused by H1 and that he had subjected her to a serious sexual assault. On this visit to her GP a friend interpreted for her. On another occasion the GP accepted a fellow patient to act as interpreter. The GP examined her for the physical assault only and failed to include the examination for the sexual assault. She told the GP that she had been thrown out of the family home and she was homeless. The GP advised her to contact the Police and made no referral to either the Police or Domestic Violence Support agencies.

The Victim returned to the practice in two days when she could speak to a GP who could speak her language, Punjabi. She returned and repeated her disclosure regarding physical assault, but did not mention the sexual assault. There had been

no communication between GPs and no record about her initial disclosure recorded by the first GP. The use of a friend to interpret especially regarding such sensitive issues was wholly incorrect.

The GP again told her to report the matters to the Police, but failed to ensure she had. There was no follow up action taken by the GP and no referral to the Multi Agency Risk Assessment Conference (MARAC), which is a local inter-agency forum designed to support those who are considered to be at high risk of harm

In December 2010 the Victim again reported to the GP of Domestic Abuse from H1 but the GP only re-assured her.

Another visit to her GP in March 2011 reporting of multiple aches and pains and feeling sleepy resulted in vitamin tablets being prescribed. No further investigation into her disclosure was made.

In April 2011 the Victim reported to the Police of another serious sexual assault committed by H1 two days earlier when he had been drunk. The Senior Detective decided that she was to be forensically examined and interviewed at a local Sexual Assault Referral Centre (SARC) which was in line with force policy and practice. A Forensic Medical Examiner carried out the examination, but he could only speak Urdu and there was no interpreter present during this process. Later a Punjabi interpreter assisted the Victim to make a short written statement.

The Victim was then returned to Wolverhampton to complete the interview process but there was a time delay of some 5 hours between her initial contact and the interview being completed. The Victim made a statement saying that she did not want to pursue the allegation so the Police referred her to an Independent Domestic Violence Advisor (IDVA) who contacted her the following day but was unable to communicate with her due to language problems. The next day a Punjabi speaking IDVA contacted the Victim but by this time the Victim had decided that she did not want to pursue the allegation. Taking into account her concerns of having to repeat the allegations, the cultural barriers, the expectation of her family telling her to ‘stick at the marriage’; these may have been the cause for her not disclosing at this time.

She expressed a wish that she wanted accommodation and she was advised to contact the local authority for housing. This may have been an indication that she wished to make a start to live a separate independent life, something that she had not experienced since she arrived in the UK.

The Police filed the report because the Victim 'declined to pursue the complaint'. She had been referred to two support organisations, albeit, the Police were unaware that the offer of assistance had not been taken any further.

H1's drinking continued through the summer of 2011. In May 2011, the victim again reported to her GP that she had been beaten by H1 and was staying with a friend. There is nothing to suggest that she was examined but was given pain killers and vitamin tablets.

The Victim knew a man from India, the perpetrator, and she had been seeing him. This was the friend she moved in with after she had left H1. They were initially living in Wolverhampton and then they moved to Sandwell. The perpetrator was unknown to any agency, but it transpires that he entered the UK illegally some time ago. The Victim moved in with him following her escape from an abusive relationship and whilst she would talk by telephone to her family in India and to her sister in Italy about H1 drinking causing problems, she did not mention her relationship with the perpetrator to anyone.

The new relationship with the perpetrator soon deteriorated within a few months due to possessive and violent behaviour by the perpetrator and eventually she decided to move again to live in Birmingham.

She was also friends with another man P2 who knew of her from India. She had met him in the West Midlands and there is a suggestion that he would give her a lift to work. She obviously confided in P2 and he offered to assist her to move away from the perpetrator, P1. Indeed he collected some of her belongings from the home of the perpetrator to take them to her new address, whilst the perpetrator was not present. This seems to have been the catalyst for the perpetrator to murder her soon afterwards.

During the course of the Review there are several issues that are worthy of mention.

H1's Alcohol Abuse

H1 had a significant alcohol addiction. He had been arrested on several occasions and received treatment both in Emergency Departments at the Hospital and from an addiction centre, but despite that he continued to drink. He was also treated by a psychiatrist but there is nothing to indicate that during these periods of treatment that he disclosed information on his violent behaviour towards his wife.

