DOMESTIC HOMICIDE REVIEW

Overview Report and Summary

Report into the death of 'Mrs.Z'

Report produced by

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Independent Review Chair

The panel sends their condolences to the family of Mrs. 'Z'

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1. Introduction

1.1 This Domestic Homicide Review seeks to understand the circumstances surrounding the tragic death of 'Mrs Z' aged 27 years, who was the victim of a homicide on the 13th November 2012. Mr. Z, husband was found guilty of manslaughter on 31st May 2013. All those involved in this review wish to extend their sympathy to the family of Mrs Z. In order to protect the identity of those involved, the victim will be known as 'Mrs. Z', the husband as 'Mr. Z', and the children in the family as 'C1' and 'C2'.

1.2 This review has been conducted in accordance with statutory guidance under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on 13th April 2011. This report of a domestic homicide review examines agency responses and support given to Mrs. Z, a resident of Leicester prior to the point of her death on 13th November 2012. The review considers agencies contact/involvement with Mrs. Z and Mr. Z from April 2001-November 2012.

1.3 At 2.21 p.m. on Tuesday 13th November 2012 the Leicestershire Police received a 999 call reporting that a male had killed his wife. On arrival at the home 'Mrs. R' was found in the downstairs bathroom, having received fatal stab wounds and a murder investigation was commenced.

1.4 Later that day 'Mr. Z' walked into a police station in Reading accompanied by a relative and admitted to the killing of his wife. He was arrested, interviewed and charged with the murder of 'Mrs. Z'. He appeared at Leicester Magistrates Court on the 16th November 2012 and was remanded into custody.

1.5 The couple's two children 'C1' [male born 2010] and 'C2' [female born 2007] are now cared for by family members.

1.6 The Leicester Safeguarding Adults Board, who undertake domestic homicide reviews on behalf of the local Community Safety Partnership (known locally as the Safer Leicester Partnership), commissioned the review following the death of 'Mrs. Z'.

1.7 The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.8 This report document outlines the circumstances of the case, the findings of the review and an overview of the recommendations made by the domestic homicide review panel.

1.9 During the time period in which the review was conducted it became apparent that no agency involved with the family or directly with 'Mrs. Z' had any prior concerns that she may have been at risk of or subject to domestic abuse. 'Mrs. Z', together with members of her family had regular contact with a number of agencies in regards to routine matters and/or receiving services informed by that agencies function, role and responsibilities.

1.10 Known prior contact with the police by 'Mr. Z' and Mrs. Z', whilst not evidencing unequivocal information as to prior incidents of domestic abuse, will be specifically detailed in this report.

1.11 This 'Overview Report ' serves to:

- Summarise the key facts of the case and the sequence of events.

- Summarise the key facts, key decisions and whether any breeches or the absence of policy or procedures required by those agencies and professional who had prior contact with the victim and their family occurred.

- Whether any noted decisions or actions taken without adherence to those policies and procedures operational at the time, may have significantly influenced a change in the course of events that led to the death of 'Mrs. Z', had they been implemented.

- Identifies examples of good practice and notes if and what systems need to improve.

- Outlines in the conclusions if there are any lessons to be learnt from the review.

- Details both recommendations from individual agencies and from the Review Panel.

2 Criminal Proceedings:

2.1 Mr. Zs trial concluded in 2013 he was found guilty of manslaughter and sentenced to 4 years imprisonment, which was then cut down to 2 years as Mr Z pleaded guilty to manslaughter. Mr Z's defense team argued that Mr Z did not intend to murder his wife and that at the time of the stabbing he had diminished responsibility due to Adjustment Disorder.[1]

2.2 Sentencing, the Judge said :

"It's clear on the evidence you had a happy marriage and were a good, placid and kind husband. All that changed two months before you killed your wife and I accept the changes in your life caused you distress and reduced you to a state recognised by doctors in this case as an adjustment disorder."

3. Background Information:

3.1 **Mr Z** came to the UK from Afghanistan and settled in Leicester. Mr Z claimed asylum at the Dover Port in April 2001. In December 2001 he was granted exceptional leave to remain and in 2008 he was awarded British Citizenship. Mr Z had local employment as a taxi driver. He spoke both Farsi (Persian) and English.

3.2 **Mrs Z** In 2006 applied for entry to the UK on the basis that her husband lived in this country. A visa was granted for 2 years and she arrived later that year in the UK. In 2008 she applied for indefinite leave to remain, which was approved. The couple's children were born in Leicester [June 2007 and May 2010]. Mrs Z first language was Farsi (Persian); when she arrived in the UK she spoke only limited English, but was keen to improve her language skills and enrolled at Leicester College to study English. Mrs Z was the main carer for the couple's children.

3.3 The criminal trial heard that Mrs Z in the months before she died formed a relationship with another man, who she was in regular contact with by telephone. Mrs Z was reported to have approached a number of professionals and agencies enquiring about divorce proceedings. The family were trying to organise a home swop outside of the area, but heard on the day of the fatal incident they heard that this had fallen through.

[1] An adjustment disorder (AD) (sometimes called exogenous, reactive, or situational depression)[1] occurs when an individual is unable to adjust to or cope with a particular stressor, like a major life event. Since people with this disorder normally have symptoms that depressed people do, such as general loss of interest, feelings of hopelessness and crying, this disorder is sometimes known as situational depression.

