DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of DEBBIE

May 2023

Independent Chair and Author: Simon Steel

Date of Completion: 28 October 2024

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the London Borough of Havering Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Debbie.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Debbie	Deceased	77	Indian
Manny	Perpetrator	79	Indian
Sarah	Daughter of Debbie	Adult over 18	Indian-British
Lisa	Daughter of Debbie	Adult over 18	Indian-British
Mark	Son of Debbie	Adult over 18	Indian-British

1.3 The subsequent investigation led to the arrest and conviction of Manny for Murder in November 2023.

1.4 The Havering CSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the Chair of the CSP determined that a DHR should be undertaken. The Chair ratified the decision, and the Home Office was notified on the 13th September 2023.

1.5 Agencies that potentially had contact with Debbie and Manny prior to the point of death were contacted and asked to confirm whether they'd had any involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) from 3 organisations that had contact with Debbie and a report from 1 agency.

2.2 Contributions from the agencies that were involved with any of the parties are shown below:

Agency	Contribution
Havering Redbridge University NHS Trust (BHRUT)	Chronology and IMR
North East London NHS Foundation Trust (NELFT)	Chronology and Report
London Ambulance Service (LAS)	Chronology and IMR
GP service	Chronology and IMR

2.3 IMRs were completed by authors who were independent of any prior involvement with Debbie and Manny. The only exception being the GP author, where it is acknowledged that they are a partner in the practice, however, were independent in relation to Debbie and Manny. The Chair acknowledges the national GP IMR challenges and notes the lack of a consistent approach in

this area of work. It is important to note, however, the support given by the named GP from the ICB services to this process and the panel are very grateful.

2.4 The authors and panel members assisted the Chair further, with several one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Paul Archer	Designated Nurse for Safeguarding Children	Childrens Safeguarding ICB
Jo Kavanagh	Dementia lead and Adults Safeguarding	BHRUT
Lurleen Trumpet	Interim Director for Ageing Well	LBH Safeguarding team
Joy Maguire	Havering Designated Nurse for Safeguarding Adults and Local Area Contact	Adults Safeguarding ICB
Fiona Robinson	Detective Inspector	MPS East Area, Public Protection and Community Safety
Sahdaish Pall	CEO	Sikh Women's Aid
Shaminder Ubhi	Director	Ashiana Network
Thilini Perera	Safeguarding Partnership Coordinator	Safeguarding partnerships coordinator for safeguarding adult board and safeguarding children partnership.
Vicki Thomas	CEO	Havering Women's Aid
Diane Egan	Community Safety and Intelligence Manager	London Borough of Havering Council
Kerry Wright	Senior Community Safety Officer	London Borough of Havering Council
Irvine Muronzi	Integrated Care Director Havering (Interim)	Integrated Care director for Havering Services, NEFLT
Byrony Harding	Safeguarding advisor	Adults team, NEFLT
Matthew Lazard	Head of Safeguarding Adults -Lead for Domestic Abuse	Safeguarding Lead, Adults team, NEFLT
Justin Armstrong	Review officer - Specialist Crime Review Group	Metropolitan Police (MPS)

Henry Akhigbe	Detective Inspector CAIT, Team 1 & 3, East Area Public Protection	MPS
Simon Hutchinson	Superintendent Neighbourhood Policing	MPS

3.2 The review panel met on four occasions.

3.3 Agency representatives had the required level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Simon Steel. Simon has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police, retiring at the rank of Detective Superintendent. During his service he gained experience in response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Simon has no connection with the Havering Community Safety Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Havering's statutory agencies and Non-Government Organisations worked together in their dealings with Debbie.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Determine what lessons are to be learned from the case regarding how local professionals and organisations work individually and collectively to safeguard and support victims of domestic violence, including their dependent children.
- Clearly identify the lessons within and between those agencies, specifying the timescales within which they will be implemented and the expected changes.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working; and
- Highlight any immediate lessons that can be applied ahead of the report publication to enhance service provision or prevent potential loss of life

5.3 Case specific key lines of enquiry included the following:

- Dynamics of gender within relationships

- Was age a factor?
- Was identity, faith and/or culture a barrier?

