Wolverhampton
A Safe City
Operating as Wolverhampton's Local Police & Crime Board

Domestic Homicide Review

Under Section 9 of the Domestic Violence, Crime and Victims Act 2004

Executive Summary

In respect of the death of

Adult A

in September 2021

Report produced by Kevin Ball, Independent Chair and Author

On behalf of Safer Wolverhampton Partnership

January 2023 (*Finalised in February 2024 following Home Office feedback*)

Statements from Family Members

Our sister had a very distinctive personality that was rare in today's society; she never judged anyone but was deeply devoted and held a strong belief in god. Every time she entered a room, her effervescent personality would make everything more cheerful. She was such a kind individual who always made an effort to help others. She loved her children deeply and always stood by them no matter what, making them the centre of her entire universe and the reason she lived. She loved without conditions, and we mourn her dearly every day, she is now looking and guiding us as she did always.

Our mum was something special; she been through the worst of times but her heart was just beautiful. She cared for everyone around and went through a lot but she would always smile. She was the most loving person - she was always there for us. She gave us life, taught us, dressed us, fought for us, held us, shouted at us, kissed us but most importantly she loved us unconditionally. She was our first and forever friend. Our mum is never far away from our thoughts and always in our heart. She was the most wonderful woman; she never thought about herself - she always put us first and made sure we were okay. She was so strong, beautiful, awesome and such a hardworking woman. She will never be forgotten - she is always with us looking down on us and protecting us how she always did.

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Safer Wolverhampton Partnership, the Independent Chair, DHR Panel and participating agencies wish to express our sincere condolences to the family and friends of Adult A for their loss.

1.0 The Review Process

1.1 This executive summary outlines the process and findings from a Domestic Homicide Review (DHR) undertaken by Wolverhampton Community Safeguarding Partnership. The review has examined the contact and involvement of professionals and organisations with a 41-year-old woman, who for the purposes of this report will be known as Adult A. Adult A was killed as a result of being stabbed multiple times by her husband (Adult B) in September 2021 following an argument. Two of Adult A and Adult B's children witnessed the stabbing. The family were members of the Sikh and Punjabi community.

1.2 Family members have described Adult A as someone who was a kind, loving and devoted mother and who always saw goodness in people. Adult A's husband was arrested at the scene on suspicion of murder and then held in custody in prison. Whilst a case was being prepared to go to criminal trial, Adult B took his own life in prison. Adult A's sudden and shocking death has deeply affected her family and due to the fact that Adult B subsequently went on to take his own life and there being no criminal trial, they feel there will be no justice – leaving a painful gap for them to live with.

1.3 This review was conducted under section 9 of the Domestic Violence, Crime and Victims Act 2004. The decision to conduct a review was agreed in November 2021, and review process has taken approximately 12 months to complete, and has benefitted from a Review Panel that have maintained regular oversight of the process.

2.0 Contributors to the Review

2.1 From an original list of 15 separate agencies and services initially contacted to find out if they had any contact or involvement with Adult A and family, it became apparent that eight agencies/services should be asked to submit an Individual Management Report. This is set out below in Table 1.

Table 1: Agencies / Services asked to submit an Individual Management Review

Black Country Healthcare NHS Foundation Trust
NHS Black Country and West Birmingham CCG (now NHS Black Country Integrated Care Board)
City of Wolverhampton Council Adults Services
City of Wolverhampton Council Children's Services
Royal Wolverhampton NHS Trust
West Midlands Ambulance Service
West Midlands Police
City of Wolverhampton Council Education Services

2.2 The review has also benefited from the contributions of three generations of Adult A's family, who have seen the final copy of the full report as well as this report, and also confirmed that they wish for the term 'Adult A' to be used to describe the victim. Opportunities for Adult B's family to contribute were also offered, however, these were declined.

3.0 The Review Panel Members

3.1 A Review Panel was established, and comprised of the following agency representatives (Table 2):

Table 2: Review Panel Members

Role	**Agency**
Independent Chair and Author	Independent
Principal Public Health Specialist	City of Wolverhampton Council
Community Safety Manager	City of Wolverhampton Council
Community Safety Adviser	City of Wolverhampton Council
Domestic Violence Specialist	City of Wolverhampton Council
Named GP for Safeguarding	NHS Black Country Integrated Care Board
Safeguarding Adults	Royal Wolverhampton Trust
Head of Adult Safeguarding	Black Country Healthcare NHS Foundation Trust
Head of Adult Services	City of Wolverhampton Council
Children's Services	City of Wolverhampton Council

Detective Inspector	West Midlands Police
Chief Executive	Sikh Women's Aid
Youth Organisations Co-ordinator	Wolverhampton Voluntary and Community Action
Headteacher	School A

4.0 Chair and author of the review and report

4.1 In January 2022, the Chair of the Wolverhampton Community Safety Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced Chair and report author, notably of cases involving the harm or death of children, but also more recently Domestic Homicide Reviews.

