HARINGEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Asen

February 2016

Independent Chairs: Althea Cribb and James Rowlands

Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date of Completion: June 2017

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Haringey Community Safety Partnership (the Community Safety Partnership for Haringey), Domestic Homicide Review Panel in reviewing the homicide of Asen, who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members: Asen (31 at the time of his death, who was from a Turkish speaking community in an Eastern European EU country and a Muslim); Katya (37 at the time of Asen's death, who was from a Turkish speaking community in an Eastern European EU country and a Muslim). Additionally, the review considered information provided by Lejla (Asen's wife) and Aisha (Katya's mother).

1.1.3 Criminal proceedings were completed in August 2016 and the perpetrator was found guilty of murder and sentenced to life imprisonment, with a minimum tariff of 16 years.

1.1.4 The process began with an initial meeting of the Community Safety Partnership (CSP) in February 2016 when the decision to hold a Domestic Homicide Review (DHR) was agreed.

1.1.5 There was an initial delay between the notification of the Home Office in February 2017 and the commissioning of Standing Together Against Domestic Violence (STADV). This was because the Strategic Violence Against Women and Girls Lead changed at the end of March 2017. Once the new post holder was in place, the process for commissioning an Independent Chair began in April 2016, with STADV being appointed in June 2016. Thereafter in July 2016 all agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.2 Contributors to the Review

1.2.1 This review has followed the statutory guidance for Domestic Homicide Reviews (2013) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. While the review was commissioned prior to the release of the 2016 edition of the Revised Statutory Guidance for Domestic Homicide Reviews, the chairs have been mindful of this latest guidance in both the conduct of the Review Panel and the preparation of the Overview Report and Executive Summary.

1.2.2 On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 18 agencies were contacted to check for involvement with the parties concerned with this review. 15 agencies returned a nil contact,

as did the local Multi-Agency Risk Assessment Conference (MARAC). 3 agencies submitted Independent Management Reviews (IMRs) and chronologies.

1.2.3 The following agencies and their contributions to this review are:

- A Medical Centre (General Practice) - **IMR provided**
- Metropolitan Police Service (MPS) - **IMR provided**
- North Middlesex University NHS Trust (NMUHT) - **IMR provided**

1.2.4 *Independence and Quality of IMRs*: The IMRs provided by the MPS and MNUHT were comprehensive and addressed the Terms of Reference (ToR). They were written by authors independent of case management or delivery of the service concerned.

1.2.5 The IMR provided by the Medical Centre was adequate but there were areas where the background information or analysis were not sufficient. During the review, further questions were sent to the Medical Centre and responses were received. In addition, the IMR audit was not fully independent. This is explored more fully in the Overview Report and recommendations have been made to address this issue.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

- Hazel Ashworth, Haringey Clinical Commissioning Group (CCG)
- Feride Kumbasar, IMECE
- Claire Kowalska, London Borough of Haringey
- Fiona Dwyer, London Borough of Haringey
- Pam Chisholm, Metropolitan Police Service
- Julie Tweedy, Metropolitan Police Service
- Nick Langford, NHS England
- Karen Ingala Smith, Nia
- Chantel Palmer, NMUHT,
- Sharmeen Narayan, Solace Women's Aid
- Eleanora Serafini, Victim Support

1.3.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.3 The first meeting of the Review Panel was held on 13th September 2016. There were subsequent meetings on 6th December 2016 and the 9th February 2017. The report was not finalised until an interview could be completed with Katya, with this occurring in May 2017. The final report was agreed by the panel electronically and the report was handed to the Haringey CSP in May 2017.

1.3.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.3.5 The Review Panel also expresses its sympathy to the family of Asen, as well as to all those affected by this tragic incident, and extends its thanks to those who directly or indirectly contributed to the review process.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair of the Review was Althea Cribb, an Associate of STADV. She has received Domestic Homicide Review Chair's training from STADV and has chaired and authored 11 reviews. Althea has over 9 years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

1.4.2 James Rowlands, is also an associate with STADV. James is an Independent Chair in Training: he acted as a co-chair and was the author of the Overview Report. He has been the lead council officer in 8 reviews and has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations. Of relevance to this review is his experience in working with men as both victims (as an Independent Domestic Violence Advisor at the Dyn Project in Wales) and as perpetrators (on behaviour change programmes, working with the National Probation Service and a voluntary sector provider). As he was a Chair in Training the report was quality assured both by the DHR Manager with STADV and by his co-chair Althea Cribb before being presented to Haringey CSP.