The Death

5.4 One day in May 2023 Manny walked into a local police station where he stated he had just killed his wife. Officers attended the home address where Debbie was sadly discovered deceased. Debbie had significant injuries, and a rounders bat was found at the scene. The postmortem examination found the cause of death to be blunt force head injuries.

6. SUMMARY CHRONOLOGY

Family Perspective

6.1 Following the decision to conduct this DHR, the partnership conducted extensive enquiries with supporting agencies to seek to determine if any were supporting the family. Victim Support (VS) were supporting Sarah and, through this organisation, the Chair and the CSP reached out to Sarah via letter on 13th December 2023. Subsequently, the Chair met Sarah in person, along with Victim Support on 28th December 2023.

6.2 Subsequently, the Chair also met with Lisa, Sarah and representatives from Victim Support. During this meeting, both Sarah and Lisa explained to the Chair that they believed Debbie met Manny around the age of 20 while in India and later married. Shortly afterwards, they moved to England, initially settling in the Yorkshire area, then the West Midlands, and finally settling in London. They had 2 daughters, Lisa and Sarah, and a son, Mark.

6.3 Sarah and Lisa explained to the Chair that they grew up in a household of Sikh faith. They do not recall any celebrations of traditions; however, they would worship as a family once a week.

6.4 Sarah and Lisa also disclosed that their mother was subjected to domestic abuse by Manny throughout their childhood. They recounted instances when, following assaults by Manny, Debbie and the children were taken to the West Midlands area on a number of occasions. During these times, Debbie and the children were left with Debbie's family members, which they perceived as an attempt by Manny to humiliate their mother in front of her own family.

6.5 Sarah and Lisa explained their mother had worked hard all her life and only retired a few years before her death.

6.6 The Chair wrote to and met with probation in relation to Manny. Probation discussed with Manny that he could voluntarily meet with the Chair if he wished. He accepted this invitation and the Chair subsequently travelled and met with Manny in prison. At Manny's request his probation officer was also present.

6.7 The Chair asked Manny whether there was any intervention that could have taken place that could have prevented the events that transpired. Manny was not able to sight anything. The Chair also confirmed with Manny that interactions between Debbie, Manny, and relevant agencies were limited.

6.8 Manny said that he felt the local authority (LA) in Havering needed to do more for Sikh people. He stated that he was aware of a local support group, Havering Asian Social & Welfare Association (HASWA) but felt it was often the LA's response to signpost people to HASWA

who were not suitably equipped or funded to assist people. He felt the local authority could do more for the local community.

6.9 He expressed a wish this report would not be published as he felt he was a prominent figure in the local community. The Chair informed him that while it was not within his jurisdiction to make that decision, he would relay the request to the panel. However, the Chair informed Manny that, from his experience, he did not feel that there was any reason for this report not to be published. The panel subsequently agreed with the Chair with the recommendation to publish this review.

BARKING HAVERING REDBRIDGE UNIVERSITY NHS TRUST (BHRUT)

6.10 On the 14th July 2021, Debbie self-presented to Queen's hospital emergency department having palpitations. She was unaccompanied at presentation. Debbie reported that she had suffered 3 episodes of palpitations the day before and experienced a 'blackout'. Investigations were carried out and results were noted to be within a normal range. It was noted that a diagnosis of arrhythmia was given. Debbie was subsequently discharged home. During Debbie's attendance, there is evidence that the Dr explored some family dynamics. Debbie advised she lived with her husband and son. At no point during any of these attendances did Debbie disclose any domestic abuse and there is no evidence this was discussed within any documentation.

6.11 The second interaction with BHRUT was on the 4th February 2023 when Debbie self-presented to Queen's hospital emergency department (ED) with a relative (the panel have been unable to determine who this relative was) with a complaint of a foreign body in throat after eating. On examination, no foreign body was seen. A further follow up appointment was offered and attended on the 21st February 2023 at the Ear, Nose and Throat (ENT) HOT clinic, which confirmed no abnormalities were identified. This was the final interaction between Debbie and BHRUT. There is no evidence of any safeguarding concerns at any of the interactions with BHRUT.

6.12 In 2021 BHRUT completed a systems transition, and a new Safeguarding tool was implemented. The Safeguarding tool is a 'Trigger Checklist' consisting of tick box entries which the triage nurse completes during the triage process.