4. Contact with family and 3rd parties.

4.1. In June 2013 a letter was sent to 'Mr. Z' for the purposes of seeking his participating in the review. The letter was also copied to the prison's Governor and translated into Farsi, this being 'Mr. Z's' first language.

4.2 Prior to this, 'Mr. Z's' solicitor was written to explaining the requirement for the review and in seeking their support in encouraging 'Mr. Z' to contribute and agree to a meeting with the review chair to be accompanied by an interpreter. The solicitor informed the review chair that they would be advising their client not to assist in the review.

4.3 In September 2013 the Review Chair was contacted by the children's social worker in Reading, to inform that social services were in the process of assessing the longer-term plans and options for permanency of the children's care. Proceedings were listed with the Family Court for a full hearing to be conducted later this year. [Revised listing February 2014]

4.4 With the additional pressures being placed upon the family members caring for the children, the review panel was requested not to seek direct contact with them prior to the Family Court hearing. It was agreed for the review chair to write to family members seeking their participation in the review, but to defer any meeting until the Family Court proceedings were concluded.

4.5 Letters in Farsi were sent to family members, accompanied by a form to return to indicate whether they would be supportive of participating in the review. Notification was also made to the Families Liaison Officer [Leicestershire Police] and the children's social worker in Reading who had existing rapport with the family.

4.6. To date the review panel has not received any reply or information directly or from any third party to indicate if family members would be supportive of a meeting in order to contribute to this review.

4.7 Consideration was given by the DHR review to contacting 3rd parties known to the family, although known contacts were limited. There were two tutors who knew Mrs Z from the years she attended Leicester College during 2008/09 to access courses to help improve her English language; they reported that there were no indications of any problems or issues within the marriage when Mrs Z attended the college. On occasions when Mrs Z visited housing offices, or when housing maintenance people attended the family home to carry out repairs; the workers have no recollection of the family. Health visitors and nursery nurses who visited the home, under normal child health programme contacts had no concerns.

5. Review process and timescales

5.1 This report outlines the process undertaken by the domestic homicide review panel in reviewing the murder of 'Mrs. Z'.

5.2 The Leicester Safeguarding Adults Board were notified of the incident by Leicestershire Police and completed a trawl exercise to understand which agencies were involved with the family prior to the point of death, findings from the trawl were gathered into a report and presented to the Adult Review and Learning Group who made a recommendation for a DHR to be commissioned, this was subsequently agreed on the 28th December 2012 by the chairs of the Leicester Safeguarding Adults Board and Community Safety Partnership (locally known as Safer Leicester Partnership).

5.3 During the trawling exercise, it was noted that 'Mr. Z' first moved to the UK in April 2001, therefore the review panel agreed this would be the timescale in which the review would begin.

5.4 The LSAB commissioned an Independent Author and Chair to lead the Domestic Homicide Review. Robert Nisbet has the following qualifications Ba (hons) sociology, post-graduate diploma social work, diploma in criminology, CQSW, Diploma Mental Health, MA film studies. Registered Social Worker qualified in 1979. Robert has varied professional experience and held posts in child protection, learning disabilities and for the past 20 years in mental health services. Formally worked for Department of Health East Midlands and worked as Lead for MCA & Deprivation of Liberty Safeguards and Community Offender programmes. Robert has worked for East Midlands Adult Safeguarding Board.

5.5 The Independent Chair and Author was supported in the DHR by a panel who met on 3 separate occasions to agree the terms of reference; review the reports from agencies and to review the overview report. The panel members were selected to bring a range of expertise and perspectives relevant to the circumstances of the review. In appointing to the panel, the Chair ensured there was no conflict of interest and that the panel members did not have direct line management responsibilities for workers who had been involved with Mrs Z or Mr. Z.

DHR Panel Members
Independent Panel Chair
Leicester Safeguarding Adult board Manager
Head of Adult Safeguarding Leicester City CCG
Detective Inspector Leicestershire Constabulary
Head of Service, Community Safety Leicester City Council
Domestic Violence Support Services – SAFE
Head of Service, Leicester City Council Housing
Service Manager, Leicester City Children's Services

5.6 The review of 'Mrs. Z's' homicide began with a panel meeting on the 6th February 2013. Following a request from the Leicestershire Police and advised to the Home Office, the decision was made by the review panel to suspend the review from February 2013 until criminal proceedings, including the trial of 'Mr. Z', were completed.

5.7 Mr.Z's' trial was concluded on the 24th May 2013 and he was found guilty of manslaughter and sentenced to 4 years imprisonment.

5.8 Post the trial the review panel reconvened and met on two further occasions.

5.9 The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

- University Hospitals Leicester – Accident and Emergency Department and Community Midwifery
- Leicestershire Partnership Trust - Health Visiting Services
- Leicestershire Police
- Leicester City Councils Housing Department,
- General Practitioner/Health Centre [Family Registered with], and
- Leicester College.

5.10 Other Agencies/Departments gave information to the narrative chronology but given their limited involvement/non-involvement the panel agreed there was no need for an individual management review.