There were a number of occasions that H1 presented to either hospital or his GP with alcohol related injuries or illnesses. Each time his condition was dealt with in isolation and there was no reference to his previous presentations, therefore preventing a holistic overview of his alcohol problem.

The Victim's disclosures of abuse and sexual assaults

Mention has already been made of the number of times the Victim disclosed to her GP of physical and sexual assaults committed by H1. The GP did not adhere to Department of Health Guidance or local domestic abuse or safeguarding policies and procedures. The GP should have referred her to Domestic Abuse Services and given her adequate advice and support. In reality the GP did nothing other than prescribe pain killers and offer reassurance.

The acceptance of a friend and a fellow patient as an interpreter was wholly unacceptable and could have compromised the Victim's safety.

Once she had reported matters to the Police, which in itself took immense courage given her cultural background and beliefs, the Police did not investigate the allegation of sexual assault by H1 which was a breach of force policy regarding Serious Sexual Assaults. Irrespective that the Victim did not support the allegation probably for the reasons outlined above, the facts show that she did make a short statement to the Police so a full investigation should have been instigated. H1 was not arrested or interviewed about this offence. His details were not placed on any intelligence system indicating his propensity to commit this sort of offence, and no consideration was given to the risk involved with any future relationships he may be involved with. His history from his previous marriage shows a significant degree of domestic violence.

These are examples of a series of serious missed opportunities to help a very vulnerable woman who was seeking help.

SARC, Crisis Point and The Haven

The Victim's experience at the SARC must have been traumatic for her. She was examined by a Forensic Examiner who could not speak her language. There was no one present at the time of the examination to tell her what was happening and the consequences of the examination. She was then taken from there back to Wolverhampton to await a Specially Trained Officer to complete the interview process. Following that she did not pursue the matter. It is probably that she lost faith and patience in the whole process, after taking the steps to report H1 for these offences.

Following this she was referred to Crisis Point and The Haven for support. Neither of the organisations was initially equipped to deal with a Punjabi speaking woman, and by the time they had found a suitable person, the Victim did not go ahead any further with the report. Once Crisis Point and The Haven discovered the Police had filed the papers, they too followed in the same way.

There was a lack of information sharing between the three agencies involved with the victim, the Police, Crisis Point and the Haven. The Police did not pass on the Victim's last name so indexing her was done by her first name, resulting in cross referencing difficulties.

The Use of Interpreters

The Victim was a woman who was in need of the services of an interpreter. She had very little ability in the spoken English language and Punjabi was her first language, She found herself in the most difficult of situations where she was required to give detailed explanations of the most intimate events to a male GP, a male Police Officer initially and a male Forensic Medical Examiner without the assistance of an interpreter. In addition she had to go through the whole SARC process without understanding.

Placing the Victim in these circumstances as she passed through these processes involving different agencies, without being understood and supported to disclose her concerns is poor practice.

Risk Assessment and MARAC

On the report of the serious sexual assault, the Police completed the ACPO Domestic Abuse Stalking and Harassment Risk indicator with the Victim and the circumstances of the case. The result was that the risk was measured as 'High Risk'. This should have triggered a referral to MARAC, but did not. This is contrary to West Midlands Police's policy on dealing with high risk victims of crime. The focus of the multi- agency meeting is the victim and to ensure that a plan is put into place to protect the victim.

In a similar way, Crisis Point and The Haven and the GP could have referred the Victim to MARAC. There is a misconception that only the Police can refer to MARAC and a recommendation is made that deals with that issue. Any agency is at liberty and indeed expected to refer suitable cases to MARAC if the circumstances meet the criteria, which clearly this case did.

The Victim's case whilst she was with her husband was dealt with in isolation by each agency and a free flow of information was desperately required. By a referral to MARAC, that information exchange would have been possible and a multi-agency care plan established.

The Victim was reported missing to the Police by the perpetrator before her body was found. The missing persons report was initially graded as a 'medium risk', but as time went on and nothing had been heard of the Victim, more intelligence was obtained the risk was not re-visited by the Police. Had it been, the risk would have increased to High and a more high profile response would have been expected. Police Guidance states; 'The case should not be left for long periods of time without active investigation taking place'

Shortcomings with the police response to the Victim being reported missing have been fairly identified within the police IMR and recommendations made within the Police report.