6.13 Since April 2014 Domestic Abuse policies and pathways have been reviewed, updated, and were circulated to all Trust staff. The Domestic Abuse policy was last updated in January 2024. The Trust delivers regular Safeguarding training to the entire staff where there are varying levels of training for adults and children. Domestic Abuse is explored at a deeper level through both Safeguarding Children and Safeguarding Adults Level 3, every three years, as per the Intercollegiate Document (2019). In addition, Clinical Group ad-hoc briefing sessions and supervision sessions are also provided. During these multidisciplinary sessions, healthcare professionals are encouraged to apply the Think Family approach, to think of the unthinkable, and consider that while DA may very well be experienced by the adult, it also puts children at serious risk too.

6.14 The panel were encouraged to see that BHRUT have a Harmful Practices Safeguarding Advisor who has been in post since January 2020. Upon her appointment Trust posters were designed and disseminated around both sites (Queen's and King George's). These posters were updated in December 2023 and signpost victims of DA and Sexual Assault to national helpline numbers

for women and men. These posters are displayed in patient and staff toilets to encourage disclosures from both patients and staff. In the last 2 years DA awareness days have been reinstated within the hospital canteens. Initially they were only available for staff due to COVID-19 restrictions, however the canteens are now open to the public. The local IDVA's and the Havering Community Safety Officer have helped support these events. The panel recognised this as an area of good practice and multi-agency working.

6.15 Learning from safeguarding cases is shared via the Trust quarterly dashboards, case studies and monthly Bulletins, and DA has featured 6 times within the Bulletins between 2020 and 2024. These cases are also often taken to Patient Summits. Case studies are introduced and discussed at the quarterly Safeguarding Operational meeting which is open to internal and external stakeholders and agencies, including NELFT and the ICB. These case studies are then turned into Bulletins which are shared widely with the entire organisation. Bulletins are issued monthly, on occasion more frequently with Special Editions.

6.16 The panel noted that, as an organisation and a key employer of a very diverse community, BHRUT acknowledge that within the UK context, although DA occurs in all cultures and races, some culture may be impacted more than others, including ethnic minorities. In March 2022 BHRUT launched the 'Better Together' campaign. It emphasised that they believe hospitals are better places to work and receive care when all feel included, respected, and welcome.

6.17 In February 2023 "See ME First" was launched, a staff-led initiative to promote Equality, Diversity and Inclusivity and commitment to having zero tolerance for any form of discrimination. Staff who are subjected to such behaviour are supported to speak up. Staff members are given a badge to wear following making a pledge.

6.18 The six-colour badge aims to represents the differing levels of melanin in skin tones. The badge reflects the famous ideology at the heart of the Dr Martin Luther King's "I have a dream" speech: "that people should not be judged by the colour of their skin but by the content of their character" (August 1963). "See ME First" is not simply a badge. Any member of staff who wishes to wear the badge is encouraged to make a personalised pledge to uphold the values that the badge symbolises.

See ME First pledge

The Trust Board pledge is "Our Trust will take action to become a fairer place to work and be cared for, celebrating the diversity of our people and actively challenging racism and other forms of discrimination."

6.19 As an organisation BHRUT plan to continue to focus on DA and how staff and patients can be encouraged to share their concerns of DA. They plan to:

1. Continue to produce regular bulletins and case studies on safeguarding topical issues to include Domestic Abuse and information on how to seek confidential help.
2. Ensure staff are compliant with their Level 3 training as per Trust KPIs.
3. Actively promote the non-mandatory DA training for staff.

4. To continue Trust wide sharing of Leaflets and Posters on DA to raise awareness and ensure they are displayed in confidential areas (such as toilets (both genders), staff rooms etc,) to encourage safe disclosures.

5. To continue DA awareness days within the main hospital atriums/canteens for staff and patients to access.

6.20 The panel are content that Debbie's interactions with BHRUT were appropriate.

NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

6.21 Debbie was referred to the Musculoskeletal Services and, in December 2019, she did not attend her first appointment. The trust followed up the missed appointment with a telephone call which was not answered, and they were not able to leave a message. As a result, a new appointment was arranged for the 24th February 2020 and a letter posted. A few days prior to that new appointment Debbie called the trust to advise she no longer required the service. It is unclear whether a notification was sent to Debbie's GP notifying that she no longer required the service. There wasn't any reason to suspect that there was any concern, and she was subsequently discharged. There is no record that Debbie had accessed psychological services provided by NELFT.