4.2 He has a background in social work, and over 30 years of experience working across children's services ranging from statutory social work and management (operational and strategic) to inspection, Government Adviser, NSPCC Consultant and independent consultant; having worked for a local authority, regulatory body, central Government and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training, which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action.

4.3 He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence and the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He has no association with any agencies involved and is not a member of the Safer Wolverhampton Partnership. There is no conflict of interest.

5.0 Terms of Reference for the Review

5.1 Those agencies providing Individual Management Reviews were asked to consider the following lines of enquiry as part of the terms of reference:

a. Communication and information-sharing between services with regard to domestic abuse and the children's safety and welfare (quality and effectiveness).

b. Community understanding of domestic abuse, awareness of how to identify domestic abuse, and routes for reporting domestic abuse: could more have been done to inform local black, Asian and other minoritized communities about services available to victims of domestic violence?

c. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator towards the victim. How well were the children's day to day experiences and voices captured?

d. Whether the work undertaken by services in this case was consistent with each organisation's professional standards, domestic violence policy and procedures, and safeguarding adult's and safeguarding children's policy and procedures.

e. The response of the relevant agencies to any referrals relating to the victim or perpetrator concerning domestic violence, mental health, child protection or other significant harm.

f. Whether there were any barriers experienced by the victim or her family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should she have wanted to.

g. Whether there were any warning signs and whether opportunities for triggered or routine enquiry relating to domestic abuse and therefore early identification of domestic abuse were missed.

h. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards, including whether

issues were challenged or escalated to senior managers or other organisations or professionals in a timely manner.

i. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective, including the quality of risk assessments undertaken by any agency.

j. Whether appropriate services were offered / provided and / or relevant enquiries made in the light of any assessments made.

k. Practice sensitivity to the sex, race, beliefs, ethnicity, cultural, linguistic religious identity of the respective family members.

l. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively i.e., changes or the introduction of domestic abuse policies, training, etc.

6.0 Summary Chronology

6.1 For the purposes of this report, the following individuals are of interest:

- Adult A: the victim
- Adult B: Adult A's husband and perpetrator
- Child 1: child of Adult A and Adult B
- Child 2: child of Adult A and Adult B
- Child 3: child of Adult A and Adult B.

6.2 In September 2021, Adult A was stabbed thirty-eight times by Adult B in the presence of their two children. Ten minutes prior to the fatal stabbing, Adult A had called the Police asking for assistance to leave the home with her children after an argument with Adult B; at the time of that call there was no hint of events that were about to unfold, or no suggestion of an emergency based on the calm and coherent phone discussions and Adult A confirming that Adult B was not being aggressive to her or preventing her from leaving the house. The children ran from the property and gained

the attention of a passer-by. The Police were then contacted whilst neighbours attempted to provide first-aid to Adult A. Adult B watched in silence as attempts were made to revive her. He is reported to have told one neighbour, when asked why he killed her, that she had 'pissed him off' over the last 21 years. Adult A could not be revived by the attending Doctor and was pronounced dead. Adult B was arrested from the property on suspicion of murder and whilst being escorted to the Police vehicle, turned to his children and said, *'I hope you are happy now'*. When he was offered a Solicitor in custody he replied '*No. My life is at the end now'.*

6.3 In January 2022 Adult B took his own life by asphyxiation, in his prison cell, whilst detained and awaiting trial. Whilst awaiting trial Adult B stated that Adult A had mental health problems, would say crazy things about his family, that she controlled him and that she wanted to break his relationship with his mother and sister. He also spoke about his marriage having problems but that they had stayed together for the sake of the children. Expert opinion concluded that Adult B presented with symptomatology consistent with a severe depressive illness involving low mood, tiredness and suicidal ideation, and that he would satisfy the criteria for a diagnosis of a psychotic mental disorder probably schizophrenia, with a strong affective element.