1.4.1 STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides

1.4.2 STADV has been involved in the DHR process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 01/01/2013 to 17/05/2016.

1.4.3 *Independence:* Althea Cribb previously worked in Haringey as a consultant on Haringey's partnership response to violence against women and girls. This work ended in May 2014, which pre-dates the timeline considered as part of this review. Since May 2014 Althea has had no involvement with, and has been independent of, Haringey and the agencies participating in the review.

1.4.4 James Rowlands has had some limited contact with Haringey prior to 2013 in a previous role when he was a MARAC Development Officer with SafeLives (then CAADA). This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.4.5 STADV does coordinate the MARAC in Haringey. However, neither the victim nor perpetrator of this review were known to Haringey MARAC. In addition, the STADV Associate DHR Chairs do not have any contact or line management responsibilities of the STADV MARAC team. Therefore, Haringey CSP deemed that STADV were adequately independent to chair and author this review.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1st January 2015 (this date was chosen because it was known that Asen and Katya had moved to the United Kingdom in 2015, with their arrival later narrowed with information shared by the police as being in August or September 2015) to February 2016 (when Asen was found deceased, but as he was last seen in January 2016, the exact time of this death could not be ascertained).

1.5.2 Agencies were asked to summarise any relevant contact they had on Asen prior to January 2015, as he had previously worked in the UK. The Review Panel also considered whether to seek information about Asen and Katya during their time in their country of origin, where they had previously been residents. While agencies were asked to summarise any information from this country if this was known, it was felt that the most likely source of this information would be the families of Katya and Asen if contact could be made.

1.5.3 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2013 Guidance and identified and considered the following case specific issues:

- Ethnicity and language (including the potential risk of so-called 'honour'-based violence)

- Pregnancy and maternity
- Sex (in this case Katya (a female) was found guilty of Asen's (a male's) murder).
- Additionally, while Katya was found guilty of Asen's murder, during the review information was shared in both IMRs and by Katya's family that described incidents where both Asen and Katya appeared to have been injured, as well as incidents where Katya was the victim. While the Review Panel is not empowered to take a view as to the circumstances of Asen's death, which is properly a matter for the criminal justice process, the Review Panel felt it important to consider the wider context of the relationship, including the fuller picture of any violence and abuse that occurred between Asen and Katya. In considering this relationship context the Review Panel therefore reflected on issues relating to the identification and management of counter-allegations, or concerns about bi-directional violence, and current practice to establish 'who does what to whom' in such cases.

1.5.4 As a result, IMECE and Victim Support were invited to be part of the review due to their expertise in work in work with people from Black, Minority Ethnic and Refugee (BMER) communities, and as the local provider of a support service for high risk male victims respectively, provided even though they had not been previously aware of the individuals involved.

1.6 Summary of Chronology

1.6.1 Asen and Katya met at work in 2011 in their country of origin. Their relationship was initially kept secret, because both were already married with children and they had concerns about the reaction of family and the wider community.

1.6.2 In August / September 2015, Asen and Katya moved to the UK and lived in rented accommodation. Their contacts with services were limited but included some contact with health services and one contact with the police.

1.6.3 No friends of Asen and Katya were identified by the police during the criminal investigation, although there was some contact with neighbours in the Public House, shopkeepers and an employer of Katya's. Additionally, further information was available from Lejla (Asen's wife) and Katya's mother (Aisha).

1.6.4 The accounts provided by these other parties presents a complicated picture, with conflicting evidence about whether Asen or Katya experienced domestic violence and abuse, and information about violence and abuse potentially being experienced or perpetrated by both Asen or Katya.

1.6.5 Asen and Katya clearly had regular arguments, indeed the frequency of these led to a notice of eviction from the rented accommodation block where they had resided.