6.22 The panel understand that appointments of this nature will be cancelled on a regular basis for a whole host of reasons. We know that, in this case, Debbie had decided to seek private treatment , and the panel are content with the response from NELFT, however it would have been considered best practice to inform the GP about the non-attendance.

LONDON AMBULANCE SERVICE (LAS)

6.23 The only interaction related to the LAS is on 13th July 2021 when Debbie called NHS 111to report palpitations and jaw pain when chewing. She was advised to visit an Urgent Treatment Centre for further assessment. We know Debbie did this the following day when she presented at BHRUT.

6.24 The panel are content with the interactions with LAS and have no recommendations in relation to LAS.

GENERAL PRACTICE (GP)

6.25 Both Debbie and Manny were patients at the same practice and had been for many years. The IMR author has reviewed the practice's interactions with Manny and been supported in this by the ICB Adult safeguarding lead. The panel have been reassured that there was nothing in this review in relation to Manny that would involve a DA question or further analysis.

6.26 The IMR stated that there was nothing in the medical notes of relevance to suggest an opportunity to prevent or anticipate the death. It stated there was no mention of discord, aggression, mental health problems and no observations of behavioural problems or unexplained injuries which would be associated with abuse. Both Lisa and Manny had a not-atypical number of ongoing medical problems. It also stated that notes/consultations and

records indicated standard levels of positive engagement, attendance and no high rate of non-attendance.

6.27 The practice was not aware of any opportunity for improvement for themselves. However, they are in the process of exploring how they can engage in local IRIS training to help optimise the team's skills.

6.28 The panel expressed concerns around aspects of the practice's response to this review. However, the panel acknowledge that very often reviews of this nature are new to a GP practice and feel this review is an opportunity to evaluate their practices related to current training and responses to domestic abuse. The panel are encouraged that IRIS training is to commence and feel that this would enhance the wider understanding within the practice.

6.29 The panel have seen no evidence of any DA questioning of any sought. The panel discussed clinical and routine enquiries and recognise that some health environments undertake routine enquiry of domestic abuse in all female patients. Whilst it does ensure all female patients are asked about domestic abuse, it can make asking the question routinised and therefore inattentive, which can in turn discourage victims/survivors from disclosing.

6.30 Gene Feder, a GP in Bristol and Professor of Primary Care at University of Bristol who Chaired NICE guidelines on domestic abuse explains: "We, clinicians, have to ask [about domestic abuse] but it has to be in the context of really wanting to know and it has to be triggered by what the patient is presenting. Your asking is triggered by someone being for example anxious, depressed, chronic pain, maybe difficulty sleeping- a whole range of symptoms we know are associated with abuse." NICE guidelines state that there is insufficient evidence to recommend screening or routine enquiry in most healthcare settings. Therefore, GPs are recommended to practice clinical enquiry, which sets the threshold for asking low and uses the information from the interaction with the patient to make an assessment.

6.31 SafeLives guidance[1] for GP's recognises that some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should always be asked about abuse. In addition, in heterosexual relationships abusive perpetrators often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically, it has not been possible to build a picture from Debbie's perspective. However, this review has had the most valuable insight from Debbie's daughters.

Dynamics of gender in a relationship

7.2 The panel acknowledge that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse. There is no direct evidence that gender alone influenced this review; however, the panel notes that gender was one of several intersecting factors evident in Debbie's case.

[1] Pathfinder GP practice briefing.pdf (safelives.org.uk)

Dynamics of the Age of the victim Debbie

7.3 The panel recognise on average, older victims experience abuse for twice as long before seeking help as those aged under 61. Also, that older victims' experiences are often exacerbated by social, cultural and physical factors that require a tailored response. Insights' dataset shows that clients over 60 are less likely to have attempted to leave than those under (17% vs 29%). There is no direct evidence that age alone influenced this review; however, the panel notes that age was one of several intersecting factors evident in Debbie's case.