6.4 Agency submissions to this review have highlighted the family had been known to services for a number of years. A concise chronological summary, taking the most pertinent points from a 160-page combined multi-agency chronology, is provided below. Additionally, information gathered as part of the Police investigation has been used where appropriate. Given the sensitivities of this case, and the continued need to safeguard the welfare of the children, professional discretion has been exercised. Much of the following information, particularly the more recent worrying concerns, only came to light after Adult A's death and as a result of the Police investigation.

6.5 Adult A was born in the United Kingdom and grew up in the Wolverhampton area. She worked for about seven years before getting married to Adult B and starting a family; she had no mental health or learning difficulties as a child, adolescent or young adult.

6.6 Adult B was born in the northern Indian state of Punjab, where his parents were farmers; he then came to the UK on a work permit and initially lived with an aunt and uncle in the Birmingham area before moving to London to live with another aunt.

6.7 The marriage between Adult A and Adult B took place in 1998 and was arranged, based on cultural Panjabi custom. Agency records indicate that Child 1 was born some three years after the marriage; it is believed that the adult relationship began to deteriorate from this point onwards.

6.8 Between May 2001 and February 2011, concerns emerged about the safety and welfare of the children, concerns also Adult A's mental health alongside reports of her experiencing domestic abuse and coercive control. This included child protection investigations and legal proceedings, Adult A taking intentional overdoses and attending AandE, being in receipt of community mental health support. She disclosed information regarding her marriage and that she had faced a lot of physical abuse and that the marriage had deteriorated further recently with her husband expressing a desire to end the marriage. Adult A expressed suicidal ideation but stated would not go through with this due to her children.

6.9 During one event, Adult A was referred to the Mental Health Liaison Service by AandE and was assessed. She presented as well kept, pleasant and cooperative albeit occasionally tearful. Anxiety was evident and that she referred to '*people being after her'* because a religious leader (whom her husband had previously taken her to see) had told her she may get bad luck because of others' casting spells on her. Records state that the religious leader in the Sikh community known as '*God*' had told her not to go to hospital and had tied a thread around her arm to '*ward off evil spirits'*. The next day when she felt unwell, having taken the overdose, her husband would not take her to hospital saying '…*if you die, you should die at home…'*. Adult A was assessed as fully orientated and denied any self-harm or suicidal ideation.

6.10 In another episode, GP records highlight Adult A continuing to suffer with depression and have relationship issues *'…thinks about her children all the time…her husband blames her for everything…'.* Records also note that the husband refuses to use condoms, with Adult A commenting that her husband saying *'…she can get an abortion if she gets pregnant…'*. In a further episode the GP notes refer to Adult A having attended AandE for a wound dressing where the *'…husband accidentally drilled into her palm 6 days ago…'*. There is no further documentation about this. Tensions between the maternal and paternal families continued, with Adult A

becoming increasingly estranged from her own family, less able to exercise independence over matters such as money, and more confined.

6.11 In 2019 Adult B had CCTV cameras installed in the family home, with him reportedly controlling Adult A's whereabouts by monitoring her movements. Inter family tensions continued with reports of Adult B's mother embarrassing and humiliating Adult A. In December 2020 Adult A's depression was noted to be worsening. It has been reported by an extended family member that at this time Adult B, with other members of his family, discussed killing Adult A, dumping her body, and saying she had mental health issues. For fear of their own safety this alleged threat was not reported.

6.12 In May 2021 the Police were contacted by Children's Services to advise that Child 2 had left home due to having a friend the family did not approve of 'because he was black'; this episode is reported to have caused considerable difficulty between Adult A and Adult B, in part because Adult A was aware of the relationship with the friend and was far less concerned about it. Based on family accounts, in July 2021 it is reported that Adult B had told Adult A he wanted a divorce. Shortly before her death in September 2021 Adult A suspected a plot by Adult B to kill her. The Police did not become aware of this alleged plot until after Adult A's death. She spoke to other extended family members about the plot, but was told the idea was false and she should return to the family home, despite being afraid to do so. She had also been messaging her own family who were speaking with her about leaving him and going into a Refuge. However, family members were aware that the couple were often having fallouts and then making up, so did not attached too much weight to Adult A's reported intentions at the time. Shortly after this Adult A was brutally killed by multiple stab wounds in the family home.

7.0 Key Issues Arising from the Review

7.1 From review of the extensive combined multi-agency chronology but also the Individual Management Reports it is evident that Adult A, and the children, experienced chronic and persisting family dysfunction and psychological abuse, coercive control, and domestic abuse alongside emotional and physical harm for many years – a great deal of which, appears to have remained hidden from agencies and professionals that did have contact. The adult relationship is believed to have begun

deteriorating around 2001 and so this has been an enduring feature for the entirety of the children's lives and for Adult A for two decades.

