BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
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A Domestic Homicide Review
under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman in November 2012

'Khaista'

BDHR2012/13-05

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Independent Chair and Author

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Glossary

AAFDA: Advocacy After Fatal Domestic Abuse
ACPO: Association of Chief Police Officers
BCC: Birmingham City Council
BSCB: Birmingham Safeguarding Children Board
BCSP: Birmingham Community Safety Partnership
BSMHFT: Birmingham and Solihull Mental Health Foundation Trust
CCG: Clinical Commissioning Group
CPS: Crown Prosecution Service
DASH: Domestic Abuse, Stalking and Honour Based Violence risk identification, assessment and management model
DHR: Domestic Homicide Review
DVRIM: Domestic Violence Risk Indictor Model, commonly known as the Barnardo's Model
Flints: Force linked intelligence system is a West Midlands Police intelligence system developed in 2000 that links several databases.
GP: General Practitioner
HEFT: Heart of England NHS Foundation Trust
IMR: Individual Management Review – reports submitted to review by agencies
IPCC: Independent Police Complaints Commission
MARAC: Multi-Agency Risk Assessment Conference (for domestic violence)
NHS: National Health Service
OASIS: West Midlands Police Command and Control incident logging.
PPU: Public Protection Unit of West Midlands Police
RAID: Rapid Interface and Discharge Service of Birmingham and Solihull Mental Health Foundation Trust
SAD: SAD assessment tool for self-harming patients at risk of suicide. The SAD PERSONS scale is an acronym utilized as a mnemonic device described below.
S: Male sex
A: Age (<19 or >45 years)
D: Depression
P: Previous attempt
E: Excess alcohol or substance use
R: Rational thinking loss
S: Social supports lacking
O: Organized plan
N: No spouse
S: Sickness
SCR: Serious Case Review
WC392: West Midlands Police Vulnerable and Intimidated Witness investigation log

Contents

1. The circumstances for the review

1. This domestic homicide review concerns the murder from multiple stab wounds in November 2012 of 33 year old Khaista by Shab her 37 year old estranged husband at her home in Birmingham.

2. This report of a domestic homicide review examines agency responses and support given to Khaista, a resident of Birmingham prior to the point of her death in November 2012.

3. In addition to agency involvement the review also examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

4. The review will consider agencies contact and involvement with Khaista and Shab from September 2008 when the first recorded report of domestic abuse was made to the police, through to the date of Khaista's death in November 2012.

5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. 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.

6. Khaista had secured a non-molestation order against Shab in September 2012 and he was required to leave the family home. Khaista also sought a divorce. A week after the final part of the divorce under Sharia law was completed Shab broke into the family home and inflicted multiple stab wounds whilst Khaista was on the phone to the emergency call handler.

7. The circumstances under which a domestic homicide review must be carried out are described in legislation and national guidance. The relevant legal requirement is the Domestic Violence, Crime & Victims Act (2004) Section 9 that came into force on the 13th April 2011. The relevant national guidance is described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews.*

1.1 Timescales

8. This review began in May 2013 and was concluded in February 2015 when the report was presented to the Birmingham Community Safety Partnership. The completion of the review was delayed pending the completion of a parallel investigation by the Independent Police Complaints Commission (IPCC).

9. National guidance issued by the Home Office provides discretion to community safety partnerships about whether to postpone the domestic homicide review until a criminal prosecution has been completed. In this case, Birmingham Community Safety Partnership decided to initiate the review in order to identify any learning at an agency level as quickly

as possible but postponed completion of the review and publication of the overview report until an outcome was known in regard to the criminal process and the IPCC investigation to allow the review panel to have access to further information to complete their work. This had implications for the overall timescale for completion of the domestic homicide review which exceeded six months.

1.2 Confidentiality

10. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

11. Khaista was 33 years old and Shab was 37 years old. Khaista had been born and brought up in Birmingham but her family had origins in Pakistan. Shab had been born in Pakistan. They were both Muslim. They were first cousins.

1.3 The terms of reference for the review

12. The national guidance describes generic terms of reference that provide a context for the development of more case specific key lines of enquiry and learning that are described.

Recognition

i. What knowledge/information did agencies have that could have identified the possibility of a domestic abuse and how did agencies respond to this information. Were there opportunities to seek the views, wishes and feelings of any of the children about their parents' relationship and any evidence of domestic abuse? What information was sought or provided from within the extended family with regard to any evidence of a risk to Khaista's emotional or physical safety or of her children?

Knowledge about Shab as a perpetrator of domestic abuse and violence

ii. What knowledge/information did agencies have that indicated Shab was a perpetrator of domestic abuse and violence and how did agencies respond to this information?

Services provided

iii. What opportunities and services did agencies offer and provide to meet the needs of Khaista and her children? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced? What action was taken to identify whether the children were at risk of significant harm or children in need of a service?

The capacity and resources of services

iv. Were there issues in relation to capacity or resources in any single agency that impacted on the ability to provide services to Khaista and her children, Shab or any to other members of either family and also impacted on the agency's ability to work effectively with other agencies?

13. Each of the key lines of enquiry was accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

14. Although domestic homicide reviews are a relatively recent statutory obligation and therefore only a limited number have been completed nationally, the panel have taken account of other sources of learning such as any relevant research or serious case reviews that have identified learning relevant to the review.

1.4 The methodology and scope of the review

15. The Birmingham Community Safety Partnership was notified of Khaista's death on 20th November 2012. On 18th December 2012 the Domestic Homicide Review Steering Group reviewed the circumstances of this case against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews* and recommended to the chair of Birmingham Community Safety Partnership that a domestic homicide review should be undertaken.

16. The chair of Birmingham Community Safety Partnership ratified the decision to commission a domestic homicide review and the Home Office was notified the same day on the 19th December 2012.

17. The circumstances were also considered by Birmingham Safeguarding Children Board on 21st December 2012, and reviewed again on 18th January 2013. Birmingham Safeguarding Children Board decided not to undertake a serious case review but requested that key lines of enquiry relating to the children should be included within the domestic homicide review[1].

18. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an appropriately senior and experienced person. The same experienced and independent person has also provided this overview report and an executive summary.

19. The domestic homicide review panel met on five occasions between May 2013 and September 2014. The initial chronology of services involvement was completed by May 2013. The first draft of the agency reviews were completed in the summer of 2013 with the exception of the police. The police individual management review was delayed due to the circumstances of the case being reported to the IPCC who undertook an investigation into aspects of the police response to Khaista's contact with the service. Although the police collated information relating to their contact with Khaista and the family, the individual management review author was unable to interview the police officers involved until the IPCC had concluded their investigation. This was to avoid compromising any further

[1] The circumstances for undertaking a serious case review are set out in national and local guidance.

potential legal or disciplinary proceedings that might have arisen as a result of the investigation. The final report was presented to an extraordinary meeting of Birmingham Community Safety Partnership on the 19th February 2015**.**

20. The panel established the identity of services in contact with the family during the time frame agreed for the review. For services that had significant involvement they were required to provide an independent management review and are listed in paragraph 29. These reports were completed by senior or specialist professionals in their organisations who had no direct involvement or responsibility for the services provided to either the children or their parents.

21. The timeframe examined by the review is from September 2008, when the first recorded report of domestic abuse was made to the police, through to the date of Khaista's death in November 2012. All information known to a service providing an individual management review was reviewed by the authors. Any information regarding involvement prior to the period of the detailed chronology and analysis was summarised in the individual management review.

22. Individual management reviews were completed in accordance with *Multi-agency statutory guidance for the conduct of domestic homicide reviews* using the Community Safety Partnership templates and were quality assured and approved by the most senior officer of the reviewing agency.

1.5 Involvement of Khaista's family in the review

23. Appendix 1 of the report provides detail of the family members contacted or who provided information to the review. Khaista's brother was notified of the domestic homicide review following the meeting of the panel in May 2013 when the criminal trial had been completed and the police senior investigating officer provided a briefing about the criminal investigation and prosecution.

24. The chair of the panel wrote to Khaista's brother via the police family liaison officer who hand delivered the letter. In that letter the chair of the panel enclosed information about sources of support for families which included *Advocacy After Fatal Domestic Abuse* (AAFDA). The family of Khaista made contact with AAFDA who have provided direct contact and support to Khaista's family and have liaised with the panel chair and professional advisor to the review [2].

25. As a result of the initial letter, Khaista's brother agreed to meet with the chair of the panel and the panel's professional advisor. This meeting took place in early July 2013 at the family's home in Birmingham. Khaista's parents and sister also participated in the discussion.

[2] AAFDA was set up in 2008 and provides advocacy and support to families and also contribute to education and training for professionals in the statutory and voluntary sectors nationally.

26. The family were able to provide important and helpful information under what were clearly very distressing circumstances. Much of this information had been unknown to services at the time.

27. The family had been aware of Khaista being subjected to physical and verbal abuse over several years; this had escalated in the last months of Khaista's life after she made clear her intention to seek a divorce[3]. Khaista had become increasingly scared and had not been sleeping and in the last couple of weeks had become increasingly careful about security in her house. Khaista's brother had been staying with her overnight (the fatal attack occurred in the late afternoon). Khaista had begun using taxis to have the children transported to and from home.

28. The family believed that Khaista was to have been offered a place in a refuge about three weeks before she died (there is no record that a referral had been made).

29. The family knew that Khaista had sought a separation on previous occasions but that she had been persuaded by Shab to reconcile. The family did not disclose or discuss any information relating to the rift that had occurred when Khaista had first expressed her wish to end the marriage. By the time of the final occasion when Khaista was determined to end the marriage the family were trying to support Khaista in her decision.

30. About two weeks before the murder, Khaista told her family of Shab's threats to the children and to burn their house down. Some of the family had not seen threats made by Shab, such as chopping the children's heads off, as representing a serious intent although recognised that Khaista was clearly frightened and was worried about what Shab was capable of.

31. The family described emotionally abusive and controlling behaviour by Shab towards Khaista over several years. He prevented Khaista from speaking to neighbours or people in the community. He controlled all of the family income including child benefit and had sent money to his extended family located outside of the UK to help fund a large property. The family felt that a significant and fatal trigger had been the divorce and the prospect of Shab losing access to and control over the family income. The family also described how Shab controlled the contact that Khaista had with her family for example during Eid (one of the most important festivals for Muslims) in 2012.

32. The family described how the children and Khaista were all on a very restricted diet; for example, the children often only had cereal to eat. The family also stated that the children often had clothes that were ripped or inappropriate. There are no reports from school or other services about inappropriate or inadequate clothing.

[3] According to the witness statement made by Khaista in support of her application for the non-molestation and occupation orders in September 2012 there had been a period of estrangement between Khaista and her family; this had arisen because although the family disapproved of the abuse, they felt that for the children's sake the marriage should be continued; their views had changed in the final weeks of Khaista's life.

1.6 Contributors to the review

33. The following agencies have provided an individual management review:

    a) Birmingham City Council Children, Young People and Families Directorate children's services who had seven contacts between 2003 and August 2012 of which two related to allegations of domestic abuse involving Khaista;
    b) Birmingham City Council Pupil and School Support Service provided a report in respect of the five schools attended by the children during the time frame which included three schools that are independent;
    c) Birmingham and Solihull Mental Health Foundation Trust who provided assessment and ongoing contact and support to Shab in regard to his mental health following the first diagnosis of depression and a psychotic episode;
    d) Birmingham and Solihull NHS Clinical Commissioning Groups in relation to the two GP practices that provided general medical services to the family; the family registered with the second GP practice after they had moved house in 2011;
    e) Birmingham Community Healthcare NHS Trust provided school nursing, dental health services and one enuresis clinic appointment;
    f) Birmingham Children's Hospital provided treatment to the children when they were presented for various ailments;
    g) Heart of England NHS Foundation Trust (HEFT) provided medical treatment to Khaista on eight occasions in the emergency department and seven times in outpatients; treated Shab in the emergency department on six occasions during the timeframe of the review, four treatment episodes to Child 1 of which three were referrals to Ear, Nose and Throat, three treatments to Child 2 in emergency service and one fracture clinic, and the remaining three children each attended at the emergency department on one occasion;
    h) West Midlands Police.

34. Information was also received from the regional ambulance service[4], the schools attended by the children (that subsequently led to commissioning an individual management review from the education service), the Revenue and Benefits Service and Birmingham and Solihull Women's Aid[5].

35. Information was also sought from the Islamic Judiciary Council in regard to the request that Khaista had made for a divorce under Sharia law.

36. Information was also sought from the solicitors who were instructed by Khaista in regard to the non-molestation orders and civil proceedings in regard to the separation and divorce

[4] The ambulance service provided an emergency response on two occasions in November 2012 when Shab took an overdose.

[5] As per the MARAC protocol in Birmingham, BSWA receives the MARAC (multi-agency risk assessment conference) referrals from the West Midlands Police and makes contact with women to offer specialist domestic violence support and represents the woman's voice at the MARAC meeting. BSWA received a MARAC referral for Khaista on the 2nd November 2012 via fax and although spoke with her by telephone and arranged appointments to see her they had not had a face to face discussion with Khaista in spite of follow up and attempts to see her.

proceedings. The solicitors provided access to information for the purpose of assisting the prevention of similar crimes and to support learning and improvement through the domestic homicide review.

37. As a result of the information provided in regard to education services and a subsequent discussion at the domestic homicide review panel in October 2013 the chair of the panel and author of this report wrote to the independent chair of the Birmingham Safeguarding Children Board to draw attention to issues that were emerging through the review. This did not concern the safety of any individual child but related to the extent to which school teaching and support staff generally were supported and advised in regard to recognising indicators of domestic abuse affecting children and the implications for their professional practice. Particular attention was drawn to the needs of the independent and free school sector that have no formal relationship with a local education service. This issue is explored in the final chapter dealing with findings.

1.7 The review panel members

38. The case review panel that oversaw this review comprised the following people and organisations;

Role or position	Agency
Peter Maddocks	Independent Chair and Author
Safeguarding Named Nurse for Children and Young People	Birmingham & Solihull Mental Health NHS Foundation Trust
Lead Nurse Complex Mental Health Joint Commissioning	Mental Health Joint Commissioning
Associate Director of Safeguarding	Birmingham Community Healthcare Trust
Practice Director at a medical practice	Birmingham South Central Commissioning Group
Head of Safeguarding	Heart of England NHS Foundation Trust
Superintendent	West Midlands Police
Senior Service Manager for Violence Against Women	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service
Designated Nurse Safeguarding Adults and Children & Mental Capacity Act Lead	Solihull Clinical Commissioning Group
Operations Manager	Birmingham & Solihull Women's Aid
Assistant Director - Safeguarding and Quality Assurance	Birmingham City Council Children's Services
Minute taker	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service

39. A senior manager from children's social care was a member of the domestic homicide review panel. Other agency representatives on the domestic homicide review panel were

also members of Birmingham Safeguarding Children Board. There was additional communication during the review between the chair of the domestic homicide review panel and the chair and professional advisor to Birmingham Safeguarding Children Board to keep them updated in regard to information being collated by the review and the development of analysis and findings relevant to safeguarding systems for children.