- Leicester City Council - Safer Communities Department – No involvement but in attendance to provide specialist input into the panel.
- Leicester City Council - Child Social Care and Safeguarding – No involvement with family but in attendance to assist with providing 'the voice of the children'.
- United Kingdom Border Agency - Home Office [To establish dates of arrival of family members]
- Safe Project – Leicester City – No involvement but in attendance to provide specialist domestic violence knowledge.
- Leicester Urgent Care Centre – Leicester. Primary healthcare out of GP hour's service. Their contact indicates no concerns/information identified regarding care or safety of the children or of 'Mrs. R' being at risk or subject to domestic abuse.
- The Children's School –Involved with family in regards to the children's education – No concerns/information identified regarding care or safety of the children or of 'Mrs. R' being at risk or subject to domestic abuse.
- Hospitals on the periphery of Leicester/Leicestershire where residents of Leicester City/Leicestershire may access. No contacts identified.

5.11 In addition 17 other agencies were contacted as part of the initial scope. Fifteen 'nil contact' returns were received, with 2 'no returns'.

5.12 Leicester Safeguarding Adults Board Office provided the administration and coordination support for this review.

5.13 The findings of DHRs are confidential in nature. Information released to the panel for the purpose of the DHR is available only to participating officers/ professional and their line managers (agencies mentioned above). The panel will release material created for the purposes of the panel with the expressed permission of contributing agencies to the police information governance lead and the coroner should this be requested.

5.14 Upon finalising this overview report copies were circulated to, members of the panel and contributing IMR authors, members of the Leicester Safeguarding Adults Board's Adult Review and Learning Group, along with the chair of the LSAB and the chair of the Community Safety Partnership.

6. Involvement of local agencies:

6.1 **Police IMR:** Paragraph 1.10 of this report advised**:** 'Known prior contact with the police by 'Mr. and Mrs. R', whilst not evidencing unequivocal information as to prior incidents of domestic abuse, will be specifically detailed in this report'.

6.2 For the purposes of clarifying this statement it is important to summarise the relevant information contained in the Police's IMR submitted to the review panel. This information was discussed further by review members at their meeting of the 3rd June 2013 and attended by the police as members of the review panel.

6.3 Assumptions might be made that an incident attended by the police on 11th July 2011 could be considered a 'missed opportunity' for intervention and of signifying that 'Mrs. R' may have been subjected to domestic abuse from her husband some 14 months prior to her death.

6.4 Further that if a closer investigation and follow up had been carried out with 'due diligence' 'Mrs. R' may have been identified at a much earlier point of time of being at risk of domestic abuse from her husband.

6.5 In summary the relevant facts of the 999 call believed to have been made by 'Mrs. R' on the 11th July 2011 from the family's home address in Leicester are as follows:

- A 999 call was received from a distressed female Leicestershire Police at 8:52pm on Monday 11th July 2011.
- The caller who was crying and mentioned her husband was in the house; she then put the phone down.
- An intelligence search identified an owner living at an address in Leicester [the family home], there was no history relating to this address and the name 'R' [Family surname].
- There was an attempt to contact the caller again.
- The incident was given a priority requiring attendance and arrival within 60 minutes. At 10:16pm it was noted that there were 22 queued incidents and all officers were committed to other incidents.
- Officers were dispatched to the address at 00:09am Tuesday 12th July 2011. At 00:43am the attending officer updated the incident stating there was no answer at the door and the flat was in darkness.
- A call taker tried calling the mobile phone but it went through to voicemail again. At 00:57am on the Tuesday 12th July 2011 the incident was reviewed by the Force Control Room team leader and deferred until morning.
- At 8:26am on the 12th July 2011 the incident was updated. The male at the address told an officer who attended the location that his wife wanted the ambulance service 'as their 3 year old daughter had fallen off the bed and needed treatment'. The attending officer accepted this explanation and the incident closed.
- There were no other issues and the incident was recorded as an abandoned call and closed.

6.6 The writer of the police's IMR interviewed the officer who had attended the incident. The officer "had no recollection of the incident or any further details written as a pocket note book entry".

6.7 In reviewing the information detailed in the IMR the following observations and comments are made by the police in relation to the seriousness and priority that domestic abuse is considered by the Leicestershire police coupled with the systems, resources and procedures now in place to respond effectively and as part of a multi- agency approach.

- In respect of domestic abuse, there is a policy document in existence that is regularly

updated. The policy states that 'Leicestershire Police will take positive action to protect the victim and any children present from further harm when domestic abuse occurs'.

- With regard to the actions of a call taker they; "Assign a resource to all abandoned 999 calls where domestic abuse is suspected (i.e. due to what is overheard and relevant history etc.). Every effort must be made to re-contact the caller before assigning a resource in order that critical information is obtained and an assessment of any risk to officers is made"

- Action, which the review notes, that the call handler reacted appropriately and in accordance with the required force policies and procedures.

- In 2010 the 'domestic abuse, safeguarding adults, honor based violence and forced marriage (DASH) check list commenced as the single domestic abuse risk assessment model officially superseding the SPECSS model; all officers in the Leicestershire Constabulary have undertaken mandatory training in using this procedure[2]**.**

- The Leicestershire Police Strategic Policing Plan 2010 – 2013 states 'Tackling violent crime in our communities continues to be a key priority for the Constabulary'.

- "Domestic Abuse Investigation Officers (DAIO) are trained detective constables now offering a force response and managed by a Detective Inspector and two Detective Sergeants, their expertise in the field of domestic abuse is used to improve services and work more directly with first response officers and provide a direct link to Multi Agency Public Protection Arrangements and Multi Agency Risk Assessment Conferences (MARAC)".