1.6.6 The Review Panel considered whether these arguments were disputes or could be symptomatic of domestic violence and abuse, the definition of which refers to “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality”.

1.6.7 In relation to the first part of this definition (“any incident”), then Asen was clearly the victim of domestic violence and abuse. He died because of stab wounds inflicted by Katya and his death is the reason that this review was initiated.

1.6.8 However, when considering the second part of this definition which, in its broader sense, refers to a pattern of incidents, the picture is less clear:

- In relation to Asen: there is information to suggest he was the victim of domestic violence by Katya. This includes reports of injuries including scratches on his chest (seen by the manager of the rented accommodation block), and scratches to his face and neck (seen by a resident, as well as two workers in a local shop). Additionally, Lejla (Asen’s wife in his country of origin) stated that Asen was unhappy, as well as telling police that she had seen scratches and that Katya had destroyed his phone and torn up his passport to stop his return to country of origin. Tragically, it is not possible to speak with Asen about his relationship and experiences with Katya and, unfortunately, in the absence of contact with his family, the review cannot further explore these issues.
- In relation to Katya: there is information that she was a victim of abuse from Asen. She was seen looking dishevelled but uninjured (by the manager of the rented accommodation block), and was also seen with old bruises (by the hairdressing salon owner) to whom she made a disclosure that her "husband” had hit her (by the hairdressing salon owner to whom she made a disclosure that her "husband” had hit her; this may have been Asen). In addition, there was the incident reported by an independent witness in October 2015, when she was kicked in public (while Katya denied this at the time, it is of note that, if she was the victim of domestic violence, it is not uncommon for victim to minimise incidents for their own safety). Further to this Katya’s statements during the criminal justice process, and in her interview as part of this review, as well as information provided by her mother (Aisha), also serve to suggest she was the victim of domestic violence abuse from Asen. Finally, Lejla also references one occasion where she may have heard Asen hit Katya.

1.6.9 The review is therefore left at an impasse. Asen was certainly the victim of a single incident of domestic violence which led to his death, and Katya has been found guilty of his murder.

1.6.10 Yet, considering the information available, there is a more complicated picture, with conflicting evidence about whether Asen or Katya experienced domestic violence and abuse in a broader sense of an ongoing pattern of behaviour. Based on this information available either Asen or Katya could have been the victim of domestic violence and abuse. On this basis, considering the specific incident that led to Asen's death, it is possible that Katya may have been a victim who used 'violent resistance' (i.e. violence utilized in response to domestic abuse) against a perpetrator (Asen). Yet equally it is possible that the relationship between Asen and Katya featured bi-directional violence and that this may have been assessed as 'situational couple violence' (i.e. violence that is not embedded in a general pattern of power and control but is a function of the escalation of a specific conflict or series of conflicts). These definitions for types of intimate partner violence are most commonly ascribed to the work of Michael Johnson.[1]

1.6.11 This issue could not be resolved during the review. However, the learning from this case can be used to consider practice more broadly. This is because a DHR is by its very nature an unusual evident, but the challenge of counter-allegations or concerns about bi-directional violence are not uncommon. The Review Panel noted in particular the tools available to manage counter-allegations or concerns about bi-directional violence and to establish 'who does what to whom'. The most well-known of these tools is published by Respect and is part of a Toolkit that has been designed to support and inform work with male victims of domestic violence.[2] It includes assessment resources to help practitioners listen to what someone says about their experiences and identify what is going on, to provide the most appropriate help and to make best use of scarce resources. It also enables practitioners to identify any behaviours that someone may themselves be using, which may include identifying if they are in fact a perpetrator.

1.6.12 Consequently, a key piece of learning from this review is the importance of ensuring that professional training includes information on the typologies of domestic violence, as well as the identification and assessment of counter-allegations and bi-directional violence

1.6.13 *Medical Centre (General Practice):*

1.6.14 There is no record for Asen being registered at the Medical Centre, or any other General Practice.

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[1] Johnson, M. P. (2008) *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence.* Boston: Northeastern University Press.