40. The panel had access to legal advice from a solicitor in the council's legal service.

41. Written minutes of the panel meeting discussions and decisions were recorded by a member of the City Council's Equalities, Community Safety and Social Cohesion Service staff team.

1.8 Independent author of the overview report

42. Peter Maddocks was the independent chair and is the author of this report and was commissioned in January 2013. He has over thirty-five years' experience of social care services, the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several local safeguarding children boards in England and Wales. In compliance with national guidance he has used the online toolkit and online learning provided by the Home Office. He has also participated in training in relation to serious case reviews including the use of systems learning as developed by Social Care Institute for Excellence in regard to serious case reviews and master class training sponsored by the Department for Education.

1.9 Contact with the perpetrator

43. In compliance with Home Office guidance the chair of the panel wrote to Shab after his conviction and imprisonment to notify him about the domestic homicide review and to provide an opportunity for him to contribute information for the review. Shab agreed to meet with the independent chair and the review's professional advisor during a visit to the prison agreed by the prison governor. An interpreter was also present to translate.

44. Shab stated that he had not been aware that Khaista wanted to leave the marriage until recently. He was very angry when he was told that about the non-molestation order. Shab stated that before the order he was verbally abusive but had not hit Khaista and had not been abusive to Khaista when the children were in the house. He understood the order but had wanted to have reconciliation. He used a friend and members of Khaista's family to speak to Khaista but she did not want to have contact. Khaista was consistent in wanting a divorce but he was not prepared to accept that.

45. Shab stated that he did not understand why Khaista wanted to end the marriage. He was opposed to the divorce and felt very angry and confused. He did not seek help or advice from any service or from within the community. He was not aware of any services that could have helped.

46. Shab stated that he had 'chastised' the older children. He felt that Khaista had deliberately 'wound the children up' during a family trip to a safari park so that they would argue and fight with each other and Shab would have to intervene. This was recorded by Khaista on her mobile phone 'as evidence'.

1.10 Parallel investigation

47. As a result of an initial internal review by the West Midlands Police of the police contact with Khaista and Shab prior to the murder, the case was referred to the Independent Police Complaints Commission (IPCC) to conduct a parallel independent investigation of the police response to Khaista and Shab in 2012. That investigation is separate to the domestic homicide review and to any other process. Because of this investigation, the police IMR author was unable to speak with several officers who had contact with Khaista and Shab. This caused initial delay for submitting an individual management report and limited the scope of analytical discussion regarding some aspects of the police involvement.

48. The investigation by the IPCC highlighted a number of areas for improvement and learning in regard to how domestic abuse is identified and investigated. This includes how information is recorded and accessed to inform risk assessment; the complexity in communication between contact centre; response officers and prisoner management units; the impact of workload and organisational arrangements; resource allocation and management and the reliance on e-learning to deliver important awareness and development training in regard to domestic abuse. Further detail is provided in relevant sections of this report.

1.11 Equality and diversity

49. The Equality Act 2010 sets out nine protected characteristics. Discrimination which happens because of one or more of these characteristics is unlawful under the Act.
    a) age;
    b) disability;
    c) gender reassignment;
    d) marriage and civil partnership;
    e) pregnancy and maternity;
    f) race;
    g) religion or belief;
    h) sex;
    i) sexual orientation.

50. The Act offers protection from discrimination for every individual. Importantly, for the purpose of analysis in regard to this domestic homicide review, the Act prohibits any protected status for domestic abuse and violence.

51. Neither Khaista nor Shab had a recognised disability although Shab had been diagnosed and treated for depression.

52. Khaista and Shab were both heterosexual and both had the gender identity they had been born with.

53. Of the remaining characteristics, the following points are relevant to this domestic homicide review. During the criminal trial that convicted Shab the prosecution argued that this was effectively an honour killing arising from Shab's refusal to accept that the marriage was over at Khaista's application and his honour being offended. Shab repeated his opposition to the divorce when the independent reviewer met with him after his conviction and sentence.

54. Asian women have particular vulnerability arising from abuse by a husband and the risk of community victimisation and face pressure to hide any evidence of abuse including psychological and emotional as evidenced in this case.

55. Domestic abuse presents an additional level of stigma and social isolation that can inhibit the ability of victims and families to disclose what is happening and can also influence the response by some professionals who either share a common cultural tradition or are unaware of the significance of different cultural systems in a complex and diverse city. In 2008 when Khaista had first disclosed domestic abuse she did not discuss it with her GP in spite of being a patient who 'could talk about anything'. Given the patient and GP were both from an Asian heritage it is conceivable based on the known pressures that can be placed on Asian women within their families and communities, that Khaista did not want to be seen to be going outside of the family about this most sensitive of subjects.

56. Khaista and Shab are from a South Asian cultural tradition that relies on the family structure to provide support and to resolve personal problems and difficulties. It is a tradition that believes strongly in the privacy and primacy of the family and encourages family members to be loyal to the family and to not look to external people and agencies to intervene. It is a tradition that encourages the family and its various members to take care and responsibility.

57. It is a tradition that is not unique to South Asia. Being aware of the core values and recognising the influence of other factors relevant in this case which included the family's experience of harassment and racism, opens up opportunity to understand the interaction between the family with various agencies. For example, when Khaista approached the police in 2008 regarding separation from her husband, it carries additional significance if the cultural traditions and barriers are understood; seeking help from outside of the family is counter to what is expected.

58. Other aspects that were revealed through the domestic homicide review are the extent to which some families live within culturally and geographically tight knit communities. Whilst this can be a source of strength and resilience, it can also be a concern that sensitive and confidential information will be compromised. This has great significance in communities where the central tenet is that the family will deal with its own problems.

59. This is supported in research. For example, Kagan[6] in 2003 discussed mental health issues writing that the 'shame' of admitting domestic abuse within the family or community is great in some Asian families and the concept of 'shame' can lead some people to stay in intolerable marriages. Indeed, according to the multi-agency chronology, it is one of the reasons why Khaista did not wish to have any intervention in 2007.

60. In the individual management review from the Mental Health Trust, there is a reference to Shab being unhappy with his wife's attitude and behaviour. This was regarded as reflecting marital tensions and associated with the pressures from a long term condition rather than indicating that domestic abuse could be a factor.

61. This mind-set allowed suggestions to be made for the couple to seek mediation or support from the family. This was inappropriate as a strategy for responding to domestic abuse and violence where mediation offers further opportunity for a perpetrator to attempt coercion. It is for this reason that mediation is unsafe practice in responding to domestic abuse and the importance of proper recognition by professionals when dealing with it.

62. Domestic abuse is also often a facet of male identity seeking to exert control and dealing with feelings of helplessness and poor socialisation. In cultural traditions that place men in a patriarchal family structure that expects the man to be in charge and taking responsibility, the onset of a mental illness can represent an additional source of stress for which the family has inadequate capacity to resolve. In this case, factors such as the degree of dependence that Shab had on Khaista for an increasing range of practical issues such as communication with external services was not sufficiently explored and therefore understood.

63. The impression is that the contact by Khaista was seen as a wife simply wanting to leave her marriage (that was in opposition to strong cultural tradition and expectation and therefore risking isolation) rather than viewing it as a disclosure of coercion and domestic abuse; there is reference to Shab threatening to remove the children from the country. Fear of losing her children held Khaista back from making disclosures as described in her statements supporting the divorce and court orders applications. The reference to sexual relations without consent is not viewed as potential evidence of coercion, sexual assault or rape.

64. The marriage had been made under Sharia law. The divorce proceedings required the couple to attend for counselling and for both parties to put their point of view. The process is based on an important principle of Islamic faith that seeks reconciliation as a first step.

65. Reference is made later in this report about the research evidence that shows the inappropriateness of mediation and reconciliation in responding to coercion and abusive intimate relationships.

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[6] Kagan, C (2003). The Context of Mental Health Difficulties and Well Being. British Ethnic Health Foundation.

66. The domestic abuse and violence can be dated from the first pregnancy. This is a common finding in domestic homicide reviews and research. Although women should be routinely screened as part of the antenatal care for evidence of domestic abuse or violence it remains the case that screening that relies on self-disclosure by the woman is unlikely to be effective.

67. Khaista was socially and economically isolated. She did not work and Shab controlled the contact that she had with her family. The extent and significance of Khaista's isolation was never recognised when she did make contact with the police and social care.

1.12 Dissemination

68. The following organisations and people receive a copy of the overview report in addition to Khaista's family and each affected agency.

1: Panel Members
Birmingham Health and Wellbeing Board
Birmingham Safeguarding Children's Board
Birmingham Adults Safeguarding Board

2: Report Authors
Birmingham City Council – Children's Social Care
Birmingham City Council – Education
Birmingham Community Healthcare NHS Foundation Trust
Heart of England NHS Foundation Trust
Birmingham & Solihull Mental Health NHS Foundation Trust
Birmingham South Central CCG
Birmingham & Solihull NHS Clinical Commissioning Groups

3: Birmingham Community Safety Partnership Board

West Fire and Rescue Service
West Midlands Police Crime Commissioners Office
West Midlands Police Service
Home Office
Member of Parliament
National Probation Service
Birmingham City Council
Birmingham Councillors
NHS Clinical Commissioning Groups
NHS Foundation Trusts
Victim Support
Youth Offending Service

4: Home Office

1.13 Background information (the facts)

69. Khaista was living with her five children in the matrimonial home; they were aged 12, 11, 9 and 7. Khaista was recently separated from Shab who was living with relatives and was completing a divorce under Sharia law. They had been married for seventeen years. The family home is in an inner city area of Birmingham that has high levels of deprivation; it is in the ten per cent most deprived in England. The area has a large Asian population that is mainly from Pakistan origins.

70. Shab forced entry to Khaista's home. Khaista dialed 999 at 15.10 screaming that someone was in her house. Khaista was stabbed several times whilst on the phone to the emergency call handler.

71. The police arrived at Khaista's home four minutes later and found her with multiple severe injuries. The fast response single paramedic arrived at 15.24. Khaista had sustained stab wounds to her neck, chest, hands and arms. A fully crewed ambulance was on the scene by 15.28 and left with Khaista at 15.42 arriving at the hospital emergency department at 15.45. The ambulance recorded that Khaista had been in cardiac arrest on their arrival and there was evidence of catastrophic hemorrhage (estimated to be two litres). Khaista died shortly after arriving at the hospital. Shab was subsequently arrested and charged with her murder.

72. Shab pleaded guilty to the charge of murder in May 2013 at the crown court which terminated the coroner's inquest. He was sentenced to life imprisonment and is to serve a minimum of 20 years. The judge had reduced the sentence by five years due to Shab being depressed at the time of the murder. No further information has been sought from the post mortem. He pleaded guilty to the charge.

73. The prosecuting counsel argued during the trial that a motivating factor in the killing was Shab's refusal to accept that his marriage was over and this was a matter of having his honour offended. Khaista's family continue to believe that it was loss of income that was the primary factor.

74. This resonates with the recurring findings from such deaths where Shab was losing control of Khaista and the relationship just prior to the killing of Khaista. The killing which involved Shab breaking in to Khaista's home in the late afternoon occurred less than a week after Shab was informed in writing of Khaista's intention to divorce him.

75. Khaista had been born and brought up in Birmingham but her family had origins in Pakistan. Shab had been born in Pakistan. They were both Muslim. They were first cousins. Their marriage in Pakistan in February 1997 had been arranged in accordance with their cultural tradition. In 1998 Shab came to Birmingham on a spouse visa and they

had lived throughout their marriage in rented property until the separation in August 2012. Shab acquired settled status under the immigration legislation in 2000 allowing him to permanently live in the UK. Khaista's brothers had married Shab's sisters although those marriages had been ended through divorce.

76. There was some temporary disagreement between Khaista and her family regarding the ending of the marriage and about what was best for the children. This appeared to initially have left Khaista without support for leaving the marriage. The family had become supportive by the time that Khaista was seeking a divorce and had applied for the non-molestation and occupation orders.

77. Khaista was bi-lingual in English and Urdu. Shab speaks Urdu and according to several of the individual management reviews has a limited understanding of English and is reliant on family members mainly to translate for him on the occasions when interpreters are not used. Some of the services such as the GP practice had Urdu speaking professionals. Children's social care and the mental health service provided no evidence that interpreters were used; the children's social report highlights this as a contributory factor in Shab not being more engaged by that service in terms of direct interviewing and checking of information. The Heart of England NHS Foundation Trust heard from two of their practitioners that Shab was able to communicate 'effectively' in English. The issue of language and communication and in particular within the context of identifying domestic abuse is explored further in later sections of the report.

78. According to Birmingham and Solihull Mental Health Trust, the family had experienced some racial abuse and harassment in the community. There is no specific information about particular incidents or when or where they occurred and the information does not include any reference to Shab or to the children being subjected to the same harassment or racial abuse.

79. Shab had been in employment until his mental health deteriorated, suggesting that he had not worked since 2004. The first diagnosed and recorded episode of depression in 2004 required a short period of in-patient care at a local hospital.

80. Shab's mental health was the subject of ongoing support through the local community mental health service and the GP. Khaista received GP and hospital treatment for a range of medical needs none of which were particularly enduring or chronic.

81. All of the children presented at different times for medical attention at the local hospitals or GP and at a walk-in medical centre. Not all of these presentations were routinely notified to the family's GP practice. For example, Child 2 had ten attendances at the Children's Hospital which were outlined in a letter in early 2012. The report on behalf of the GP services highlights some issues in regard to communication between hospital and community services.

82. The separation of parents always has an impact on children. One of the children appeared to be more favoured by Shab. One child expressed a wish to live with Shab who was staying with his sister. The other children appeared to want to remain with their mother

although there was a brief period when a second child was living with Shab and paternal aunt.

83. It is now apparent that there had been difficulties in the relationship from about 2000 although the first public disclosure was in 2008 when Khaista went to the local police station asking for information about how to leave her husband. According to Khaista's statements in support of her application for the non-molestation and occupation orders in September 2012, the marriage had initially gone well and Shab had worked hard to provide for the family. However, by 2000 Shab had changed and had become short tempered and was beginning to suffer from depression. The first contact with mental health services did not occur until 2004.

84. There were additional tensions arising from the crowded conditions in the house and this appeared to be exacerbated at times when relatives had lived with the family. Some of these family relations were the subject of a referral to children's social care on different occasions; one had been reported as being verbally abusive to the children.

85. According to the written statement made by Khaista in support of the divorce application, Shab would smack the children when they were screaming, shouting or playing. He also began to physically assault Khaista; this is at odds to the information given to the police in 2008 that no physical assaults had been made. Khaista had been initially sympathetic feeling that it was his depression that was causing Shab to feel stressed. Khaista then became increasingly frightened of Shab and that if she took a stand against his abuse it would result in an escalation of the abuse and violence. The couple separated in August 2012.