- "The implementation of a 'Comprehensive Referral Desk' (CRD) brings together the Child Abuse Referral Desk, Adult Referral and Co-ordination Team, MARAC coordinators, Child Protection Case Conference coordinators, Child Sexual Exploitation coordinators and Domestic Abuse Referral Officers (DARO). The aim of the unit is to "protect the lives of the vulnerable and those exposed to domestic and child abuse by the effective co-ordination of multi-agency resources to risk'. The purpose of bringing together this safeguarding specialism is to more readily and efficiently identify risk to the most vulnerable and share information with partner agencies more effectively".

- In September 2012, to further support protecting the lives of the vulnerable and reduce repeat victimisation, Contact Management issued a briefing guide 'Identifying and Managing Vulnerability' throughout the 'journey' of an incident'. This provided a new structured call taking approach based upon the National Decision Making Model and is used across all police forces in the UK.

- Procedures and Requirements in cases where there is a known/or indications of the potential for 'repeat incidents of domestic abuse:

    - Repeat offences at locations will be flagged to LPUs daily on the third occasion within a year
    - Repeat offences where it is the fifth occasion in a year will be reviewed by a DAIU Supervisor
    - If it is a high-risk case after being reviewed by an Enhanced DASH Risk Assessor the DAIU Dept. will own it.

[2] **DASH - Domestic Abuse, Safeguarding adults, Honor based violence and forced marriage** - is an evidence based risk identification and assessment model designed specifically to identify risk to an adult victim of domestic abuse and improve decision making increasing the likelihood of a victim being responded to appropriately and therefore correctly addressing the risks faced.

- The DAIU team is here to manage high risk perpetrators and to support LPUs in tackling domestic abuse

- Safer Neighbourhood Teams and partners should work together to tackle serial domestic violence perpetrators and protect victims of multiple offences/incidents.

- If you suspect (HBV) honor based violence or (FM) forced marriage then you must contact the DAIU

6.8 In reviewing the incident notified to the police on the 11th July 2011 it is noted:

- There is no substantiated evidence as to identity of the caller.

- We do not know the specific reason why the caller was distressed.

- There had been no intelligence of previous concerns at this address notified to the police.

- Had the police been aware that the family had moved from a previous address in Leicester they would have the intelligence of an incident in which 'Mr. R' was wounded during an altercation with a 'relative' on the 24th April 2008. The risk assessment focused on the assault between 'Mr. R' and the 'relative was appropriate and completed in accordance with the SPECSS assessment tool[3] however the assault between 'Mr. R' and 'Mrs. R' was not recognised'.

- The statements made to the police at the time both record that 'Mr. R' 'pushed his wife in the face with his hand' and that this took place in front of their daughter who was crying.

- There was a further disclosure that 'Mr. R' would 'get angry' in the home and described how he would leave the home to calm down.

- There are also noted contradictions in relation to how the statements tally with the police officers records.[4]

- A number of different spellings are associated with the family's surname.

6.9 In undertaking the IMR the Leicestershire police have stated: "In reviewing this decision more could have been done to satisfy or support the explanation being given to the officer, the ambulance service could have been contacted for example to establish if there was a call made to them or whether the family had taken their child to hospital for treatment. Conversely the fact that the house was in darkness and there had been no reply to knocking on the door when officers attended in the early hours could also lend support to what was being said. As referred to earlier the family had moved from [address1] to [listed current address] meaning no direct link to the intelligence held at [address1]. However, had that link been there then it would have related to the wounding incident between 'Mr. Z' and a ['relative'] four years earlier but would not have indicated any domestic abuse issues between 'Mr. Z' and 'Mrs. Z' [the deceased].

[3] **SPECSS Assessment Tool** - **S**eparation, **P**regnancy, **E**scalation, **C**ultural issues, **S**talking, **S**exual assault) Designed to enhance prevention work by frontline police officers;

[4] **Leicestershire Police IMR Report for DHR Dated 08/04/2013 provided to the DHR Panel 03/06/13**: *Whilst statements clearly record that 'Mr.Z' 'pushed' 'Mrs.Z' in the face whether the term is misinterpreted through translation is not clear as it could mean hit or slap however the action would amount to an assault and that should have been acted on in a positive manner. There are however opposing indicators. The officer dealing with 'Mrs.Z' at the hospital recorded in his pocket note book 'Y' and 'R' - a peaceful relationship', his recollection for writing this was in response to what she had told him whilst at the hospital and, in the closing paragraph of 'Mr.Z's' statement, it is recorded that 'he has a good relationship with his wife and she does with him'.*

7. Conclusions and recommendations from the review:

7.1. The review panel finds that no agency or person failed to comply with the required protocols and procedures regarding having relevant knowledge of previous risk. Such that may have subsequently contributed to the prevention of 'Mrs. 'Z's' death, committed by her husband at their home in Leicester on the 13th November 2012.

7.2. The review panel could only establish unsubstantiated information from the police's previous contact with the family as to a possibility that her husband may have subjected 'Mrs. Z' to domestic abuse.

7.3. There is no information from any other service or source contacted as part of the review to inform of a previous history of incidents or concerns relating to 'Mrs. Z' as being subjected to domestic abuse from her husband.