[2] The Respect Toolkit can be accessed at: http://www.mensadviceline.org.uk/help-and-information/frontline-workers-and-male-domestic-violence-victims/toolkit-for-work-with-male-victims-of-domestic-violence/ (last accessed 12.02.18)

1.6.15 Katya registered at the Medical Centre on the 10th November 2015 and she was seen for a new patient health check on the 16th November 2015. She was seen on the 23rd November 2015 and the 1st December 2015 in relation to a pregnancy. At two of these four contacts (the 23rd November 2015 and 1st December 2015) the record noted that a telephone interpreter was used through Language Line. On the other contacts, it is not recorded whether an interpreter was used.

1.6.16 *North Middlesex University Hospital Trust (NMUHT)*

1.6.17 Asen had a single contact with NMUHT, specifically the Accident and Emergency Department (A&E). On the 29th of June 2015 Asen presented to A&E with a hand injury. There is no record in relation to Asen and whether any language barrier was noted, although reflecting the information from the police, the Review Panel is aware that Asen had limited English. Asen's presentation was such that he was not flagged to triage staff as requiring urgent assessment. When Asen was subsequently called by a practitioner to be assessed in triage, he was found to have left the department prior to being seen.

1.6.18 Katya attended a booking appointment with the maternity service as well as two scans in the ultrasound department. Katya also failed to attend a further two appointments during this period.

1.6.19 On the 7th January 2016, Katya attended her booking appointment for maternity care. She was accompanied by Asen and there was a Turkish interpreter present. At this appointment, Katya was asked about her medical and social history. Katya was also asked, on her own, regarding domestic violence and abuse she did not disclose any past or current abuse.

1.6.20 Katya attended her final appointment before the death of Asen at the ultrasound department on the 26th January 2016, where she was booked for a further scan in March 2016.

1.6.21 *Metropolitan Police Service (MPS)*

1.6.22 The MPS (Enfield Borough) had contact with Asen and Katya on one occasion prior to the incident that led to Asen's death. On the 15th October 2015, an independent witness called police after Asen was seen to grab Katya's handbag, search through it and then kick her left leg. Katya was spoken to with the assistance of a Turkish-speaking officer, CCTV enquiries were conducted and Asen was interviewed and made no comment. Following an evidential review of the case, no further action was taken and Asen was released from police custody later that night.

1.7 Conclusions and Key Issues Arising from the Review

1.7.1 This is a tragic case, triggered by an incident which led to the death of Asen. His limited contact with services, and unfortunately the absence of additional information from Asen's family, has meant that Asen's voice is less well represented in this review than would have been hoped.

1.7.2 Complicating this further is the conflicting information about the relationship between Asen and Katya and, looking more broadly than the incident that led to Asen's death, whether either or both experienced domestic violence and abuse in a broader sense of an ongoing pattern of behaviour.

1.7.3 There is lastly the wider context of the relationship between Asen and Katya; regardless of their relationship their experience as members of a Turkish speaking community in an Eastern European EU country informed their relationship and decision making. This is this most clearly explained by Katya in relation to her account of gossip and family conflict when their relationship was first discovered, through to her concerns about returning to their country of origin.

1.7.4 As the review is unable to resolve some of these issues, the focus has therefore been on the identification of any learning, including its application to other cases, as well as reflecting more broadly on the experience of victims who are male, are from BMER communities and/or who do not speak English or speak only limited English.

1.8 Lessons to be learned

1.8.1 The review did not identify any practice issues that were a cause for concern in relation to the outcomes for Asen or Katya, although there are specific recommendations for the police relating to recording and supervision. The lack of clarity about how an update was provided to Katya following a report of domestic violence should serve as a salutary reminder for all professionals of the importance of accurate recording keeping, as well as clarity in how updates are provided following a report.

1.8.2 The review highlighted areas of good practice, most notably the use of translators or other interpreting services, as well as the importance of frontline professionals having a good knowledge of domestic violence and abuse and building relationships with service users. However, it also identified the potential barriers for those affected by violence and abuse in identifying their experiences and feeling able to seek help, as well as the challenges for services in providing information in a way that can be used by someone at both a point of crisis or after the event.