86. Khaista's family knew about the abusive relationship and although had initially hoped the marriage could survive for the sake of the children they had offered support to Khaista in seeking a separation and divorce in 2012. They had become worried about Khaista's safety in the last few weeks of her life although had not anticipated the killing.

87. In the West Midlands, 30 per cent of victims who report domestic abuse are repeat victims within a year and it is estimated that around 75 per cent of all domestic abuse incidents are witnessed by a child.

88. Birmingham Safeguarding Children Board believes that between 33000 to 40000, which equates to roughly 12-14 per cent, of Birmingham's children and young people are affected by domestic abuse. Many of these children will have witnessed or heard domestic abuse, will sense that their carer is unhappy and some will have been abused themselves.

1.14 Chronology of information about the contact and involvement of services.

89. Shab was initially referred for a mental health assessment in August 2004 when he was admitted for inpatient treatment for just over three weeks. He continued to receive outpatient support through the community mental health team and GP.

90. There were two referrals to children's social care prior to the first disclosure to the police of domestic abuse in September 2008. The first referral was in May 2006 which had followed

Child 2 reporting that Khaista had hit their head; this was investigated and judged to have been accidental.

91. In 2007 there was an allegation that a relative staying with the family was being abusive to Child 2. An initial assessment was completed; the relative was moving out of the home and no concerns were identified.

92. In September 2008 Khaista made the first contact with West Midlands Police asking for help in leaving Shab. A domestic violence marker was placed on the address and information report sent to children's social care. No other action was taken by either the police or children's social care.

93. There was a second initial assessment completed by children's social care in November 2008. This followed a referral from Child 2's school regarding an incident that had occurred at school. No concerns were identified.

94. In January 2009 a fourth referral from Child 2's school to children's social care reported that a member of Shab's family was living with the household and was being abusive and threatening. It was the same relative that had been the subject of a previous referral. The relative moved out of the household.

95. In March 2010 Child 1's school were told by Khaista that Child 1 had expressed a wish to harm them-self and was crying a lot at home. One to one mentoring was provided. Child 1's attendance at school was good.

96. In late April 2010 Child 2 attended the Children's Hospital emergency service with a headache, blurred vision and dizziness that had persisted for two days saying that they had been hit by a swing seat. Child 2 presented with similar symptoms and a nose bleed in November 2010; Child 2 left before any treatment was provided.

97. In late 2010 and early 2011 two of the children presented at hospital with various digestive ailments. Child 2 was treated for a sprained finger that was reported to have occurred following a fall at school.

98. In August 2011 the family were registered with a new GP practice following a move to another part of the city.

99. In September 2011 Child 1 and Child 2 started attending school 4 and were there until March 2012. Transfer information when they went to the independent school refers to bullying at the previous school. Child 2 presented with some behaviour difficulties that required Khaista and Shab to be called to the school.

100. In October 2011 Child 4 was referred to a specialist enuresis clinic.

101. In February 2012 Child 2 received treatment for a second injury to a finger (this time a fracture attributed to a sports injury). In February 2012 the family registered with another GP practice.

102. In February 2012 Child 2 was presented at the Children's Hospital complaining of chest pains over several days. The history noted that Child 3 had similar symptoms a few months earlier.

103. From March 2012 Child 1, 2 and 3 were variously enrolled at school 5, a faith based independent school. Khaista and Shab told the school they were concerned about the behaviour of the children; Child 2 in particular was using 'abusive words' about both parents. Child 1 had a history of high incidents of authorised and unauthorised absences from school between September and November 2012.

104. In April 2012 Child 1 was taken to the children's hospital by Khaista with a history of three or four weeks of intermittent chest pain.

105. In July 2012 Shab consulted his GP about the reoccurrence of his depression; subsequently diagnosed as a moderate depressive episode.

106. Two days later Khaista went to the hospital emergency service with a knife laceration to a finger.

107. On the 26th August 2012 Khaista telephoned the police to report that she and one of the children had been assaulted by Shab. She stated that she was frightened of Shab. The police attended but were unable to take a statement because Shab came home while they were there. Khaista was invited to attend the police station the following day.

108. When Khaista went to the local police station she asked for help in getting Shab to leave the house. The police stated that they could not assist with that and advised Khaista to speak to a solicitor. This arose because the police did not classify the information as representing domestic abuse. Khaista subsequently made a declaration to the local Neighbourhood Advice and Information Service that Shab had moved out on the 26th August 2012.

109. On the 29th August 2012 Khaista phoned children's social care to inform them that Shab had assaulted Child 1 (this appears to be the same assault initially reported to the police). Khaista also reported that he had hit the other children at other times. When children's social care contacted the police the following day (30th August 2012) it was agreed that children's social care would conduct single agency enquiries and children's social care subsequently completed a core assessment in late October 2012.

110. On the 5th September 2012 Khaista was granted an ex-parte non-molestation order.

111. On the 2nd October 2012 the WMP received an anonymous emergency call reporting that a male was trying to break into the property; the police linked the number used to Khaista's property and police attended but found nobody there and the property was secure.

112. On the 7th October 2012 Khaista made an emergency telephone call to the police to report that Shab was at her mother's home and that he had threatened to cut the children's heads off.

113. The police went to the house but Shab had left. The officers were told by members of the family that they were trying to encourage the couple to resolve their problems amicably. Both Khaista and Shab were seen by police officers and Shab was advised that he might be arrested if he harassed Khaista.

114. On the 10th October 2012 Khaista completed a case registration form with the Islamic Judiciary Board making a formal request for a divorce under Sharia law on the grounds of violence and abuse of the children.

115. On the 18th October 2012 Khaista's brother made an emergency call to the police to report that Shab was in the house and had a knife. A Taser (electro shock device) equipped response vehicle and local police patrol were deployed. Shab was arrested although no knife was found. Khaista showed the police officers the non-molestation order and it was the alleged breach that was processed (rather than the assault). It is not clear that a detailed search was ever made for a knife.

116. Shab was held in police custody overnight but was released the following morning when the discrepancies in wording and the fact that the order had not been properly served on Shab were identified as making the order un-enforceable.

117. On the 2nd November 2012 Khaista asked School 1, where Child 4 and Child 5 were pupils, not to allow them be collected by Shab. There was consultation between the school and children's social care; Khaista had come to the school to show the non-molestation order. The school were not satisfied that they would have legal grounds to prevent Shab from having contact with his children.

118. Birmingham and Solihull Women's Aid received a referral from the police and spoke with Khaista by telephone on the 6th November 2012. An appointment was made to see Khaista but this was subsequently cancelled by Khaista.

119. On the 10th November 2012 Shab took an overdose; Child 3 was present. He was taken by ambulance to hospital and discharged himself before a mental health assessment could be completed.

120. On the 12th November 2012 Shab received a letter from the Islamic Judiciary Board to inform him that Khaista had requested a divorce. On the same day he attended the emergency hospital department at Heart of England Foundation Trust complaining of palpitations and chest pain.

121. A week later Shab murdered Khaista.

1.15 Overview

122. It is now apparent that there had been difficulties in the relationship from about 2000 although the first public disclosure was several years later in 2008 when Khaista went to the local police station asking for information about how to leave her husband. According to Khaista's statements in support of her application for the non-molestation and occupation orders in September 2012, the marriage had initially gone well and Shab had worked hard to provide for the family. However, by 2000 Shab had changed and had become short tempered and was beginning to suffer from depression. The first contact with mental health services did not occur until 2004.

123. There were additional tensions arising from the crowded conditions in the house and this appeared to be exacerbated at times when relatives had lived with the family. Some of these family relations were the subject of a referral to children's social care on different occasions; one had been reported as being verbally abusive to the children.

124. According to the written statement made by Khaista in support of the divorce application, Shab would smack the children when they were screaming, shouting or playing. He also began to physically assault Khaista; this is at odds to the information given to the police in 2008 that no physical assaults had been made. Khaista had been initially sympathetic feeling that it was his depression that was causing Shab to feel stressed. Khaista then became increasingly frightened of Shab and that if she took a stand against his abuse it would result in an escalation of the abuse and violence. The couple separated in August 2012.

125. Khaista's family knew about the abusive relationship and although they had initially hoped the marriage could survive for the sake of the children they had offered support to Khaista in seeking a separation and divorce in 2012. They had become worried about Khaista's safety in the last few weeks of her life although had not anticipated the killing.

126. Khaista had initiated divorce proceedings through the Sharia law in mid-October 2012. A letter dated seven days before Khaista was killed was sent on behalf of the Islamic Judiciary Board to Shab to inform him that Khaista had requested a divorce. This was a significant factor identified during Shab's trial in the final escalation of violence by Shab who it is now known had been abusive and violent in his relationship with his estranged wife from when they had their first child in 2000. There are five children, aged 7 to 14 years of age, who also experienced abuse from Shab, either by witnessing or being subjected to direct assaults.

127. Khaista's first disclosure about abuse to the police in September 2008 described coercive and controlling behaviour by Shab. According to information recorded by children's social care when the police subsequently passed information on to them, she was being 'pressurised' to have sexual relations. The police do not have this detail in their information system. Shab threatened to remove the children from the UK if she left him. A marker was placed on the address in the police information system as being the home of a victim of domestic violence although no other action was taken other than to pass an information report to children's social care.

128. It was August 2012 when Khaista next contacted the police (or any other service) about the domestic abuse and told the police about the physical violence being perpetrated on herself

and her children. The police advised Khaista to seek legal advice regarding a divorce and to seek guidance about what was appropriate child chastisement (this was in regard to Shab's physical punishment of the children). The couple separated in late August 2012 although Shab continued to make contact with Khaista either directly or through relatives. The police received three further calls during October 2012 in relation to threats made to Khaista.

129. A non-molestation and occupation order was made in early September 2012 ex-parte (on the sole application of Khaista without the presence of Shab). The order cannot be enforced by the police and the judicial system until it is served in person as described in a specific protocol for process servers published by the Family Justice Council.

130. The orders were not served on Shab and this was significant in how the police responded to at least one of the further reports of violent and threatening behaviour by Shab in 2012. As part of their contact with Khaista and Shab, the police completed DASH (domestic abuse, stalking and harassment) assessments none of which had graded Khaista at more than medium risk. An assessment of high risk would have resulted in a referral to a MARAC (multi-agency risk assessment conference).

131. Seven referrals were made to children's social care between 2006 and September 2012 (although one of those referrals is a duplicate). There was also a joint domestic violence screening assessment that had concluded that the level of risk to the children was at level 4 indicating a highest level of risk. The subsequent social work core assessment concluded that Shab's behaviour was 'inappropriate chastisement'. There were plans to close the involvement of children's social care when the murder took place. Children's social care had concluded that Khaista had taken steps to protect herself and her children.

132. A referral on 2nd November 2012 to Birmingham and Solihull Women's Aid was followed up by an initial telephone risk assessment that recorded the risk of domestic abuse to be high. Khaista did not subsequently attend a scheduled appointment on the 14th November 2012. The 14th had been the earliest time that Khaista could attend. A follow up call was made on the 16th November 2012 but Khaista was not available.

133. Shab had intermittent contact with mental health services since 2004 although the first symptoms of depression had, according to Khaista's statement in support of the non-molestation order, begun in 2000. Although he had experienced depression and some episodic psychotic symptoms, from 2004 this was managed with medication. No depressive or psychotic symptoms had been evident during the routine psychiatric consultations.

134. There was a significant break down in how the non-molestation order was managed after it had been granted in 2012 and this highlights a potentially significant and systemic weakness in giving protection to the victims of domestic abuse.

135. Khaista sought a non-molestation and occupation order under the Family Law Act 1996 Part IV in September 2012[7]. The application included a detailed history of the relationship and of dates of incidents of domestic abuse. This was a private application without advice or support from any agency other than a private law partnership of solicitors.

136. Although Khaista initiated a legal process to secure court protection from Shab, important legal requirements were not complied with to make the orders enforceable. It remains unclear if Khaista fully understood the significance of this; the result was that having taken action against Shab in a civil court she had not secured the legal protection she was looking for. Several professionals working with Khaista did not know that the orders were unenforceable until the errors were identified after Shab's arrest and overnight detention by the police in October 2012.

137. The court application was made without Shab being present at court (referred to as a 'without notice application' or ex-parte). This order was made on the 6th September 2012 with a requirement for both parties to attend a further court hearing, which is usual practice.

138. The second hearing listed for the 21st September 2012 was so that Shab could attend that hearing once he had been personally served with the papers in order to either contest or to agree to a final order being granted. That hearing was not attended by either party.

139. The solicitor acting for Khaista was required to arrange the serving of the application, the interim court orders and the Notice of Hearing for the 21st September 2012. The solicitor did not have the address for Shab and wrote to Khaista on the 10th September 2012 asking for that information. Khaista responded on the 23rd September 2012 saying that she knew that Shab was living with his sister but that she did not know the address.

140. A letter dated 31st October 2012 from the solicitor to the court states that legal representation would not be provided due to Khaista not providing financial information to the Legal Services Commission (for the administration of legal aid[8]).

141. The same letter confirms that Shab had not been served with papers and requested an adjournment. It therefore seems that neither Khaista nor her solicitor were at court on the 21st September 2012. A further hearing was listed for the 4th January 2013. The solicitor attended court on that date to advise the court that Khaista had died on the 19th November 2012.

[7] The non-molestation order can forbid the respondent from molesting the applicant or a relevant child. Molestation can include, for example, violence, threats, pestering and other forms of harassment. The Court can forbid particular acts of the respondent, molestation in general, or both. The occupation order indicates who can live in the family home and can direct another person to leave the home. The court can make an order initially ex-parte although will set a further date for the respondent and applicant to be in court to allow evidence from both parties before a final order is granted. The police have now been given powers to issue Domestic Violence prevention Notices (DVPN) that for example can remove a perpetrator from a family home; these were not available at the time of the events examined in this DHR.

[8] Access to publicly funded legal aid is available to victims of domestic abuse subject to means assessment.

142. A letter was sent to Khaista on the 25th September 2012 to confirm that an order had been made; it was not served. The solicitor had made several attempts to contact Khaista for the address where Shab was living but without success.

143. The legal action taken by Khaista therefore did not provide the protection that she thought. The securing of legal representation relied on Khaista being able to comply with a request for financial information to process the legal aid application. She was unable to provide an address for Shab in order to have the legal papers served.

144. As part of the application for the non-molestation and occupation orders, Khaista's solicitor completed a matrimonial checklist that confirmed a social worker was involved. There was no liaison with any services at any stage even when it was becoming clear that the legal action was being compromised. There is no guidance for lawyers dealing with a case such as Khaista and her children to help reconcile the duty of confidentiality to a client but balancing that against a wider responsibility in regard to helping promote the safety of dependent children.