Wolverhampton Domestic Violence Forum

Wolverhampton Domestic Violence Forum is a charity that has been in existence since 1997. It acts as a focus for information and advice on domestic violence. The aims of the charity are to encourage agencies to work together to stop domestic

violence, to ensure the safety and empowerment of victims and their children, and to bring perpetrators of domestic violence to justice.

Based on the criteria for referrals, the Domestic Violence Co-Located Multi-Agency Team should have received this case as a DV high risk victim referral. Opportunities were missed to refer this case to these risk assessment and safety planning meetings. It is not known whether the Victim would have engaged with an Independent DV Adviser, but it is considered that this was a further missed opportunity for a specialist to identify the true risks that the Victim was subjected to, to provide the Victim with options that were available to her including crisis intervention, access to refuge accommodation and support locally or further afield, and to put in place multi-agency safety plans and specialist support.

The Victim's relationship with the perpetrator

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

After a few months the new relationship failed and the Victim made further arrangements to leave the perpetrator and move into Birmingham with the assistance of P2. That was the catalyst for the perpetrator to take her life.

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

There is also concern that the Victim's acceptance into the UK was based on a financial threshold and without any consideration of a risk assessment of her safety in respect of potential domestic abuse given the history and antecedents of H1.

New Guidance and Procedures

Since this tragic event took place there have been new guidance and procedures implemented in two main areas that would have affected these circumstances.

West Midlands Police have reviewed the policy on measuring risk and undertaken to review the process of investigating offences even if the complainant has or wishes to withdraw any allegations made.

In respect of GPs, guidance from the Royal College of General Practitioners called ' Responding to Domestic Abuse – Guidance for General Practitioners dated June 2012, now mandates that each GP practice has a more proactive approach to identifying signs and symptoms of domestic abuse, having a much more robust connection with domestic violence support services, identifying a single point of contact within each surgery for responding to patients who are or who are likely to be victims of domestic abuse and finally, training for all medical and non-medical staff in each GP practice.

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

Both of these initiatives will go a long way to assist the identification of victims, followed by the support and correct investigations of these serious offences.

Conclusion

There were areas of the Victim's life that could have been supported more positively by agencies.

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

If agencies had acted appropriately towards this vulnerable Victim, and provided the appropriate support and assistance that was available she may have left H1 after gaining confidence that assistance was available to her. This is also the case with regard to any move from the perpetrator. The Victim did not get the support she warranted, which limited her choices and affected her decision making.

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

The Overview Report makes a total of 8 recommendations which have been accepted by the Safer Sandwell Partnership Board and are listed here. They are designed to remedy the issues found during the process of this review.

The individual agency reports contain recommendations that concern those agencies and these are supported by the Overview Report Author and the Safer Sandwell Partnership Board.

Addendum following Home Office feedback to DHR Report July 2014

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

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

The DHR panel who undertook this review affirms that the Action Plan addresses the issues raised in the report, and the recommendations have been fully implemented. Since the statutory responsibility to carry out domestic homicide reviews which came into force in April 2011 Sandwell has undertaken 4 domestic homicide reviews. The reviews have outlined a number of recommendations, common themes to the area and lessons learnt. A Domestic Homicide Review Standing Panel was established in December 2012 to oversee all of Sandwell's DHR cases and ensure that recommendations from DHRs are implemented and lessons learnt disseminated to partner agencies. The Standing Panel also ensures that a joined up approach is taken to identify common themes and lessons learnt. The DHR Standing Panel consists of statutory and voluntary organisations including: West Midlands Police, Community Rehabilitation Company, Health, Sandwell Women's Aid, Sandwell Metropolitan Borough Council Domestic Abuse Team, Adults Social Care and Safeguarding Team, and Children's Social Care. The DHR Standing Panel reports to the Domestic Abuse Strategic Partnership and Safer Sandwell Partnership Board. Two Learning Events have also taken place to disseminate the lessons learnt from DHRs and Serious Case Reviews. The events have been well attended with 200 people from various organisations including voluntary and statutory partner agency frontline officers and managers. Sandwell has also contributed to research undertaken by the University of Middlesex: - Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands DHRs.

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

Malcolm Ross M.Sc.

Independent Overview Author

July 2014

Recommendations

Recommendation No 1

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

Recommendation No 2

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

Recommendation No 3

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

Recommendation No 4

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

Recommendation No 5

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

Recommendation No 6

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

Recommendation No 7

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

Recommendation No 8

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