7.4. The review has made every effort within its authority and means to seek contact with the perpetrator, victim's close family members and 3rd parties. The perpetrator and family have not indicated that they wish for 'their voice' to be included in the review.

7.5. The panel notes the necessity of engaging with people who are 'newly arrived' to the city of Leicester for many reasons including study, economic migration, to seek asylum or other personal or professional matters. The panel referenced the need to ensure domestic violence services are promoting their services in a way which will reach out to everyone. The SAFE project in Leicester have recently translated their literature into Farsi as part of this review which was, previously not available and plan to create literature in a variety of other languages as a learning point from this review.

7.6. The SAFE Project and the police in September 2013 launched a joint campaign to raise awareness of domestic violence services available in Leicester with the aim of providing a coordinated response to domestic abuse so that agencies can offer the best support available to victims and families.

7.7. There has been no evidence of previously known and substantiated incidents of domestic abuse such as to require or recommend action(s) that an agency or agencies should take to improve practice, systems and interagency working.

7.8. All agencies working in partnership are mindful of their continued responsibility to quality assure their services to ensure that they are robust and functional in the prevention and management of domestic abuse.

7.9. In addition it is important to note that a community's population and ethnography can change overtime and in some circumstances quite rapidly. This requires for commissioners and providers of services to ensure that changing needs are actively considered and responded to.

8 Key findings

8.1 The review panel could only establish from unconfirmed reports in the police's IMR of the possibility, but not substantiated, that the incidents requiring the police to attend at the home of 'Mr. Z and Mrs. Z' may have been of domestic abuse.

8.2 No prior risk indicators of actual or potential for domestic abuse had been notified to those agencies that had regular contact with 'Mrs. Z', her children or other family members.

8.3 Simply, nothing was known or identified to those agencies as such to require:

- 'Mrs. Z' being directly approached and/or enquiries made as to whether she was experiencing or had experienced domestic abuse, or

- Information/concerns/observations from services in direct contact with 'Mrs. Z' and her family, that she may be subject to domestic abuse requiring concerns to be referred to an agency with a duty to investigate with or without the permission of 'Mrs. Z', or.

- Information regarding concerns/observations/witnessed (by) from the family members, neighbours, or by any third party source to require any agency or person to make further enquiries and/or share that information

9 Conclusions

9.1 The review panel finds that no agency or person failed to comply with the required protocols and procedures regarding the prevention of domestic abuse.

9.2 The review panel finds that no agency or person failed to comply with the required protocols and procedures for the management of domestic abuse if required to do so.

9.3 The review panel finds that no agency or person, failed to comply with the required protocols and procedures if and when it is identified that a person[s] **not** living in the household of a known perpetrator of domestic abuse continues to remain at risk.

9.4 The review panel could only establish 'soft information', unsubstantiated from the police's previous contact with the family, as to a possibility that 'Mrs. Z' **may** have been subjected to domestic abuse by her husband.

9.5 In considering 'Circumstances of Particular Concern', outlined in the Home Office's Guidance[5] and as to whether such were applicable or evident preceding the death of 'Mrs. Z'**,** we can find no information to inform our findings that they were.

9.6 The review has made every effort within its authority and means to seek contact with both the perpetrator and the victim's close family members. They have not directly advised whether they would wish for their 'voice' to be included in the review.

10. Recommendations

10.1 This review has not identified any substantiated incidents of domestic abuse that required recommendation(s) for an agency or agencies to improve practice, systems and interagency working.

11. Remaining focused on quality improvement

11.1 Whilst informing that the review has no specific recommendations to make in relation to this case, agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention and management of domestic abuse. Further that their commitment to ensuring that singularly and together, agencies

[5] **Home Office:** *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* [Revised Version August 2013]. HMSO

continue to scrutinise how they support and promote interagency arrangements and responsibilities, remains an ongoing high priority. Through audit and scrutiny gaps can be identified and preemptive action taken.

11.2 The Leicester Interagency Domestic Violence Strategy 2009 - 2014 informs of the continued need ... "to work together to prevent domestic violence and to provide support and protection to anyone affected by domestic violence, with an underpinning commitment to equality, evidence based practice and partnership working" [Page 4].[6] In doing so it recognises that "amongst all ethnic groups there can be a high tolerance of domestic violence. For both new and established communities in Leicester there can be tolerance of domestic violence and a desire to keep such matters within the private, family or community sphere. There can be specific language and immigration barriers". The panel has requested the Community Safety Partnership to reflect on this as part of the wider learning from this review.

11.3 The SAFE Project in Leicester[7] has since strengthened their programme of outreach events in Leicester College specifically with the ESOL[8] students. SAFE have recently translated their literature into Farsi, which previously had not been available. The SAFE Project and the police in September 2013 launched a joint campaign to raise awareness of domestic violence services available in Leicester. They aim provide a co-ordinated response to domestic abuse so that agencies can offer the best support available to victims and families.

11.4 Whilst not directly relevant to these case, agencies may consider a regular programme of service audits to quality assure their policies and procedures. This should cover levels of awareness of indicators of abuse, the required risk assessment and risk management of domestic abuse, access to training, ability to apply policies and procedures both as single as single agencies and in supporting joint working.

11.5 In addition it is important to note that community, population and ethnography can change overtime and in some circumstances quite rapidly. This requires for commissioners and providers of services to ensure that the changing needs of new communities are actively considered and responded to.