1.8.3 Reflecting its focus on identifying any learning in this case, and then considering what this learning means more broadly for the local partnership response and how it could be put into practice, the Review Panel has made recommendations about a range of issues. Many of these recommendations build on the initiatives that are already underway in Haringey to develop local processes, systems and partnership working. These included: taking forward the review of the development and delivering training; raising awareness of domestic violence (including through bystander interventions); and ensuring that there are pathways to support for victims, including

those that support people from BMER communities or who are male, or through health setting in the form of the IRIS Project. Other issues also include the work that is vital to sustain an effective partnership response, including ensuring that all parts of the health sector can participate in reviews, as well as sustaining local specialist support provision, including provision designed specifically to support victims from marginalised groups.

1.9 Recommendations from the Review

1.9.1 The single agency recommendations, made by the agencies in their IMRs, are as follows:

Medical Centre (General Practice)

- No recommendations were made in the IMR submitted by the Medical Centre.

North Middlesex University Hospital Trust (NMUHT)

- NMUHT should continue ongoing training for staff for domestic abuse and ensure that compliance is maintained at 90% to ensure that learning for staff is embedded.
- The maternity service and A&E department at NMUHT should continue with planned area specific training events on domestic abuse to increase staff awareness and understanding as these are common areas where patients may present or disclose domestic abuse.
- The good practice and learning from the DHR to be shared across the organisation through training and communication bulletins to staff.
- Although this recommendation has no specific bearing on this case, in order to further support patients, staff and further embed learning, NMUHT to consider the sourcing of an IDVA (Independent Domestic Violence Advisor) to work within the trust.

Metropolitan Police Service (MPS)

- It is recommended that Enfield BOCU Senior Leadership Team (SLT) debrief officers involved in this incident to disseminate the lessons learnt regarding completion and supervision of risk assessments in line with MPS domestic abuse toolkits.

1.9.2 The Review Panel has made the following recommendations. These should be acted on through the development of an action plan, with progress reported on to the Haringey CSP within six months of the review being approved by the partnership.

1.9.3 **Recommendation 1:** The Training & Development Task and Finish Group of the VAWG Strategic Group ensures that training around typologies of domestic abuse is included in the minimum training standards that are currently being developed.

1.9.4 **Recommendation 2:** The VAWG Strategic Group ensures that the findings from this review inform the development of a bystander intervention campaign locally.

1.9.5 **Recommendation 3:** NHS England & Haringey CCG, as co-commissioners of primary care, should ensure that the practice has undertaken training in line with recommendation 16 from the NICE guidance - "GP practices and other agencies should include training on, and a referral pathway for, domestic violence".

1.9.6 **Recommendation 4:** The Medical Centre institutes a domestic violence policy based on good practice and the NICE guidance, supported by its planned participation in the roll out of the IRIS project locally.

1.9.7 **Recommendation 5:** The Haringey CCG should identify how it could provide support to General Practices to enable their participation in the DHR.

1.9.8 **Recommendation 6:** The Department of Health and NHS England consider how to ensure that there is a clear guidance for the engagement and representation of General Practices in DHRs and ensure that such guidance is embedded in contractual arrangements.

1.9.9 **Recommendation 7:** The MPS SLT in Enfield Borough should take steps to ensure that the issues identified in this specific case are not an issue more broadly and that there are robust process in place to provide ongoing assurance as to the quality of recording and supervision**.**

1.9.10 **Recommendation 8:** The MPS should share the learning from this review across the service regarding the importance of ongoing assurance as to the quality of recording and supervision.

1.9.11 **Recommendation 9:** The Mayor's Office for Policing and Crime (MOPAC) to scope opportunities to develop an online directory of local specialist support services as well as information about different types of crime.

1.9.12 **Recommendation 10:** The VAWG Strategic Group scopes the requirement for specialist BMER led provision in the borough.

1.9.13 **Recommendation 11:** The Haringey CSP works with other commissioning bodies in London, including MOPAC, to ensure that there is sufficient specialist BMER led provision available.

1.9.14 **Recommendation 12:** The VAWG Strategic Group, as part of the scoping for specialist BMER led provision in the borough, should include consideration of how to ensure that translation services are made available.

1.9.15 **Recommendation 13:** Victim Support should review the promotion of services for men to be assured that these take specific account of the needs of this client group.