145. There was confusion about the circumstances of Shab's arrest for breaching the order which meant that details of the assault were not adequately taken into account when he was released with no further action.

146. Decision making by police and social workers was significantly influenced by a belief that Khaista was asking for help and taking steps to protect herself and her children and therefore diminished the level of intervention seen to be required. There was a reliance on Khaista having the emotional and physical capacity to protect herself. Professional decision making about risk has to be informed by sufficient understanding about the potential for domestic abuse to escalate and for there to be heightened risk at critical points when for example victims disclose abuse or take action to end abusive relationships.

147. The fact that Shab had left the matrimonial home and Khaista had taken legal steps to prevent contact provided a misleading sense of safety that influenced how some professionals, such as children's social care and the police, approached risk assessment and managed their contact with Khaista and Shab. Rather than seeing separation from a controlling and coercive relationship as signifying loss of control on the part of Shab and therefore potential for an escalation in the risk to Khaista, the separation was seen as a resolution requiring no further substantial input.

148. The case illustrates the importance for practitioners in all services to have sufficient understanding about the hidden nature of domestic abuse and the reasons for this; the extent to which all victims will face barriers and inhibitions that can be exacerbated by culture and coercion, as well as concern about the repercussions for dependants such as children.

149. The children presented with some symptoms of stress that can now be understood as reflecting the level of domestic abuse that was a longstanding issue and was apparently escalating in 2012. The absence of enquiries by education and health provided no opportunity for the children to disclose information about life at home.

150. There was a plan to undertake an assessment with Shab when he attended the hospital emergency department on the 10th November 2012 and he had been admitted as an inpatient to the assessment unit as a voluntary patient. However he left the unit before the mental health practitioner visited the unit. Shab was a voluntary patient and therefore was not detained and his movement could not be restricted.

151. The risk assessments that were completed were largely conducted in single and separate organisational silos and none were focussed sufficiently on the attitude and behaviour of Shab. Although Birmingham and Solihull Women's Aid had believed that Khaista's circumstances were due to be discussed at a MARAC, the case was never scheduled in November 2012. This misunderstanding arose because the referral form used by the police at the time was used for MARAC as well as lower risk referrals and there was not an opportunity to have a multi-agency sharing of information.

2 Analysis of information against the key lines of enquiry

2.1 Knowledge and information known to agencies about Khaista

152. The fact that domestic abuse was long standing in the 17 year long marriage and started with the birth of the first child is consistent with research evidence that shows a strong correlation between domestic abuse and pregnancy. Pregnancy, far from being a time of peace and safety, can trigger or exacerbate male violence (Bohn, 1990; Helston and Snodgrass, 1987[9]) and especially if as it was in this case, exacerbated by depression and mental illness. It is estimated that 30 per cent of domestic abuse commences during pregnancy (DoH, 2004; McWilliams and McKiernan 1993[10]). Women experiencing domestic abuse can be helped if someone asks them about problems in their relationship although disclosure of abuse may not be forthcoming.

153. Khaista's delay in disclosing abuse is not unusual as evidenced in research and from other domestic homicide reviews. It is increasingly understood that domestic abuse is rarely disclosed at an early stage and on average 35 incidents will have occurred before a disclosure or complaint is made to the police or other services[11]. At the time, Khaista felt isolated and there was a rift with her own family. She had five dependent children, was not financially independent and had been coping with Shab's depression and being abused.

154. When Khaista asked for help, the response from services was generally unable to provide effective enough intervention and support. Some of this reflected a fundamental misunderstanding about the nature and risk of abusive and coercive relationships that cannot be addressed through mediation and reconciliation. There were also issues of deeply felt religious and cultural traditions that had an influence on how information was processed between Khaista, the family and some professionals.

155. There was long term emotional abuse and coercion and escalating physical violence after Khaista had made clear her intention to leave the marriage. This is also consistent with the research evidence that highlights a heightened risk and incidence of violence associated with a victim leaving an abusive relationship[12].

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[9] Domestic violence and pregnancy: Implications for Practice Journal of Nurse-Midwifery Volume 35, Issue 2, pages 86–98, March-April 1990

Helton AS, Snodgrass FG (1987) Battering during pregnancy: intervention strategies. *Birth*. 14:3 142-7

[10] Department of Health (2004) *Why mothers die: report on confidential enquiry into maternal deaths in the United Kingdom 2000-2002*. London. TSO; McWilliams, M, McKiernan, J. (1993) *Bringing it out into the open*.

[11] Yearnshaw, S. (1997) 'Analysis of Cohort.', in Bewley, S, Friend J and Mezey G (eds.) *Violence Against Women*, London: Royal College of Obstetricians and Gynaecologists

[12] Several studies including (Humphreys and Thiara 2002 *Routes to Safety: Protection Issues Facing Abused Women and Children and the Role of Outreach Services*. Bristol: Women's Aid Publications.; Radford and Hester 2006 Radford, L. and Hester, M. (2006) *Mothering through Domestic Violence*. London: Jessica Kingsley) have established that a substantial proportion of domestic violence occurs in the course of or following separation.

156. In August 2012 when Khaista next contacted the police to report that she was the victim of domestic violence from Shab, she was clearly frightened and made clear that she did not want Shab to know that she had made the call.

157. Research evidence from previous deaths following domestic abuse consistently show that disclosure represents heightened risk of an escalation in the abuse. During the phone call Khaista reported that Shab had assaulted the children. The police officer who responded found Shab at home with Khaista and was therefore unable to take a statement from Khaista.

158. That officer reported that there was no immediate danger and that the children appeared 'safe and well'. The police individual management review author refers to a recent domestic homicide review in Coventry that had already resulted in all police officers in the West Midlands being required to address whether there were safeguarding issues rather than relying on generic and superficial 'safe and well' observations that can lead to unduly optimistic mindsets that influence subsequent enquiries and the processing of information. In this case there was insufficient awareness about the history and the level of threat and fear felt by Khaista and nothing recorded about what any of the children felt.

159. The individual management review from West Midlands Police explains that the electronic vulnerable and intimidated witness log that is intended to alert the specialist officers in the Public Protection Unit to any contact with a victim of domestic abuse was not completed and therefore the Public Protection Unit had no opportunity to review and intervene in the police response thereafter.

160. When Khaista went to the local police station the following day on the 27th August 2012 she wanted the police officers to go with her to her home with the purpose of asking her husband to leave. When police officers sought further information from her they were told that she was not hit by Shab but that he hit the children when they misbehaved. The officers were unaware of the earlier history.

161. Khaista was advised that this was not an offence if the punishment was 'proportionate'[13]. Khaista was asked if she was afraid of Shab and she said that she was not, although the officers were not aware that she had expressed concern in her initial telephone contact. The police officers advised her to seek legal advice about seeking a divorce; the officers also mentioned that she could seek a non-molestation order and that they could give her information about going to a solicitor.

162. It is not confirmed in the police records whether any other information was given to Khaista other than that she was told that the police would not go to the house to remove Shab and was advised to consult and instruct a solicitor. A DASH assessment was not completed because the police officers did not regard the information as representing domestic abuse despite the reference to non-molestation orders. No referral was made to children's social

[13] The police took prompt action to issue practice guidance on the 21st December 2012 throughout the service to all officers to address the apparent misunderstandings about policy and protocol.

care because the officers believed that this was a difference of parental view about behaviour management and chastisement.

163. None of the police officers (the one who made the original response or the two that interviewed Khaista when she went to the police station) completed the W392 that requires the police to record their contact as either a crime or non-crime contact and have a crime number allocated to it. The lack of recording meant that there was no further check or oversight by supervising officers.

164. When Khaista telephoned children's social care on the 29th August 2012 to tell them that Shab had hit Child 1 and that he had assaulted the other children Khaista told children's social care about her contact with the police on the previous Sunday. There was no clarity in the agency records about what the police had done or what the outcome was.

165. The police relied on a single agency inquiry by children's social care in late August 2012 to follow up the allegation of an assault on the eldest child. It was a social worker who also confirmed that Khaista was no longer in a relationship with Shab. This had led both children's social care and the police to conclude that Khaista had resolved the threat to herself and to the children and no further action was required. The approach indicates a naïve understanding about the extent of the abuse and the risk of escalation now that Khaista had achieved separation against the wishes of Shab. The referral was archived without any crime or non-crime being recorded. The police individual management review states that the information was discussed the following day at the joint screening panel on the 11th September 2012 where it was assessed at scale 4 and for no further action by any service.

166. The emergency telephone call to the police five days later on the 7th October 2012 by Khaista was to report that Shab was at her parent's home where there were three of her children and that he had threatened to chop the heads off the children if he could not have them. Khaista was at her own home with her other two children.

167. The police patrol that was deployed had anticipated dealing with an ongoing incident. On arrival the police officers found no evidence of a disturbance. There was nobody outside or near to the property and when they knocked on the door it was answered by Khaista's brother who appeared surprised to see the police at the property and asked why they were there. The officers explained that they had been summoned via a 999 telephone call. The brother explained that Shab had been to the house asking to see his children but when he was refused access he had left apparently returning to a nearly property where he was living. Khaista had made the telephone call from her home apparently without telling her brother or family. It was an indication of the fear and anxiety she had about Shab having contact with her or any of the children.

168. When Khaista subsequently arrived at her parent's home she was invited to sit in the patrol car to speak with the police officers. She explained that Shab was trying to get custody of all the children so that he could have all of the benefit money (and therefore she was being subjected to financial coercion). She wanted to know how to get custody and prevent him from having the children. The officers saw the dispute as a civil law issue (rather than

domestic abuse) and advised Khaista that she needed to speak to a solicitor. Khaista disclosed that she already had a non-molestation order but did not have it with her. The circumstances for the order being made were not explained and do not appear to have been the subject of any follow up inquiry by the officers. They did not know about previous contacts which had been at Khaista's address rather than her family's home; according to the officers they routinely receive 'view similar incidents' (VSI) over their airwaves on the way to an incident and no previous contact or concerns were flagged. They worked on an assumption that their control would give them any relevant information.

169. As previously, no crime or non-crime domestic violence incident was recorded and therefore again no referral was made to the Public Protection Unit where specialist officers would have screened the information. No DASH was completed and none of the children were spoken to by any of the officers. This was the third occasion when Khaista had reported her concerns about the safety of her children.

170. Eleven days later Khaista's brother made a 999 telephone call from their parents' home saying that Shab had forced his way into their property and that he had a knife. A Taser equipped response vehicle together with another patrol vehicle was deployed. Shab was attempting to leave the property as they arrived. Khaista had taken refuge in a ground floor lavatory. The police searched Shab but found no weapon.

171. The officers as on the previous occasion had arrived expecting to deal with a potentially dangerous confrontation and in fact found no incident in progress although Khaista was clearly very distressed. The account of the incident was that Shab had not forced his way into the house but when Khaista made clear she did not want to see him she had taken refuge in the lavatory and he had then made an effort to first of all speak with her through a window and had then forced entry to the lavatory and taken hold of her wrists.

172. Khaista informed the officers that she had separated from Shab in August 2012 and that she had since been subjected to harassment from constant phone calls from him.

173. When the non-molestation order was shown to the officers Shab was arrested and taken into police custody at the police station. The apparent breach of the order became the primary ground for the arrest and detention and the allegations of assault and use of a knife were not investigated or recorded in any detail. This became significant when the irregularities in processing the non-molestation order were identified the following day. The officers had other urgent incidents requiring a police response in the area.

174. The DASH assessment completed by the police officers concluded that Khaista was at medium risk; this was subsequently downgraded to a level of standard risk by the supervising sergeant on the basis that Shab was already in police custody but took no account of the history and the level of threat felt by Khaista. There were several factors that influenced decision making; the lack of information about the knife and allegations of assault, the fact that police officers were called away to deal with another incident before processing the information, the handover and processing of information and of Shab that involved several different individual officers and sections.

175. Khaista made a 'reluctant' statement of complaint about Shab's breach of the non-molestation order; the police officers had to spend time encouraging her to speak at all. A victim's reluctance to make statements of complaint against a husband or partner is not unusual. In her victim support statement she stated that she had been 'occasionally assaulted' but that she had never reported it because she was afraid of him. Khaista also went on to say that his behaviour had become increasingly coercive and controlling and that this was the reason for Khaista seeking a divorce. She had sought the non-molestation order because of his harassment after the separation in August 2012.

176. Khaista contacted the police station later in the evening to say that she wanted to retract her statement; there is no information about the circumstances or reasons and no evidence of the police following this retraction up. It is West Midlands Police policy that a retraction statement should be taken. Few of the officers appeared to be aware of this whilst one felt that it might well reflect good policy in an ideal world but was a lower priority compared to other tasks and jobs that had to be allocated especially in a busy inner city area. This appears to indicate a view that the policy is an issue of administration and compliance rather than an important element of finding out if a complainant has been subjected to further coercion and influence to make the withdrawal.

177. The retraction became significant when the problems with the non-molestation order became apparent. A retraction is not uncommon when victims of abuse are fearful of repercussion or have a residual emotional attachment and concern for their former partner. Given the pattern of escalating harassment and threat and that separation, making disclosures or statements about abuse and violence are all associated with heightened risk to a victim.

178. Shab was held overnight and the early shift sergeant reviewed the paperwork and was informed that the wording of the non-molestation order was incorrect and also noted that the order had not been formally served on Shab[14]. When the sergeant checked the electronic police portal system regarding the incident there was no mention of a knife in the record. The sergeant did not read the statement taken from Khaista which contained greater detail about the assault.

179. Shab was released without any further referral or discussion with children's social care who were not made aware of this incident until an agenda for the multi-agency domestic violence screening panel scheduled for the 31st October 2012. This panel did not involve the children's social care staff who were in direct contact with the family although the service was represented; the record of the incident was not placed on children's social care

[14] When the court makes a non-molestation order and/ or any other order/s to which a power of arrest is attached the orders have to be set out in a Form FL406 or Form FL404a. That form (and any other order of the court made at the same time) must be served directly and personally on the respondent (or he must have been present when the order was made or be told by telephone or told directly in some other way). The respondent does not need to take the form or orders in his hand but some attempt must be made to hand them to him and tell him of their contents. Without delay, the Form FL404a or FL406, and a copy of the statement showing that the respondent has been served with a copy of the order and/or informed of its terms, must be delivered to the officer in charge at that time at the police station for the applicant's address or the police station which has been named (or specified) by the court.

records until the 7th January 2013. This was a significant gap in sharing of information and meant that the social workers in direct contact with Khaista and the children remained unaware of the threatening behaviour with a knife until much later. The children's social care individual management review describes how responsibility for ensuring that the information about this incident, when it was scheduled and discussed at the multi-agency domestic violence screening panel, was not clear.

180. A police safeguarding officer was allocated the task of contacting Khaista with the purpose of discussing her safety and protection along with that of her children; this was after the DASH had already been downgraded by the response team sergeant to a level of standard risk.