[6] A copy of the strategy can be found here: http://citymayor.leicester.gov.uk/EasysiteWeb/getresource.axd?AssetID=102794&type=full&servicetype=Attachment

[7] The Safe project is a domestic violence service commissioned by Leicester City Council until 2015 which provides support to people living in Leicester who are experiencing or who are at risk of domestic violence. http://www.safedvs.co.uk/ Performance of Integrated Specialist Domestic Violence Services 1/9/12 – 31/12/12 http://www.safedvs.co.uk/files/ART93_Performance%20of%20LCC%20Integrated%20Specialist%20Domestic%20Violence%20Services%20FINAL%20Q3%20Year%20One.pdf

[8] ESOL: English for Speakers of other Languages. Courses include speaking, reading, writing and listening and cover spelling, grammar and punctuation.

12. Glossary

CRD	Comprehensive Referral Desk
CSP	Community Safety Partnership
DAIO	Domestic Abuse Investigation Officers
DARO	Domestic Abuse Referral Officers
DHR	Domestic Homicide Review
ESOL	English for Speakers of other Languages. Courses include speaking, reading, writing and listening and cover spelling, grammar and punctuation.
FLO	Family Liaison Officer
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LPU	Local Policing Unit
LSAB	Leicester Safeguarding Adult Board
MARAC	Multi-agency Risk Assessment Conference
OVR	Overview Report
SPECSS	An assessment tool - Separation, Pregnancy, Escalation, Cultural issues, Stalking, Sexual assault) Designed to enhance prevention work by frontline police officers.
SAFE	The SAFE project is based in and provides support to people living in Leicester that are experiencing or who are at risk of domestic violence. All of the services help women, men and young people regardless of age, ethnicity, disability, sexual orientation, religion and social class and includes those with or without children. The project consists of a helpline, outreach, SAFE home and IDVA services that together provide a holistic service that fits around client needs. The SAFE services form an integral and fundamental part of delivery of Specialist Integrated Domestic Violence Services in Leicester. SAFE works in partnership with the Jenkins Centre, which will provide opportunities for people to change their abusive behaviour and the Living Without Abuse Family Service. SAFE carries out its work as part of Domestic Violence Services 'Working together to build lives free form violence' and is commissioned by Leicester City Council until 2015. SAFE regularly visit organisations to talk about the work they carry out across the city.

13. Appendix A: terms of reference

The terms of reference for the review were to:

- Review the involvement of each individual agency, statutory and non- statutory, with 'Mrs.Z' and 'Mr.Z' between August 2006 and 13th November 2012.
- Summarise the involvement of agencies prior to November 2012.
- This timeframe was agreed for the review due to 2006 being the year which an initial trawl of records indicated had arrived in the UK from Afghanistan to join her husband living in Leicester.
- Provide a chronology of their involvement with Mrs.Z' and 'Mr.Z' during the time period. Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an individual management review if necessary: identifying the facts of their involvement with Mrs.Z' and 'Mr.Z', critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:

- Communication and co-operation between different agencies involved with the couple.
- Opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues in relation to 'Mrs.Z'.
- Organisations access to specialist domestic abuse agencies
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

For the panel to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their children.

- 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.

Appendix B: Matrix for the main agency contact

Agency Name	Involvement Type	Time Period	Specific Family Member/All Family Members	Information re Possible Domestic Abuse Concerns – YES/NO	Number of Face to Face Contacts	Comments	Language Communication Difficulties Noted in IMR
Leicester College	Education Language classes - ESOL	2006 - 2012	'Mrs. Z''	NO	ALL	Academic Years. Completed 2 courses. Last class attended 29/10/12	*"Staff has confirmed that 'Mrs Z' had sufficient capability and contact with staff and fellow students to have raised any issues and to have accessed the College's support services".* [9]
Leicester College	Language Classes- ESOL	2001-2012	'Mr.Z'	NO	ALL	Academic Years. Completed 5 courses	N/K
GP Practice	Health/Treatment	03/11/12 – 04/0912	'Mrs.Z'	NO	5		NO
City Council Housing Dep't	Repairs/Re-location	01/02/08 – 05/12	'Mrs.Z' [1] 'Mr and Mrs Z' [2] Unspecified [5]	NO	8		NO
Schools	Children's Education		All	NO			N/K
AandE	Injury [Minor]	06/11/12	'Mrs.Z'	NO	3	Seen by 3 clinicians	NO
General /Maternity Hospital	Maternity inpatient Outpatient	06/07 and 05/10 2006 - 2009	'Mrs.Z' All	NO	N/K Outpatient X8		NO
Urgent Care							

9

Entry level 2 Key Stage Two (10 to 11 year olds) is able to hold a simple conversation on familiar topics and facts. Gives a basic description. Creates sentences of more than five words and uses link words such as 'and' and 'but'.