Was identity, faith and/or culture a barrier.

7.4 The panel acknowledges the expert input from both Ashiana and Sikh Women's Aid. The panel acknowledges the input of Debbie's daughters in this review. They state after Debbie was subjected to DA she was taken to her own family in the West Midlands as a form of humiliation. The panel conclude that there is direct evidence that faith and culture were a barrier for Debbie which, along with other intersectional factors, placed her at a significant disadvantage in feeling able to disclose to agencies the abuse she was a victim of for the majority of her life.

7.5 The panel have been advised and recognise the normalisation of violence against women, as well as the significant influence of patriarchy in silencing women and fostering fear in reporting such incidents. Factors such as tolerance, collusion, issues of shame, and concepts of 'honour' contribute to this dynamic. Consequently, remaining in an abusive relationship or marriage may appear to be the only viable option for some individuals, driven by acceptance and the fear of not being believed. All these things likely prevented Debbie from seeking any help. One of the key principles of Sikhism is equality between men and women but the cultural practice can be very different. The intersectional lens is vital. The outcome may have been different if Debbie had accessed a 'by and for' specialist organisation where she would not be judged and feel safe to disclose the abuse. She would have been offered options and appropriate risk assessments would have been conducted. Had there been awareness raising/education programmes delivered by specialist services within the Sikh community, it might have offered another opportunity to disclose.

7.6 The Chair has considered whether Sikh women are proportionality represented in the local area in terms of request for services. The Chair suggested an audit to identify how many Sikh women are identified as service users. From discussions at panel, it is clear that such data collection at a local and national level is not a requirement and therefore is not available. The panel believe this is a gap and current criteria are too broad, resulting in agencies lacking a clear understanding of different ethnic groups and faiths.

Clinical enquiries

7.7 The panel agree that clinical enquiries are its preferred methodology for patients at a GP practice. It is very clear, given Debbie's presentations, that she would have fulfilled the clinical threshold and should have been asked about DA.

8. LESSONS LEARNED

8.1 Debbie's death was a tragedy, and her children are affected deeply by the loss of their dear mother.

8.2 In approaching learning and recommendations, the Review Panel has sought to do two things. Firstly, to try and understand what happened and consider the issues in Debbie's life that might help explain the circumstances of her death. Secondly, to use this case to consider a wider range of issues locally, including provision for victims of domestic abuse.

8.3 The Review Panel would like to extend their sympathies to all those affected by Debbie's death.

8.4 The review identified several learning points that build upon agency IMRs. However, if an agency has already introduced the learning into their practices because of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary.

8.5 The review highlights several important themes related to Debbie's death. These themes have been thoroughly examined, and the resulting learning points and recommendations aim to assist victims and survivors facing similar challenges. The Review Panel has focused on understanding what happened and identifying key issues in Debbie's life.

The themes identified are:

Lack of understanding of Sikh culture and impact on victims of DA.
Lack of bespoke services for Sikh victims of DA.
Lack of clinical DA questions by GP's.

9. RECOMMENDATIONS

9.1 **Home Office Recommendation:**

The following recommendation has been agreed by the panel.

Home Office

National Recommendation 1: The Home Office to ensure collection of specific data on ethnicity and faith is a mandatory requirement to be captured for service users.

9.2 **Local Recommendations:**

The following local recommendations have been agreed by the panel.

BHRUT

Recommendation 1: BHRUT provide an IDVA to be available across the Trust.

ICB

Recommendation 2: The GP practice is to embed IRIS training and ensure that clinical DA enquires are utilised at appropriate presentations.

Recommendation 3: GP'S to seek support from the ICB when completing safeguarding referrals.

All

Recommendation 4: Collection of specific data on ethnicity and faith to be captured for service users.

Recommendation 5: All agencies to review their current provision of DA awareness training, to ensure that such training is delivered as a standalone program and incorporates cultural nuances.

CSP

Recommendation 6: VAWG strategic group to review community engagement programme, assess what is being providing to marginalised communities and implement a women's group for community development.

Recommendation 7: The CSP to Lobby MOPAC and local councils for the provision of bespoke services for Sikh women regarding Domestic Abuse and support "by and for" groups.