181. The first contact by the safeguarding officer was not made for almost two weeks on the 2nd November 2012; the reason for the delay is not known. Khaista confirmed that she had 'rectified' the non-molestation order (although this was not the case) and she agreed to a referral being made to Birmingham and Solihull Women's Aid. The referral also stated (incorrectly) that Khaista had been referred by the police for the MARAC panel and was therefore categorized on receipt at Women's Aid as high risk. In the event the case was not put on the agenda by the police or discussed at the MARAC because the police had not ever seen this as a high risk case. According to police records, the case was discussed at the joint screening panel on the 31st October 2012 which was before the safeguarding officer had spoken to Khaista and before the referral to Women's Aid.

182. There were gaps in how information about Khaista was shared and communicated. There was a delay in the police reporting the break in and attempted assault on Khaista at the end of October 2012 and there was confusion in regard to the use of the multi-agency screening panel and risk assessment framework. At one point a MARAC referral was opened although Khaista was never assessed as being at high risk of domestic abuse and there was only one occasion when she was assessed at medium risk. There were delays in making referrals. The extent of the abuse was hidden for many years and remained hidden for the most part even when Khaista called for help on more than one occasion in 2012. Information was not collated.

183. The extent to which information and observation was taken at face value is significant. There was often a dissonance between for example the initial call for help to the police and what was actually observed when the officers responded. Matters were compounded by the fact that for some of the officers, they had no recent up to date training in regard domestic abuse and the changes to policy in regard to DASH and WC392 which relied on individual officers accessing video based training material; the officers had attended training provided in 2009 and 2010 by West Midlands Police throughout the police service.

184. They were frequently under time pressures and faced problems in securing clear accounts sometimes because of language issues and often because of reluctance to speak; officers could have accessed the Language Line translation service.

185. In Khaista's contact with services asking for help, there was insufficient understanding demonstrated about Khaista's circumstances and having her need for help clarified.

186. This may have contributed to the core assessment by social care services not being more rigorous and comprehensive in the collation of history and information about the dynamics and functioning of the family, ascertaining the views of the children and trying to speak with members of the extended family. The police statements taken during the murder investigation provided evidence of concerns by members of the extended family. All of this is against a background where all of the services are dealing with high levels of demand and superficially this appeared to be a family that had little need of statutory involvement.

187. The children's social care individual management review comments that the allocated worker SSW1 gave a lot of weight to Khaista's presentation and her positive reflection of her circumstances and infers that this influenced the way that SSW1 was processing information and led to an optimistic frame of mind. Khaista was not behaving like a victim. This can become more pronounced for busy services that are naturally trying to prioritise where they need to direct their resources to cases that appear to display a higher degree of need or risk. Although Khaista sought help, she appeared to have already taken sufficient steps to protect herself and her children. They all appeared to be emotionally and physically well and therefore were not regarded as an urgent priority.

188. No consideration was apparently given to any continued risks posed, either already known about or potential, and it appeared that the belief that the parents were now separated and the fact that there was an injunction in place would be sufficient to protect Khaista and the children. No consideration was given to the views of Shab as to how he perceived his separation or even what he planned to do in relation to his future and any ongoing contact with his children and the risks this might pose in itself.

189. Although the social worker had attended domestic abuse training, their practice, certainly with the benefit of hindsight and reflection of this review, appeared naïve in not representing a more research aware approach to risk assessment and management. The individual management review refers to the research evidence that identifies separation as a period of enhanced risk. No clear strategies were put in place in regard to how contact between Shab and the children would be managed. One of the children was particularly favoured by the paternal family compared to the others and was staying with the paternal family. When School 1 contacted children's social care in early November 2012 about Khaista's request for restricting contact between Shab and the children, the advice was that was a matter for the school to make a decision. The social worker was not helped in their task by the delay that occurred in the information being sent through from the police about the incident on the 18th October 2011 and which was not uploaded onto the children's social care system for several weeks.

190. Just over two weeks before she was murdered, a risk assessment completed by Birmingham and Solihull Women's Aid recorded the history and extent of abuse. There was a disparity in the level of risk assessment of the police and Women's Aid (which was higher). Given the specialist knowledge of Women's Aid, this may have been significant in the different higher threat level being identified as much as acknowledging that risk is not a static or permanent condition; it can increase and decrease dependent on different factors.

In this case the action by Khaista to separate and end the marriage against the wishes of Shab caused an escalation of risk.

2.2 Knowledge/information that agencies had that indicated Shab's domestic violence and how agencies responded to any information.

191. The initial contact in 2008 had been to all intents and purposes dealt with as a private matter and not as an issue of domestic abuse for the police to investigate. The reference to sexual violence appeared to be overlooked by the police and children's social care and may have reflected a misplaced understanding about issues of consent within marriage.

192. There was a continuing mindset that the issues reported by Khaista in 2012 were primarily a private matter. The non-completion of the relevant processes for recording risk and vulnerability as well as crime was an apparent reflection of this overall approach and mindset.

193. Shab was not the subject of any direct risk assessment in regard to domestic abuse. West Midlands Police do not have a system for such risk assessments; the DASH focusses on Khaista as the victim. The only method available to risk assess offenders is the Integrated Offender Management. This is predominantly used for serious and acquisitive crimes and does not adequately reflect the type of risk from a domestic abuse perpetrator given that it collates intelligence and recent offending. This is currently being addressed by West Midlands Police who have also created 18 posts for domestic abuse offender managers in the newly formed domestic abuse teams. On the one occasion that he was arrested and detained he was released without any detailed inquiry or assessment.

194. There is a general lack of information and curiosity about the nature of Shab's illness and how it had an impact on him and his relationships within the family. There is little evidence of professional awareness about the nature of domestic violence in terms of the increased risk of violence at the point of separation, the increased risk of children being exposed to domestic abuse after separation when there is dispute about arrangements, the barriers to disclosure and the corrosive impact of coercive and abusive behaviour especially for young children.

195. It is significant the extent to which all of the services in contact with Shab did not communicate directly with him on many occasions. His command of English was generally accepted to be much less developed than Khaista. None of the individual management reviews are able to satisfactorily explain why interpreters were not used more consistently; all confirm that they have access to these services and none reported that budgets were a factor in not using them.

196. Although one of the individual management reviews indicate that Shab had more English vocabulary than was assumed by others, it is clear that communication on many occasions faced a fundamental barrier in being able to reveal the feelings and emotions of Shab.

197. Information about the incidents of abuse that were reported to West Midlands Police was not known to the mental health services working with Shab. The individual management

reviews acknowledge that this had implications for the risk assessments that were completed that focused on Shab's capacity for self-harm and tended to be optimistic because of his lack of ideation or intent to cause harm to himself. It also contributed to what with hindsight can now be seen to have been misguided signposting to drop in sessions and mediation. It may also have contributed to the lack of pace in processing a referral back into mental health services by the GP in July 2012; rather than receiving an appointment within the expected six weeks, it was ten weeks before an appointment was offered. The reason for this is not clear to the Mental Health Trust author; if there had been more complete information about the extent of underlying needs and problems this may have led to a more prompt response.

198. The fact that Shab was receiving support but did not need to be the subject of any more formal or intensive intervention because he was not assessed as being a risk to himself or to others was consistent with expected standards and guidance. It also meant that contact time with specialist medical staff was more limited. This was not conducive to a more discursive and reflective approach to collating information and enquiry. Adult psychiatric services had no contact with the children; the Mental Health Trust author makes the point that an adult psychiatric clinic would not be a place for children to attend although still deserves some exploration about how the impact on children is assessed in such services.

199. When Shab became mentally ill in 2004 it is clear that mental health professionals were alert to the implications of psychosis and keeping under active review any evidence of Shab presenting any risk of self-harm or to others.

200. There was limited exploration of Shab's mental health history and the implications for the family. There was insufficient account sought and recorded from the children and there was no explicit exploration about domestic abuse. Matters were further hampered by an interpreter not being used to help clarify communication; this was a factor for other interactions by services other than children's social care who all relied heavily on Khaista providing translation.

201. Following the overdose that Shab took, while two of his children were in the house, in November 2012, he was admitted to the HEFT Acute Medical Unit. The mental health assessment should have included a check in regard to whether there are children and if so whether there are safeguarding concerns. This was overlooked and not completed according to the individual management review. This is an issue identified in an individual management review completed some months previously for a different review and an audit of practice is being completed. A contributory factor identified by this individual management review is that hospital staffs were aware that the police had contact with the family and assumed that the police would be liaising and making referrals with the relevant services. The individual management review author acknowledges that this is not compliant with standards and protocols.

202. The assessment of Shab was focused on his risk of self-harm rather than whether he represented a risk to anybody else in the family. The Acute Medical Unit was not aware of any of the history of recently disclosed domestic abuse. He was assessed as being at low risk of self-harm although the individual management review acknowledges that this

reflected a misapplication of the framework that did not factor in additional risk factors for example associated with his unemployment and previous history; the individual management review also cautions the use of the SAD self-harm assessment[15] in isolation from a medical or mental health assessment. If it had been he would more likely have been placed at higher risk of self-harm and by implication would have represented a higher degree of risk given the threats he had issued previously to Khaista.

203. Although the Acute Medical Unit made referral for Shab to be assessed by the Rapid Interface and Discharge (RAID) service he had left the unit before anybody from that service saw him[16]. Because there was no order detaining him within the unit he was not classified as a missing person and no follow up was made. The individual management review acknowledges that this was a missed opportunity and that his self-discharge should have triggered a missing person action and there should have been a follow up by the RAID service.

204. A significant contributor to the lack of follow up was that RAID did not have a written referral and they were not told that Shab had left the Acute Medical Unit. The unit relied on a practice of verbal communication combined with RAID checking whether there were patients in the unit who required their service.

205. The Mental Health Trust individual management review comments that if there had been a mental health assessment by RAID there would have been a better opportunity for background information of the family to have been explored including the domestic abuse. The nurse in the emergency department who initially saw Shab had intended making a referral to children's social care but this was overlooked. All of this was within the context of a busy emergency department managing competing and complex patient needs and requirements.

206. There was a further complication in that Shab was transferred from the emergency department to the assessment unit and the fact that a safeguarding referral had not been completed was not recorded on the transfer. There was a further issue in regard to the risk assessment not being completed accurately in regard to considering all factors which would have put Shab in a high risk of self-harm and would have had implications for how his self-

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[15] SAD assessment tool for self-harming patients The SAD PERSONS scale is an acronym utilized as a mnemonic device. It was first developed as a clinical assessment tool for medical professionals to determine suicide risk, by Patterson et al.
S: Male sex
A: Age (<19 or >45 years)
D: Depression
P: Previous attempt
E: Excess alcohol or substance use
R: Rational thinking loss
S: Social supports lacking
O: Organized plan
N: No spouse
S: Sickness

[16] RAID is a specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham, for people aged over 16.

discharge was followed up as well as being relevant in considering the implications for his children.

207. The Mental Health Trust individual management review discusses how although social histories are routinely taken, there is no template or pro-forma to complete in regard to adults. This does not imply that having a template would necessarily improve quality or ensure any greater consistency. There is a standardised framework for history taking in regard to children.

208. Information about the police arresting Shab at the home of Khaista on the 18th October 2012 when he had gained access into the property with a knife was not passed to other services, including children's social care, until the screening panel on the 31st October 2012. The information was then not placed on the case records until the 7th January 2013. Although Khaista had mentioned the incident, the full details were not known to the social worker until January 2013 and was after Khaista had been murdered. Children's social care was completing a core assessment at the time.

2.3 The opportunities and services that agencies offered and provided to meet the needs of Khaista and her children

209. It is acknowledged that with the benefit of hindsight, there could have been more purposeful and effective responses to Khaista and for her children particularly from the police as well as from children's social care. Some of the confusion may have been reflected in the various risk assessment frameworks for example in regard to DASH or joint screening. There was an apparent reliance on Khaista having the capacity and confidence to protect herself and her children and she had, with the support of her family, sought advice and had taken action to separate from Shab and to end her marriage to him.

210. Analysis from the case reinforces key themes from national evidence and research in regard to the escalation of both risk and actual violence at the point of separation. The response from the police in 2008 was to encourage Khaista to find a private resolution rather than seeing it as a risk of escalating abuse and coercion. Children's social care were reliant at the time on unqualified people processing information from the police and other services and were therefore not in a position to challenge a recommendation to treat the police report for information only.

211. The children's social care author reported finding evidence that the children were seen during the core assessment that began in September 2012 but there was little evidence of exploring with them what their knowledge of their parents relationship was or how it had an impact on them.

212. The information following that first police contact was sent through to children's social care as an information report rather than a referral. Children's social care staff processing the information also did not recognise the behaviour as indicating domestic abuse and sexual violence or the implications for the children as well as for Khaista. In 2008, information reports were being received and processed by staff that were not social workers or professionally trained and qualified; this system had changed following an Ofsted

inspection of safeguarding services in July 2010 that identified the arrangement as unsatisfactory.

213. The referral in late August 2012 to the police from children's social care in regard to Khaista having reported the assault of the eldest child by Shab and that the other children were also being hit by him was processed by an acting sergeant in the Public Protection Unit who advised children's social care that they should conduct a single agency enquiry given the recent contact by the police. The initial assessment that children's social care had just started was halted and a decision taken that children's social care would undertake all the enquiries as a Child In Need core assessment[17].

214. The police individual management review acknowledges that the referral should have been an opportunity for the specialist officers in the Public Protection Unit to have reviewed the case. The response was not consistent with policy. Information to emerge from the IPCC investigation is that the unit was particularly busy on the day the telephone call came in and at the time all telephone inquiries were coming to the unit and not being answered by a central referrals unit. The sergeant who dealt with the call from children's social care was not aware of any previous police contact and this contributed to the decision that children's social care would make the only enquiries and collate any further information.

215. In the event, children's social care contacted the police ten days later to report that there had not been any disclosures from the children.

216. There is very little information recorded by any service regarding the views, wishes and feelings of the children although they did receive a range of services in relation to health as well as education. The assessments provided limited information and did not appear to anticipate some of the likely impact and symptoms of emotional distress and behaviour for children living with domestic abuse.

217. There is reference to several professionals from different services including schools, children's social care and the police talking with the children although little detail about what was actually discussed. Although it is apparent that people ensured the children's' immediate safety was secure there was less apparent understanding and insight about what the impact was on the children; of Shab's illness, the parents' separation, the allegations of assaults; there was limited collation of information about what the children knew and understood about Khaista's concerns.

218. The schools remained largely outside the loop of assessment, enquiries and information sharing even in late 2012. When School 1 were asked by Khaista to prevent the children being collected from school by Shab in early November 2012 it was the first occasion when any of the schools were apparently made aware of domestic abuse. That school was aware of the non-molestation order and Khaista had expressed her fear of violence from Shab. The school was not aware of the history of domestic abuse either in regard to information

[17] The national framework for the assessment of children in need and their families that distinguished between initial and core assessments was abolished by the coalition government from April 2013 to be replaced by locally determined single assessment arrangements.

shared with them or displaying a degree more curiosity when for example information about separation was mentioned.