Centre Primary Healthcare – Out of Hours Service	Health/Treatment/Minor Injuries.	2009 -2011 01/10/10	Parents and Children 'Mrs.Z'	NO NO	3 1		NO
Health Visitor	Health promotion and early intervention to all children 0-5 years	09/07/07 – 09/07/12	'Mrs.Z' and Children.	NO	9	Note: Mr.Z also attended some of the appointments/present at visit	*'No one can recall the family with clarity in order to comment on 'Mrs.Z's' understanding or communication skills'*
Police	Criminal Investigation/Protection/Prevention	[Contact 1] 24//04/08 [Contact 2] 11/07/11	[1] Mr.Z and Mrs.Z [2] Mr.Z	YES	2	See Section 5 of the Overview Report and Summary.	NO

Appendix C Action plan

Remaining Focused on Quality Improvement	Scope of rec.	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Progress
1. *Agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention, identification and management of domestic abuse*	Local	• *Agencies participate in the development of DA strategy* • *Agencies sign up to the DA strategy*	DVDG / SLP	• *Agencies agree DHR action plan* • *Agencies agree commitment to development of next DA strategy* • *Agencies sign new DA strategy*	Feb 14 Mar 14 Aug 15	Planning session held in February, draft strategy expected end of august 2015. Slight delays to timescale
2. *Agencies continue to scrutinise how they support and promote interagency arrangements and responsibilities*	Local	• *Agencies maintain a document control log of all interagency agreements relating to DA they are a signatory to*	DVDG / SLP	• *Agencies submit list of all agreements* • *DVDG compiles "Issues" log and reviews at each meeting*	Apr 14 Jun 14	Audit completed There is a standing agenda item of the victim's voice on the Domestic Violence Delivery Group.
		• *Delivery monitors engagement of agencies, works to resolve problems and highlights any persistent difficulties*	LSAB	• *Delivery group and LSAB monitor agencies attendance at multi-agency meetings.* • *Executive leads are informed if any concerns arise*	Ongoing	Board meeting minutes evidence that partnership engagement is consistently reviewed.
3. *To reach out and engage with individuals and communities who may either be isolated and/or lack awareness of how to seek assistance*	Local	• *Delivery group engages with New Arrivals Strategy Group (NASG)* • *Commissioners assess equality impact assessments and*	DVDG / SLP	• *DVDG agrees members to sit on NASG* • *DVDG invites NASG member to join* • *NASG and other relevant groups*	Mar 14 Mar 14 Apr 14	Agreed and attending Achieved Achieved

		performance against ongoing plans • *Delivery group leads and co-ordinates communications activity* • *Agencies provide figures to evidence whether service recipients reflect local community* • *Delivery group track access and engagement of key services over time*		*are identified to input into forthcoming awareness raising campaign plans* • *Agencies provide service user data* • *DVDG analyses service data on demographics* • *Data informs DA strategy*	Jul 14 Sep 14 Oct 14	Achieved Achieved Achieved
4. *Agencies to consider a regular programme of service audits to quality assure their policies and procedures. This should cover levels of awareness of indicators of abuse, the required risk assessment and risk management of domestic abuse, access to training, ability to apply policies and procedures both as single agencies and in supporting joint working*	Local	• *Agencies to assess whether future training needs audits can take into account this level of detail, and on what frequency such information can be obtained*	DVDG / SLP	• *DVDG requests information from partner agencies* • *DVDG agrees improvement plan*	Mar 14 Sep 14	Audit completed Partnership Agreement in effect for SVDG and DVDG
		• *Delivery group to collate such data, assist in the analysis and assist in the response to need arising from such data*	Delivery Group	• *Multi-agency adult safeguarding procedures to support response to DV locally.*	April 2015	Launch of revised adult safeguarding procedures 1st April 2015.
				• *SAAF audit of agencies policies, training, procedures to support DV response*	November 2014	Audit progressed

Add end

um to the DHR report: Information that arose from criminal trial

Mr. Z's' trial at Leicester Crown Court was concluded on the 24th May 2013 and he was found guilty of manslaughter and sentenced to 4 years imprisonment. Taking into consideration time spent in prison on remand it is anticipated that 'Mr. Z' will be eligible to be considered for supervised release in mid-2014.

Sentencing, Judge Michael Pert QC, said: 'It's clear on the evidence you had a happy marriage and were a good, placid and kind husband. All that changed two months before you killed your wife and I accept the changes in your life caused you distress and reduced you to a state recognised by doctors in this case as an adjustment disorder' .

The court heard evidence that 'Mrs. Z' had a few days before her death asked her husband for a divorce. In addition the court heard that "Mr. Z' believed his wife to be having another relationship and referenced that for several months there had been a noticeable change in her Behaviour. 'Mrs. Z' was reported to have been making and receiving numerous text messages from a person not identified to the court, but believed to be someone she had met whilst attending a course at a local college.

It is noted that 'Mrs. Z's' sister whilst giving evidence in the trial of 'Mr. Z' for causing the death of his wife, informed the court that during a stay with her in October her sister had mentioned 'divorce 'in a light hearted way'.

In a later telephone conversation with 'Mr. Z' he stated 'they were having problems'. 'Mrs. Z' had said [we presume a separate telephone call with her sister] 'it was all his ['Mr. Z's] fault. "She said that he had pushed her down the stairs. The Barrister for the defense dismissed this assertion that "Mrs. Z' had previously been subject to domestic abuse, accusing the sister of "lying about the push in a bid to get her client found guilty of murder".

The sister's partner in giving evidence to the court that 'Mr. Z' had contacted him by telephone upset, saying his wife wanted a divorce…that there had been an argument and resulted in him beating his wife and pushing her downstairs'. 'Mr. Z' told the court that he 'denied assaulting her, saying she had fallen accidentally and he had taken her to hospital to be checked over'.