219. The school was advised by children's social care in response to a phone call to clarify arrangements that the social worker did not consider Khaista's 'fears to be well grounded'. The head teacher at School 5 was made aware by Khaista and Shab that they had separated and that children's social care were involved. The date and details of the meeting were not recorded and there was no contact made between the school and children's social care to clarify the circumstances.

220. When on the 31st October 2012 Shab had tried to collect two of his children from their school there was telephone consultation between the school and children's social care. The head teacher was concerned that in the absence of any legal orders there were limitations in being able to prevent Shab from collecting the children. The head teacher was advised that copies of the non-molestation orders would be provided; these are the orders that the police were unable to enforce.

221. For several years, research (for example reviewed by Kolbo et al 1996[18]) indicates that most, if not all children are seriously affected by exposure to domestic abuse particularly when it is repeated over a period of time as is usually the case. The children were clearly affected by their circumstances such as living between different households, changes to schooling as well as being victims of assaults. Children living in a household where there is domestic abuse can be expected to exhibit emotional and behavioural as well as physiological symptoms that reflect their stress, fear and confusion about what is happening.

222. The impact of domestic abuse on children's emotional, psychological and physical health can trigger changes in behaviour and social presentation at places like school as well as being a factor in specific conditions such as enuresis that do not have a clear biological or organic cause can be indicative of children living with abuse. One of the children attended a specialist clinic on one occasion but was discharged when Khaista told the clinic that the enuresis had cleared up. The school was never made aware of the enuresis. There is no evidence that the possibility of abuse was queried for example in differential diagnosis. There were further complications in regard to the way some of the children particularly in 2012 changed schools very quickly.

223. The individual management review for Birmingham Community Health Care Trust acknowledges that if there had been a follow up it could have created an opportunity to consider other underlying factors over and above managing physical symptoms. The same individual management review also highlights that their services, which included school nursing as well as the specialist clinic, were not aware of any domestic violence or mental health concerns until the information was shared as part of the domestic violence screening in September 2012, two months before Khaista died.

[18] Kolbo, JR et al (1996). *Children who witness Domestic Violence: A review of empirical literature*. Journal of Interpersonal Violence 11: pp 281-293.

224. The physical, psychological and emotional effects of domestic abuse and violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may act out the aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under stress. Several of the children displayed symptoms of stress that with hindsight were not identified or understood at the time. The symptoms of stress that can been seen in children living in households where there is domestic abuse and violence include:

- Withdrawal
- Aggression or bullying
- Tantrums
- Vandalism
- Problems in school, truancy, speech problems, difficulties with learning
- Attention seeking
- Nightmares or insomnia
- Bed-wetting
- Anxiety, depression, fear of abandonment
- Feelings of inferiority
- Drug or alcohol abuse
- Eating disorders
- Constant colds, headaches, mouth ulcers, asthma, eczema

225. Not all of these symptoms were seen in the children but there were several that might have triggered more enquiry and discussion such as when Child 3 was found very distressed about their parents separating; there is no record of any inquiry into the circumstances at home. Two of the schools had information about the domestic abuse and separation in 2012 but did not discuss this with any other professional.

226. Reference has been made to specific contacts that with hindsight could have been disguised disclosures of abuse: one of the GP practices referred to Khaista disclosing on more than one occasion that there were 'many issues in the family' although no further detail was forthcoming. In the absence of anything more specific there was no further enquiry or concern that domestic abuse might be an issue. When Khaista did make reference to violence during a consultation with the GP in October 2011, there was no further exploration of the subject. When the practice received a notification from the police about the domestic violence incident that had occurred in August 2012, less than two weeks after the consultation, a safeguarding flag was placed on Khaista's medical records but there was no further follow up.

227. This report has made reference to the research evidence that has been accumulated that highlights the barriers and difficulties associated with domestic abuse. Abuse that occurs in private and intimate relationships is often difficult for those who are victims to disclose and presents complex ethical and legal issues for the professional services trying to provide help.

228. In the individual management review from the Mental Health Trust, there is a reference to Shab being unhappy with his wife's attitude and behaviour. This was regarded as reflecting marital tensions and associated with the pressures from a long term condition rather than indicating that domestic abuse could be a factor.

229. This mind-set allowed suggestions to be made for the couple to seek mediation or support from the family. This was inappropriate as a strategy for responding to domestic abuse where mediation offers further opportunity for Shab to attempt coercion. It is for this reason that mediation is unsafe practice in responding to domestic abuse and the importance for proper recognition by professionals when dealing it.

230. Domestic abuse is also often a facet of male identity seeking to exert control and dealing with feelings of helplessness and poor socialisation. In cultural traditions that place men in a patriarchal family structure that expects the man to be in charge and taking responsibility, the onset of a mental illness can represent an additional source of stress for which the family have inadequate capacity to resolve. In this case, factors such as the degree of dependence that Shab had on Khaista for an increasing range of practical issues such as communication with external services was not explored and understood.

231. Several assessments were completed by children's social care in response to referrals made as early as 2003 when Khaista asked for help in responding to one of her children. The children's social care individual management review has identified problems in how the assessments were managed. The response to the first referral from the police in 2008, when Khaista sought advice about leaving Shab, was inappropriate even though it had been processed from the police as being for information. The fact that it went to an unqualified worker which was the system in place at the time meant that there was a lost opportunity for a more experienced, qualified and curious response from children's social care.

232. Although Khaista stated that she was not suffering any physical assaults she had disclosed information about the coercion she was being subjected to including the withholding of money and sexual coercion.

233. Given the threat of children being removed from the country, a more appropriate response would have involved some further enquiries that could have helped identify additional indicators of need such as Shab's mental illness. At the time, all contacts in children's social care were initially managed by unqualified staff without the training or professional experience to look beyond the information being immediately and explicitly presented.

234. More reflection and mindful enquiry and discussion for example with schools and adult psychiatric services as well as discussion with Khaista and the children could have created better opportunity to discover what stresses were in the family and were exacerbated by factors such as overcrowding. This requires individual practitioners as well as organisations having the appropriate capacity to do this. The decision was to effectively treat Khaista's approach as reflecting a private family matter that required legal advice. Khaista was seen as an adult who was able to seek advice and take appropriate action for her children.

235. The disclosures in August 2012 of physical assaults on the children, was subject of a strategy discussion between children's social care and the police and a decision to undertake a core assessment. The children's social care individual management review highlights that this assessment which was subject to delays was also not completed to the standard expected in local and national requirements that applied at the time. Although the assessment involved some contact and visits to the family, there was insufficient exploration of the full family history and the complexities and difficulties that were apparent from earlier contacts.

236. The phone call to the police on Sunday 26th August 2012 included disclosure of physical assaults on all the children. The police concluded that no offences had been committed.

237. The police individual management review acknowledges that officers should have made a referral to children's social care but did not. The IPCC investigation has limited more opportunity for the police individual management review to analyse why a referral was not made. However Khaista made contact herself on the 29th August 2012 and repeated the allegations about Shab's behaviour and assaults. There was a strategy discussion with the police and an appropriate decision was taken to complete an assessment. This was an opportunity to identify the needs of Khaista and the children.

238. The assessment was hampered by several factors. It was slow in starting; the first visit to the home was several days after allegations of physical assaults had been made. The fact that Khaista had made Shab leave the family home had removed an immediate threat and appeared to influence the pace and focus of the assessment. Shab was out of the family home and there is little evidence in the records of discussions taking place with him by services other than the various mental health professionals. His lack of English language was a barrier to communication that does not appear to have been considered; there is great reliance on various members of the family translating.

2.4 Issues in relation to capacity or resources in the agencies

239. Although most of the individual management review authors do not identify issues in regard to capacity or resources as being factors that influenced how contact with the family was managed it is evident that it is a factor influencing important aspects of the case.

240. All of the services faced constraints in the allocation of resources and for some, this has meant reconfiguration and reducing services. Not all of this has been in response to national financial pressures; for example West Midlands Police had implemented *Paragon* (the change program) in 2009 to address inefficiencies and performance issues. That program merged 21 operational command units and aligned delivery through ten local policing units. The implementation of a major strategy unsurprisingly has some influence on how aspects of this case were handled.

241. There had been changes in how the local policing units were staffed, managed and monitored. Policing across a larger local area accompanied by changes such as the establishment of the prisoner management units, together with changes in some aspects of operational practices, for example in regard to the logging of crime and non-crime contact,

illustrate the degree to which professionals were coping with organisational change. Devolving training to local areas and the introduction of e-learning as a method for delivering new knowledge for example in regard to domestic abuse are also contributory factors in understanding how and why people were processing information in the way that they were.

242. The introduction of new working and recording arrangements in regard to vulnerable adults had been an issue for the police. The data collection form (WC392) had been created in 2010 to record crime and non-crimes generated from domestic violent incidents in order to then trigger further actions. In 2010 there was confusion and misunderstanding which was reflected by a significant fall in referrals; in 2011 staff were given training on the new procedures for DASH risk assessments, it is understood that some officers thought they had the same discretion for WC392 as they had for the DASH risk assessment.

243. This is an issue highlighted in recent domestic homicide reviews in the West Midlands, including Wolverhampton DHR02. The reviews made a recommendation to remove the discretion for officers to complete DASH to make it mandatory at each domestic abuse incident. There is also consideration for the DASH to be electronic and a requirement that the report cannot be filed without endorsement from a supervisor.

244. Additional factors affecting WMP included a change from paper reporting to a computerised 'crime portal' system. The police task and finish group for domestic violence had been exploring how to work more closely with local police units to understand how risk was being identified, assessed and recorded. Evidence was currently being examined with anticipated changes to come into effect in 2014.

245. There were also issues in regard to working arrangements in how information was managed between different shifts managing custody and the transfer and management of communication. This was highlighted in regard to how the defects in the wording and service of the non-molestation order was not linked more clearly to the detail and history of Shab's behaviour and the fear of violence that Khaista had reported on more than one occasion.

246. Other services such as Birmingham and Solihull Mental Health Trust, describe the limited contact time with a user of a service. For example, the adult psychiatrist has a limitation of one hour for an initial consultation and a limit of 20 minutes for subsequent follow up contact. Their individual management review acknowledges that this places limitations on exploring family circumstances for example. Reference has been made to the competing demands on the response police officers.

247. A couple of the individual management review authors discussed the dilemmas and challenges of creating the organisational capacity for individual practitioners to recognise possible indicators of domestic abuse or have the capacity and confidence to encourage disclosures and particularly within cultures and communities where there may be an enhanced level of risk of abuse or barriers to disclosure.

248. The individual management review on behalf of education services identified a shortfall in training for schools in regard to domestic abuse. Four of the schools identified this issue and had made a commitment to address this in response to the domestic homicide review. A fifth school was unable to recognise the need to address this. Further comment and analysis is provided in the final chapter describing findings and recommendations.

249. A common feature across all the individual management reviews was the absence of interpreters being used to assist the communication between Shab and the various professionals in contact with him. He spoke Urdu as his first language and had limited command of English; none of the individual management reviews were specific about how much English he either spoke or understood and in one of the reviews there was a conflicting account about this. All of the individual management reviews confirmed that arrangements for using interpreters were in place and adequate but there was a common practice in this case of relying on Khaista to translate. This is acknowledged to be inappropriate.

250. There were gaps in the provision of policies to guide decision making in the Mental Health Foundation Trust and the medical general practices who also had the most limited training in regard to domestic violence. The process of providing information and analysis for this domestic homicide review has already resulted in work on policy and training within the individual practice as well as with the Clinical Commissioning Group. Similar work is also planned by the Mental Health Trust including the development of multi-agency safeguarding master classes.

251. The children's social care individual management review refers to large caseloads that might have had an impact on the timeliness and quality of the core assessment and the rigour of management oversight. The individual management review comments that there was no evidence of supervision evident on the case recording. The service was the subject of a regulatory inspection by Ofsted in 2012 found arrangements for safeguarding to be inadequate. There are plans for the service to save £22 million in 2012/13. The government appointed a special commissioner following the publication of an independent panel report chaired by Professor Julian Le Grand in March 2014.

252. The individual management review on behalf of the Mental Health Trust draws attention to the insufficient services for perpetrators of domestic abuse. If professionals are not confident that they will be able to refer to an appropriate service, there will be a converse impact on enquiring about domestic abuse. There is a particular need highlighted through this case for such programmes to have the ability to offer culturally appropriate help and intervention.

253. The Heart of England Foundation Trust author analyses the process and quality of risk assessment and referral in November 2012 when Shab was admitted to the assessment unit. The risk assessment tool provided a misleading indicator of risk that has implications for training and development.

254. The same individual management review also highlighted several aspects of operational liaison in regard to the RAID and managing patients who go missing from the hospital before an adequate assessment has been completed.

255. Several of the individual management reviews also highlight the different understandings that applied in regard to the managing of information and risk assessment when domestic violence is disclosed or detected. For example, the multi-agency screening panel was used to discuss two incidents of violence that had not been reported to the social worker who at that time was completing a core assessment.

256. The organisation of data systems and access to effective recording and information sharing is a theme often highlighted in serious case reviews which have been conducted over a longer period of time compared to domestic homicide reviews.

257. More than one individual management review highlighted problems in accessing computers to input records (for example the RAID service at HEFT) although in that setting there has already been further investment to improve access.

258. Reference is made to time consuming administration for staff who may not have seen a patient or service user. There was also evidence of confusion in other services about the use of different risk assessment frameworks and pathways.

259. Other factors were the conflicting pressures to manage episodes of contact with the users of services. For example, a drive to reduce waiting times for patients in emergency departments can be at variance to creating referral pathways to specialist services.

260. Khaista was registered at the same GP practice from when she was a pre-school toddler. Shab was registered at the same practice just over a year after they were married. It is a family run practice that provides a general practitioner service to one of the most deprived areas. It is a practice that shares a common culture and racial identity with Khaista and Shab that potentially becomes difficult when issues such as domestic abuse are identified.

261. The GP practice had not had a domestic abuse disclosure policy until after the murder of Khaista. A practice event analysis was completed and a policy has subsequently been implemented.

3 Conclusions and lessons to be learnt

262. A meaningful analysis of the complex human interactions and processes for decision making that characterise multi-agency work relating to domestic abuse and homicide has to understand why things happen and the extent to which local systems help or hinder effective work within 'the tunnel'[19].

263. The key findings in this chapter are framed using a systems based typology developed by SCIE (Social Care Institute for Excellence). Although the SCIE methodology has been developed specifically for serious case reviews rather than domestic homicide reviews and this review has not used systems learning to collate evidence there is value in using the following framework to identify some of the underlying patterns that appear to be significant for local practice.

    a) Cognitive influences and bias in processing information and observation about domestic abuse;
    b) Family and professional contact and interactions;
    c) Responses to incidents and information about domestic abuse;
    d) Tools to support professional judgement and decision making in regard to risk;
    e) Management and agency to agency systems to protect victims and manage perpetrators.

264. In providing the analysis and recommendations to the Community Safety Partnership, there is an expectation that the Partnership will want to provide a response to each of the key findings as well as to the recommendations and action plans that are described in the individual management reviews. The review is mindful that the IPCC will make recommendations to West Midlands Police. The findings and recommendations also take account of action plans being implemented in regard to other domestic homicide reviews and learning.

265. The Community Safety Partnership will determine how this is managed and communicated to the relevant stakeholders.

Cognitive influence and bias in processing information and observation about domestic abuse:

Understanding that domestic abuse is about coercion and control and implications for processing observation and information about Khaista and Shab behaviour and

[19] View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people's assessments and actions, the purpose is to attain the perspective of the people who were there at the time, their decisions were based on what they saw; not on what happens to be known today through the benefit of hindsight.

disclosure; ensuring that language to describe incidents does not minimise abuse including sexual as well as emotional abuse; cultural influence on how domestic abuse is recognised and disclosed; separation/flight to safety when leaving a controlling and coercive relationship creates increased levels of risk for a victim and children risk and implications for risk assessment and management; working cultures that compartmentalise and prevent the bigger picture being seen.

266. Several of the individual management review authors commented on the extent to which Khaista's presentation as a confident, competent and articulate woman gave no indication that she might be a victim of abuse and appears to have been influential in how enquiries and assessments were completed. She was not regarded as being in need of additional professional help; when she sought advice for example in regard to separating from Shab or seeking non molestation orders this was taken as evidence of a woman with the confidence to make appropriate arrangements for herself and for her children.

267. All of the officers along with other professionals for example from children's social care had a difficulty in understanding domestic abuse and the implications for Khaista behaviour and interaction with them. Khaista's reluctance to talk with police officers, her decision to retract her statement of complaint were clearly frustrating; only one of the police officers appeared to know about the policy of taking a retraction statement from a victim although was doubtful it was ever done in a service trying to meet other demands.

268. The initial disclosure in 2008 was not defined and understood as an incident of domestic abuse, or alleged sexual offences by the police officers who spoke with Khaista. It is because of such cultural and cognitive problems associated with understanding coercive and abusive behaviour that the definitions of what constitutes domestic abuse have been more clearly defined in national guidance and law that now make clear any form of coercion is abuse.

269. Evidence from research and from the work of reviews such as this consistently show that there is a long delay before victims of domestic abuse and sexual violence seek help. It is for this reason that improving the opportunity to identify potential indicators of abuse and creating the opportunity for adults and children who are living with domestic abuse to speak out is so important. Victims and perpetrators often show an equal reluctance (although for different reasons) to disclose information especially to statutory services such as the police and children's social care.

270. In this case, Khaista had suffered eight years of abuse before she felt able to ask for help from the police. The written record of that first contact uses non-specific language such as 'controlling behaviour' and a 'jealous husband' rather than more specific description about his behaviour and incidents and the impact on Khaista and children.

271. West Midlands Police along with other services has developed new policies since 2008 although these can be undermined unless their purpose is properly understood and professional staff develop the cognitive understanding about Khaista and Shab. In the record of the information held by children's social care there is reference to Shab

'pressurising' Khaista to have sexual relations that is not included in the police's original record.

272. The impression is that the contact by Khaista was seen as a wife simply wanting to leave her marriage (that was in opposition to strong cultural tradition and expectation and therefore risking isolation) rather than viewing it as a disclosure of coercion and domestic abuse; there is reference to Shab threatening to remove the children from the country. Fear of losing her children held Khaista back from making disclosures as described in her statements supporting divorce and court orders. The reference to sexual relations without willing consent is not viewed as potential evidence of coercion, sexual assault or rape.

273. The cultural traditions and religious belief of the family and their community is another cognitive factor that had an influence on how the family and professionals were processing information. Reference has been made in earlier sections of the report to the particular challenges that arise from customs, culture and beliefs within South Asian communities. At its heart is a belief in the family being able to resolve difficulties, in supporting couples to maintain their marriages for the sake of their children and a patriarchal view about the role and status of husbands and has implications for how wives and children should behave.

274. The fact that some professionals shared the same cultural and religious traditions may have discouraged Khaista from speaking with them about the abuse that she was suffering in the marriage. For professionals who were not of the same traditions, there was probably an absence of understanding about the significance and influence of such traditions for Khaista and how she spoke about her circumstances.

275. The marriage had been made under Sharia law. The divorce proceedings required the couple to attend for counselling and for both parties to put their point of view. The process is based on an important principle of Islamic faith that seeks reconciliation as a first step.

276. Reference has been made in earlier sections of this report about the research evidence that shows the inappropriateness of mediation and reconciliation in responding to coercion and abusive intimate relationships.

277. An approach has been made to the local Mosque during this review to seek further advice and information with a view to sharing and developing learning from this case. This will require careful and thoughtful discussion from all religious and professional parties.

278. Professionals who either are offered a disclosure of information or have reason to believe that they may be dealing with a victim of domestic abuse need to have the confidence and sensitivity to ask questions that can help identify the patterns of behaviour that include economic, emotional and physical coercion and assault as well as sexual and psychological attacks.

279. An additional aspect to this case is the danger of any person believing that when the victim of an abusive partner or spouse leaves the relationship that the danger has diminished. This tragic case along with others that have been the subject of domestic homicide reviews has demonstrated that rather than the danger becoming diminished, it can escalate the

severity of risk. Partners leaving relationships is often a trigger for an escalation of abuse that can result in a fatal assault. It is therefore necessary when conducting assessments to ensure that this enhanced level of risk is recognised and that continuing help is provided to secure the safety of the adult victim and any dependent children. Unless this is understood there is a bias towards closing professional involvement at the point of greatest threat.

280. Given the barriers to disclosure, it is even more important to create the best opportunity for responding effectively.

281. The mental health problems that Shab had over the course of several years included a psychotic condition. Untreated psychosis can represent a source of risk to the patient as well as to other people that they for example live with. This risk was recognised in the process of ongoing reviews that took place. In Khaista's witness statement in support of the non-molestation and occupation order she described being initially sympathetic to her husband's mental illness.

282. It is possible that in her mind and possibly for those working with the couple that there was an assumption that Shab's abusive behaviour was symptomatic of a mental illness rather than representing coercion and abusive behaviour. This has implications for assessment practice in mental health as well as other settings where information is being sought from partners and spouses and other close members of family.

2.6 Family and professional contact and interaction

Importance of 'Victimless' led assessment, investigation, inquiry and prosecution when dealing with domestic abuse; understanding why adult and child victims of domestic abuse are reluctant to disclose information; understanding that children's behaviour and emotional or physical health can be indicators of living with domestic abuse.

283. Professionals cannot rely on victims of domestic abuse being able to disclose and then support ongoing inquiry and investigation by the statutory services; the onus has to be on professionals having the capacity to conduct effective enquiries and assessment to have a fuller understanding about the circumstances. The impact of domestic abuse on children can be profound and yet did not feature significantly in the risk assessments. An assertive approach has to be taken throughout in respect of collating evidence and information; the focus has to be upon the behaviour of the perpetrator and removing responsibility from the victim for stopping their continued victimisation and preventing future abuse.

284. The decision to close the criminal and non-criminal investigation by the police and enquiries as well as assessment by social workers were influenced by Khaista's reluctance to support prosecution or further intervention against her estranged husband. This is not uncommon behaviour for victims trying to leave an abusive relationship.

285. Evan Stark[20] describes how domestic violence has to be recognised more clearly as coercion in order to understand the impact on the women and their children and to understand why these relationships endure so often for many years; in this case for 17 years.

286. Khaista described in her witness statement for the non-molestation and occupation order how she had thought about leaving her marriage several times but that she was not on speaking terms with her family and that she had felt isolated from any support. In two of the statements made in response to police officers she described feeling frightened. No information is recorded about how the children felt.

287. All of the different services, and the police and children's social care in particular, describe how the children did not make disclosures about the abuse that the children were no doubt witnessing on a regular basis or even disclosing the assaults that they suffered.

288. Several of the children presented with health symptoms which appear to have become more acute from 2010 onwards. Two of the children had digestive problems in 2010, another had chest pains in 2012 and another attended an enuresis clinic on one occasion. Many of these presentations were at the hospital emergency department rather than through the GP practice which may or may not be significant. If the children had been more regular attendees at the GP there would have been more regular direct contact with the primary health professionals in a small practice.

289. Some of the children's school attendance also declined and three of the children were involved in arguments at school and showed clear symptoms of distress about their home circumstances. Some of the children had several changes of school in a relatively short period of time and this limited an overview of what might be happening.

290. There is no recorded evidence that in the various organisations contact with the children that any professional queried whether there were underlying problems that required discussion and work with other services. One of the head teachers sought clarification regarding the non-molestation order although it was left to the school to make any judgements they thought appropriate.

2.7 Responses to incidents and information about domestic abuse

Danger for the victim if professionals deal with incidents of domestic abuse as isolated episodes; having access to relevant historical evidence and intelligence and establishing context for particular incidents; managing the behaviour and threat presented from perpetrators; investigation and protection strategies that rely on victims cooperating or giving consent; effectiveness of referral and information sharing at multi-agency panels.

291. Identifying, investigating and recording evidence of domestic abuse is an essential foundation for effective intervention and support being provided to victims and children. It

[20] Coercive Control: How men entrap women in personal life Evan Stark: Oxford University Press 2007

gives improved opportunity to identify for example behaviour that is intended to harass and control.

292. It is a common misapprehension that domestic abuse will be clearly evident and obvious; in truth domestic abuse often remains hidden and especially if systems and people are passive in their approach to identifying and dealing with it. In this case for example, the majority of contacts with West Midlands Police were not categorised as domestic abuse and this had consequences in how information was recorded and subsequently processed.

293. When further contacts occurred there were no flags to alert response officers to the fact that they were not dealing with an isolated incident. Even if the information had been recorded adequately the case has highlighted potential areas for development in regard to how information is checked and processed.

294. Once a victim has made a disclosure or compelling evidence such as an injury has revealed evidence about the abuse, there is only a short window of opportunity to secure evidence for the purpose of pursuing protection and prosecution and of engaging Khaista in an exit strategy from the relationship. The point has already been made that the risk of further and even fatal harm is increased very considerably at the point of separation in the relationship or marriage.

295. Professionals, particularly in the police and social care services with statutory powers and duties to adult victims and children, need to have a very clear focus on how the perpetrator is managed and prevented from having the opportunity to exert control and harm on the victim and any children. This has to take account of how vulnerable a victim who is a parent will be and that in spite of their intent or resolve they may face difficulty in processing or dealing with issues such as legal processes.

296. There needs to be a clear understanding and an anticipation that for victims to attempt to make an exit from the relationship will require concerted and continuing support to help them maintain their resolve. Ironically, victims at the point of exiting the relationship may feel even more isolated and especially if it means leaving the home and community that they are familiar with and coincide with dealing with a new group of professionals such as solicitors and courts.

297. Dealing with domestic abuse is not a matter of public order or of managing a single incident of crime. It is about intervening in a cycle of coercion where a perpetrator is endeavouring to exert even greater control especially if they feel under threat of losing control over a victim and can be exacerbated by a sense of lost status or authority.

298. Victims will be afraid of further victimisation and especially if they are expected to initiate formal proceedings against their abusive partner. Victims may also have great difficulty in being able to help them-self. The emotional and physical demands and the complexity of judicial and professional systems can overwhelm and be confusing. In this case, the process of seeking the non-molestation and occupation order was undermined when Khaista had been unable to supply details about where Shab was living. This is unlikely to be an uncommon experience.

299. All of the response police officers described how they relied on their control and contact centre staff to update them about any relevant historical information or markers. Most described this as being given to them rather than them making a particular check for example after taking initial statements at the incident. Earlier sections of the report for example described how the non-molestation order was first mentioned by Khaista following a call out to a violent ongoing incident that according to the response officers did not equate with what they found on arrival.

300. The apparent dissonance described by the response officers being told they were being deployed to deal with a domestic abuse incident and not finding an incident in progress but being told that there was a non-molestation order did not provoke further checks and inquiries to be made (either at the incident or in the subsequent action by other officers). Workload appeared to be a factor; the officers who arrested Shab were deployed on two other incidents before the end of their shift and completing their writing up back at their base.

301. The officers mentioned checking on whether there was any view similar incidents (VSI). There was very little recorded and what information there was related to Khaista's home address; two of the incidents occurred at the home of her parents. Information about the non – molestation order was not on the system, initially because it had not been properly served and processed but was not recorded after the first mention on the 7th October 2012.

302. Officers were unsure where information about a non-molestation order would be recorded on police systems. Officers thought (correctly as it transpires) that it would be on the police national computer which they assumed was where the control and contact centre staff searched for information. Response officers are not able to access systems directly except when in police stations (they have no personal or vehicle based data access) although when they do their own checks some of them appear to prefer using the local police intelligence 'FLINTS' system because it is easier to use.

303. During the ongoing incident it was unclear who had an overview. The contact centre was supervised by an officer covering two locations and there was a sergeant with 13 constables available for deployment with the sergeant having to directly deal with some of the requests for a police response.

304. Following an arrest individuals are brought to the police station and are transferred to the prisoner management unit who then have responsibility for conducting interviews, making a decision as to whether there is evidence of a crime and liaising with the Crown Prosecution Service.

305. It was evident from this case that there were systemic issues at the time in regard to what information was being recorded on the WC392 and the police electronic portal system which was compounded by police officers being deployed to deal with another incident before returning to process the information which was then used in the handover package to the Public Protection Unit.

306. In this case there was a significant gap in information recorded about an allegation of assault and a knife being used when Shab had been arrested with a reliance on the breach of the non-molestation order. When that was found to be unenforceable the Public Protection Unit was focussed on complying with legal timelines for detention and the response officers role had come to an end at the close of shift.

307. Domestic abuse cannot be dealt with as a single agency matter. In this case there was a tendency for services and people to work within their own silos and to conduct single agency enquiries. There were also silos within single agencies such as the West Midlands Police. The case was never the subject of any multi-agency discussion; although there was a referral to the joint screening panel it was not discussed because of current involvement by children's social care. The referral to MARAC was not made. No multi-agency assessment was completed.

308. The issue of the wrongly served court order and the decision to release Shab lost sight of the threat and therefore that he evidently represented especially knowing that the police were not in a position to enforce the order. It required a response which was not forthcoming. The decision to down grade the threat level because he was in custody also took no account of the real nature of Shab's threat through his need to control Khaista. There are new powers available to the police through the use of Domestic Violence Prevention Notices that could now be used to provide an immediate element of control.