The IMR submitted by the University of Leicester Hospitals confirmed that 'Mrs. Z' attended alone at the A and E department on the 6th November 2012. She received treatment for a fracture to her left wrist.

Contacts Family Members as Part of the Domestic Homicide Review.

A letter was sent to 'Mr. Z' at the commencement of the DHR advising him of the purposes of the review.

In June 2013 a further letter was sent to 'Mr. Z' for the purposes of seeking his participating in the review. The letter was also copied to the Governor at HMP Leicester and translated into Farsi, this being 'Mr. Z's' first language.

Prior to this, 'Mr. Z's' solicitor was written to explaining the requirement for the review and in seeking her support in encouraging 'Mr. Z' to contribute and agree to a meeting with the review chair to be accompanied by an interpreter.

The solicitor responded by e-mail to the review chair, dated the 12th June informing: "We will not be advising our client to take part in this process. He is too fragile and currently on medication. There were no agencies involved with this family prior to the incident. There is no history of domestic violence in this case".

In September 2013 the Review Panel Chair was informed by the children's social worker in Reading, that due to the likely supervised release of 'Mr. Z' from prison being mid-2014, proceedings at the Family Court had been discontinued. The plan had been for a 'Special Guardianship Order' by the Court so as to enable the children to remain living with the deceased's sister and her partner at their home in Reading. Longer term plans and options to enable permanency for the children's care were required to be reassessed with a listed hearing in November 2013. Applications for care orders on the children were likely to be applied for. The hearing has now been deferred until February 2014.

Letters in Farsi were sent to family members in Reading, accompanied by a form to return to indicate whether they would be supportive of participating in the review or not. Copies were sent to the Victims Liaison Officer [Leicestershire Police] and the children's caseworker in Reading. To date we have not received any reply or information from any third party to indicate if family members would be supportive of a meeting in order to contribute to this review.

It is noted that 'Mrs. Z's' sister whilst giving evidence in the trial of 'Mr.Z' for causing the death of his wife, informed the court that during a stay with her in October her sister had mentioned divorce in a light hearted way'.

In a later telephone conversation with 'Mr. Z' he stated 'they were having problems'. 'Mrs. Z' had said [we presume a separate telephone call] with her sister] 'it was all his ['Mr. Z's]. "She said that he had pushed her down the stairs. The Barrister for the defense dismissed this assertion that "Mrs. Z' had previously been subject to domestic abuse, accusing the sister of "lying about the push in a bid to get her client found guilty of murder". The sister's partner in giving evidence to the court that 'Mr. Z' had contacted him by telephone upset, saying his wife wanted a divorce…that there had been an argument and resulted in him beating his wife and pushing her downstairs'. 'Mr. Z' told the court that he 'denied assaulting her, saying she had fallen accidentally and he had taken her to hospital to be checked over'.

The IMR submitted by the University of Leicester Hospitals confirmed that 'Mrs. Z' attended alone at the A and E department on the 6th November 2012. She received treatment for an un-displaced fracture to her left wrist.

Section 6: Agency IMR submissions to DHR panel; identified no previous incidents of domestic violence within the family or concerns.

6.10 **Leicester Partnership Trust**: Health Visiting IMR Report: the family received visits from Health Visitors and Nursery Nurses according to routine child health programmes, in respect of both children in the family. Mrs Z wanted to improve her English speaking and was supported by the health visitor service to enroll onto a local college course. Mrs Z was also referred to local Sure Start Centre, to help her to meet and socialise with mothers in the local community. There were no concerns raised to the service from family members or from other agencies in relation to any domestic violence.

6.11 **Leicester City Council Housing Division IMR report**: Mr & Mrs Z lived in council properties since 2.2008. Mrs Z attended housing office in 2010 and was seen during a home visit by a housing officer the following month. Maintenance staff visited the property during 2011 and 2012 to conduct house repairs. There were no concerns raised from family members or from staff who visited the family.

6.12 **General Practitioner IMR Report:** Mrs Z registered with the local surgery in 2010; she and the children attended GP appointments for minor illness issues. There were no disclosures of domestic violence within the home. Mr. Z did not attend the surgery for any significant health problems; there were therefore no opportunities to identify any health related issues with Mr. Z in the months before the death of Mrs Z. At the trial it was identified that he was suffering from adjustment disorder when he committed this crime.

6.13 **United Hospitals of Leicester IMR report**: provided maternity care to Mrs Z during her pregnancies and early post-natal period. Maternity Services reported no concerns being raised during their contact with Mrs Z. Before 2011 pregnant women were not routinely asked about domestic violence within booking arrangements; however this has now changed and routine enquiry is now made when women book for maternity care.

6.14 On 6.11.12 Mrs Z attended the hospital emergency department at UHL; she provided an explanation that she had fallen down the stairs. There were no disclosures of any domestic violence during Mrs Z contact with staff working within the Emergency Department. Mrs Z attended the department on own and was seen by a nurse, doctor and radiographer so had opportunities within privacy of the department to talk about any concerns raised. Mrs Z was treated for an un-displaced fracture to her left wrist which was splinted and she was then discharged home. Information was shared with GP following discharge according to normal procedures. Mrs Z received appropriate medical attention.