309. The assessment by children's social care did not seek explicit evidence about the children's worries, wishes and feelings in regard to their circumstances.

310. The children's presentation of behaviour for example in school or with ailments in hospital emergency or clinical settings did not include any record of exploring the family circumstances and history to identify causes for their symptoms.

311. The effectiveness of multi-agency panels to oversee information and develop risk assessment was undermined. There was confusion as to whether the case had been referred to MARAC and that arose through the use of a common referral form (as well as apparently an erroneous reference to a referral being intended). When the case was discussed at a screening panel there was a significant delay in information being placed on the agency recording system of children's social care and no communication between the agency representative and the practitioner directly involved with Khaista and her children. The implementation of the Multi Agency Safeguarding Hub provides a quicker opportunity for information sharing than existed in 2012.

Tools to support professional judgment and practice in regard to risk

The availability and use of different risk assessment frameworks; clarity and understanding about the respective multi-agency risk assessment meetings; recognition that separation from a perpetrator of domestic abuse and violence represents elevated risk to the victim.

312. Four different assessment tools were used; the DASH, the (Barnardos) Domestic Violence Risk Identification Matrix, the national statutory Children Act assessment for children in need and their families, and finally the assessment by Birmingham and Solihull Women's Aid (which was developed with the police DASH model). None of these were apparently completed as a multi-agency process and there were differences in the conclusions that were made in regard to the risk to Khaista that range from standard through to high risk. Under current West Midlands Police operating principles, the only multi-agency risk assessment in use currently is the joint screening between police, children's social care and health using Domestic Violence Risk Identification Matrix. West Midlands Police assess risk by using the National Decision Making Model[21] in conjunction with DASH.

313. The referral that was sent to Birmingham and Solihull Women's Aid by West Midlands Police shortly before the murder caused confusion; the form that is used for seeking support from Women's Aid was the same as the one used for the highest risk victims who would be referred to the MARAC. Matters were further complicated when the police officer completing the form had begun completing the MARAC section 'out of habit'. An assumption was made in Women's Aid that this was a case that would be referred to MARAC which in fact was not the case on the basis of the risk assessment that had been completed by West Midlands Police.

314. The approach to assessment by both the West Midlands Police and children's social care revealed a focus on the immediate incident or events and showed very little curiosity. For example, both services were told about the non-molestation order but made little progress in collating an adequate history of evidence. The extent to which individual professionals have sufficient understanding about the purpose of particular tools or systems combined with heavy workloads created conditions that were not conducive to more sceptical and curious inquiries.

315. West Midlands Police had introduced new systems for recording risk and evidence that had contributed some confusion, for example, in regard to the completion of DASH and non-crime recording.

316. The consistency of recording and access to historical information is also a factor in how police officers and other professionals make their judgements. Many of the police officers who came into contact with Khaista were not aware of previous contact.

317. The police responding to incidents rely on being provided with relevant information by their control; there is a high reliance on what is contained in the Police National Computer although it is clear that there are other systems such as 'OASIS' and 'FLINTS' that are not routinely checked unless and until more detailed inquiries are required. The officers did not complete historic checks and this was in breach of West Midlands Police policy.

318. Although there is reference to discussion at a multi-agency screening meeting there is no record of this anywhere other than in the recording of West Midlands Police. It appears that

[21] https://www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/

because children's social care were already involved it was referred onto children's social care without any detailed multi-agency discussion or decision making. According to one of the individual management reviews the panel does not discuss cases that are already open to children's social care.

319. The establishment of the Multi-Agency Safeguarding Hub in Birmingham will provide opportunity for improved and more efficient joint agency collating of information and managing enquiries and assessment.

320. None of the assessments of risk completed by the police and social care acknowledged the elevated risk that arises when a victim makes a disclosure of domestic abuse and violence. Assessing such risk requires an assessment of the victim's circumstances and the attitude and response of the alleged perpetrator. In this case, the fundamental objection of Shab to accept Khaista's effort to separate and end the marriage was never explored.

Management and agency to agency systems

Complexity and lack of co-ordination across different organisational and professional silos dealing with civil protection; adequacy of local systems for alerting the police to non-molestation orders; reliance on e-learning and operational briefing; dangers of working cultures that are focussed on dealing with immediate need or threat and crisis management; capacity and co-ordination of local risk assessment systems; training and awareness raising in schools and education settings; engagement between solicitors and local professional safeguarding systems and networks; promoting links and understanding with local religious leaders in advice and support during divorce proceeding involving domestic abuse; developing understanding about cultural and religious traditions and their relationship with domestic abuse;

321. Several issues are highlighted by this case in regard to the arrangements for the administration and enforcing civil legal orders to protect victims. The importance of victims having access to legal advice and being able to secure legal protection is recognised in the revised arrangements for legal aid. From April 2013, the scope of services covered by legal aid was reduced significantly and legal aid support was withdrawn for the most frequently seen family disputes in courts. Legal aid funding has been limited to cases involving issues of domestic abuse or violence. Emergency legal aid remains available if a victim requires an immediate application for non-molestation or occupation orders.

322. In Birmingham and Solihull there is no single point of oversight in respect of applications for civil orders such as non-molestation and occupation orders. There appear to be at least four routes by which a person harmed by domestic abuse can apply for a civil order. Not all of the routes are widely known either to professionals or to the general public. There are also issues in regard to ensuring that orders are administered correctly and there is no single point of oversight.

323. On 9th December 2013 West Midlands Police policy changed in respect of the recording of non-molestation orders. The new policy tries to achieve engagement from the various county courts around the West Midlands area although with limited success. There appears to be a significant knowledge gap for victims obtaining the non-molestation order and what

to do next. It has been suggested that a nationally produced leaflet explaining what the order means and that it must be served otherwise it gives a victim a false sense of security. This would need to be produced in a range of languages and for the courts to ensure it was promoted at the point of an order being made.

324. Once the orders are received within West Midlands Police (along with certificate of service), a non-crime is generated which is categorised as a medium risk domestic abuse incident due to the reason behind obtaining a non-molestation order. The actual order is scanned so that it can be retrieved at any point. A marker is placed on the Police National Computer for the subject of the order and a domestic abuse safeguarding officer will make contact with the victim.

325. The provision of legal advice and representation to Khaista in respect of the application for non-molestation and occupation order was through a private legal practice. As part of the routine matrimonial checklist the solicitor should have been aware of children's social care being involved with Khaista and her children. When the solicitor faced difficulties in Khaista providing information to secure the legal aid and the serving of the court orders and notices there could have been an opportunity for discussion about the lack of protection that was being achieved for Khaista and for her children. There also may have been opportunity for coordinating a plan to have the papers served at a police station if children's social care and the police had been made aware of the problems with serving of the order.

326. When West Midlands Police are informed of a non-molestation order it is entered on to the Police National Computer and is the expected practice across England and Wales. The police rely on being told about an order to enforce it if required to; this is an essential element of the protection.

327. The importance of knowing about an order and having evidence that it has been served is illustrated by this case. Of the non-molestation orders that are notified to West Midlands Police (and presumably to other police services) it is not always the case that evidence of service on the co-respondent has been achieved.

328. One of the specialist sergeants has drawn attention to the recommended best practice set out in the national protocol for process servers that they should complete a statement of service under oath or affirmation so that it can be relied upon in any subsequent civil or criminal proceedings[22].

329. When the problems with serving the order had been revealed, there could have been an opportunity for the order to have been served subject to agreement and availability of a process server. This requires police officers having the knowledge and capacity to take that additional step rather than, as in this case, simply deciding there was no further action to be taken.

[22] *Protocol for process servers: non-molestation orders*; Domestic Abuse Committee of the Family Justice Council; November 2011.

330. A significant contributory factor appears to have been the high reliance on e-learning and shift briefing to achieve sufficient understanding about relevant policy and procedural developments relevant to domestic abuse. In some services such as schools there was very little evidence of training and development in relation to domestic abuse and this had implications for how some of the contact and information was managed.

331. Unless professionals have a good understanding about what domestic abuse is and the implications for victim and perpetrator attitudes and behaviour they will treat risk assessment tools and other aspects of policy as primarily a compliance issue. The manner and method of allocating resources to incidents is also influenced by the level of understanding of both police civilian staff as much as warranted police officers.

332. Two particular incidents highlight this; firstly the lack of response to Khaista withdrawing her statement of complaint after Shab was in custody.

333. The importance of anticipating and understanding why victims will be reluctant to make statements and may seek to withdraw and influence decision making is critical to crime detection and Khaista's protection. Some officers felt that such a policy might be good in principle but will take a lower priority in completion with more urgent calls for police help.

334. The second relates to how the issue of the non-molestation order was managed. There was no pause to consider that in spite of the problems with the order, the fact that an order had been granted was real evidence of domestic abuse and threat. Detecting and preventing crime and protecting victims should be a core purpose for the police and be supported from other services.

335. The individual management review on behalf of the education service has highlighted strategic issues in regard to learning and improvement for identifying and supporting children living in households where there is domestic abuse.

336. The first concerns the level of training and awareness that teaching and support staff in school are receiving across the city that can help them identify potential signs and symptoms that a child may be exhibiting but has not explicitly disclosed any evidence of domestic abuse. Birmingham Safeguarding Children Board have a strategic commitment to training being made available to the school's Designated Senior Person (for safeguarding) and teaching staff although this case has identified that some schools have not updated training for their staff in regard to domestic abuse. Four of the five schools had already committed themselves to implementing this training.

337. Of some concern, one school that is not part of the local education provision was unable to identify any learning or opportunities for improvement in spite of having been in possession of information that indicated there was potentially domestic abuse in the household. The local education service has no authority or remit in relation to this school. This has implications for the conduct of inspections being an opportunity to evaluate the robustness of arrangements for protecting children from the impact of domestic and other forms of abuse.

338. The administration of the divorce application through the Sharia legal system is entirely separate to any other local or national systems. This case has highlighted a potential source of heightened risk for women seeking to leave a marriage where domestic abuse is the reason for the application where the emphasis is on reconciliation as a first step.

339. The case has highlighted the additional complexity that strong cultural or religious traditions can represent in identifying and supporting adult victims and children of domestic abuse to disclose information or access and accept help when women are expected to comply with cultural and religious practices and to follow the traditions of their family or community in order to be accepted into society. Culture and religion can be used as a means to control the behaviour of women and to keep them disciplined. There is such a fine line between religion and culture that it can be hard for an individual to distinguish between the two.

3.1 Recommendations

Recommendation 1

The Community Safety Partnership should review the effectiveness of communication strategies to promote awareness about domestic abuse and sources of advice across the different cultural and religious communities in the city and the extent to which they are represented in strategic partnerships.

Recommendation 2

The Community Safety Partnership should satisfy itself that all Birmingham services featured within this review have clear working definitions and policy supported by robust audit about what constitutes domestic abuse and have arrangements in place for promoting and monitoring participation in training and development. This should take account of action taken in response to a previous review (BDHR2012/13-04).

Recommendation 3

The Community Safety Partnership should seek further information from the local law society as to whether accessing legal aid by victims of domestic abuse is a barrier to using civil proceedings to restrain perpetrators of domestic abuse.

Recommendation 4

The Community Safety Partnership should ensure that further discussion takes place with local courts in regard to the learning regarding the application for and processing of court orders designed to protect victims of domestic abuse.

Recommendation 5

The Community Safety Partnership should receive further information regarding the circumstances and effectiveness of local risk assessment tools and frameworks to identify risk and are able to provide effective multi-agency intervention and protection. The review should determine whether these need to be simplified into one risk assessment model.

Recommendation 6

Training for key individuals, in certain organisations, in how to use a *Risk Identification Checklist* must be in place, so that professionals can recognise high risk characteristics such as separation. Training should include how to develop a robust safety plan for victims who are intending to leave an abusive relationship.

Recommendation 7

The Community Safety Partnership should consult with the Birmingham Safeguarding Children Board about any additional contact and action that is required in regard to any schools that are independent of the local education service where there may be concerns about the policy and professional development in regard to safeguarding that includes domestic abuse.

Recommendation 8

The Community Safety Partnership should ensure that information is provided on the outcome of discussions with the local faith leaders with a view to facilitation and support further guidance and professional support in regard to divorce or separation involving domestic abuse.

Recommendation 9

The Community Safety Partnership should initiate discussion with the local law society about the best approach and strategy to developing closer links between solicitors and local professional safeguarding networks to improve communication and oversight of arrangements for the administration and enforcement of civil orders providing protection to victims of domestic abuse.

Issues for national policy

340. There is currently no professional or practice guidance for solicitors providing legal advice and representation to victims of domestic violence over and above the family law accreditation scheme that establishes minimum standards for accreditation and for continued professional development. Working knowledge about local safeguarding systems and professional relationships and cultural understanding being included in the core knowledge along with guidance could promote greater protection for victims of domestic abuse.

341. The Home Office may wish to initiate discussion with the Law Society about an agreed set of standards for practice and procedure in relation to non-molestation and other legal injunctions designed to protect victims of domestic abuse and whether these should be codified within the risk assessment framework and the national family law accreditation scheme for lawyers acting in domestic violence cases.

342. The issues highlighted in regard to the procedure for divorce under Sharia law in cases involving domestic abuse will extend across the UK and invites consideration of developing national guidance in consultation with national and local religious leaders of all faiths.

343. The development of Independent and Free Schools in the city are outside the system of local professional support and oversight in regard to arrangements for safeguarding children. One of the schools that is from that sector was unable to recognise any learning in regard to designating a senior lead professional for safeguarding or ensuring training and development is provided for teaching and support staff.

Appendix 1: Index of family and schools

	Relationship to the subject	Age at the time of the death
Khaista		33 years
Shab	Estranged husband	37 years
Child 1	Eldest child	14 years
Child 2	Second eldest child	12 years
Child 3	Third eldest child	11 years
Child 4	Fourth eldest child	9 years
Child 5	Youngest child	7 years
	Brother of Khaista	Not known
	Sister of Khaista	Not known
	Father of Khaista	Not known
	Mother of Khaista	Not known
School 1 Primary school	Child 3 attended June 2005 – August 2012 Child 4 attended September 2006 – June 2013 Child 5 attended September 2009 – June 2013	
School 2 Local authority secondary school	Child 3 October 2010 > Child 2 January 2013 > Child 1 June 2013 >	
School 3 Local authority secondary school	Child 1 September 2009 – September 2011	

School 4 Independent school	Child 1 September 2011-March 2012 Child 2 September 2011 – March 2011 Child 3 September 2012 – October 2012	
School 5 Faith based secondary school for girls	Child 1 April 2012 – November 2012 Child 2 April 2012 – November 2012 Child 3 September 2012 – October 2012	
SSW	Senior social worker involved August 2012>	N/A
SWA	Social work assistant	N/A
DSP	Designated senior person	N/A
FHN	Family health nurse	N/A