7.2 By way of context, the British Sikh Report[1] (2017) found that 75% of respondents to their survey considered that violence towards women was one of the most important issues affecting women at that time. More recent research[2] (2021) conducted by Sikh Women's Aid found that *'… the Sikh community are a very proud community and there can be a reluctance to ask for help when dealing with hardship. Victims will mostly disclose within their social and community setting, rather than going to the Police …* [which] *… translates to a chronic underreporting of certain crimes within minority communities …* [and that] *women experience coercive control over a long period of time so domestic abuse becomes normalised …'.*

7.3 In their 2021 report, Sikh Women's Aid also consider other research which highlights that '*… violence against women and girls starts pre-birth within the Sikh/Panjabi community. So not only are we dealing with domestic and sexual violence within the community, but we are also dealing with a gender-based violence crisis that places little to no value on the lives of women and girls …'.*

7.4 Alongside this research report, the BBC published a news item[3] in March 2021 highlighting doubling numbers of Sikh women seeking help from abusive relationships during the Covid-19 lockdown. The report highlighted that *'… domestic abuse was often 'brushed under the carpet' by the wider community …*' citing *'… forced marriage as a particular problem, with women often becoming totally isolated and losing their friends and family when they move to live with their husband …'*. This is also against a backdrop of a national increase in domestic abuse related incidents during the lockdown restrictions[4], and increased demand on support services[5].

[1] British Sikh Report 2017: An insight into the British Sikh community.

[2] Sikh Women's Aid, From Her, Kings are born: Impact and prevalence of domestic abuse and sexual violence in the Sikh/Panjabi community, Sadhaish Pall and Sukhvinder Kaur, p.18, 2021.

[3] BBC - Calls to Sikh domestic abuse group more than double in pandemic

[4] Office for National Statistics: Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020

[5] Women's Aid, A perfect storm: The Impact of the Covid-19 Pandemic on Domestic Abuse Survivors and the Services Supporting Them, 2020.

7.5 From review of information submitted, access to Police witness statements, discussions with family members and reflections from Review Panel members, the following key issues arise from this review.

7.6 Adult B exercised an increasing level of control over Adult A, restricting her access to her family, money, and liberty. This progressively affected Adult A's mental health, undermined her confidence and self-worth.

7.7 The majority of this remained hidden from professionals, with friends and neighbours not seeing or appreciating the relationship dynamics between Adult A and Adult B. However, from an internal perspective i.e., that which is more hidden to the outside world but within the immediate and close family network, relationship difficulties were known about to varying degrees. It appears that as a result of the tragic events, the children have only recently been able to disclose and share their experiences, highlighting the challenges for professionals in truly understanding what life might be like for children at home, and being able to effectively capture the child's voice.

7.8 Agencies and professionals that did come into contact with Adult A have recognised that they did not exercise sufficient professional curiosity to properly understand how her mental health was being affected by her relationship with Adult B.

7.9 Adult A's persisting mental health, notably anxiety, were never considered and flagged on records as symptomatic of her circumstances. Specific comments by Adult A about feeling persecuted, the relationship difficulties with her mother-in-law and having a religious leader tell her she had bad spells cast on her, were not explored – but instead described as further symptoms of her anxiety. As noted by family close family members, Adult A did not experience emotional or mental health difficulties as a child.

7.10 Recent research by Kaur, Shaine and Lillie[6] (2019) helps us to begin to unpick the comorbidity of mental health difficulties whilst being the victim of domestic abuse, with them citing research by Bancroft[7] (2003) commenting on *'… this bi-directional relationship between mental health and domestic violence, … it is difficult to ascertain whether the domestic abuse causes mental health issues or whether predisposed*

[6] Kaur, H., Shain, F., and Lillie, A. K. (2019). A gap exposed what is known about Sikh victims of domestic violence abuse (DVA) and their mental health? European Journal of Mental Health, 14(1), 179-189. https://doi.org/10.5708/EJMH.14.2019.1.10

[7] Bancroft, L. (2003) Why does he Do that? Inside the Minds of Angry and Controlling Men (New York: Berkley).

factors make women more vulnerable to it. The pathologisation of women's mental health has been a regular tool in the armoury of abusive men …', and importantly *'… that making a woman out to be unstable or getting her to question her mental health is a common strategy that abusive men use. This serves many functions: it gets the victim to question her own mental health, thus making her an easy target, and furthermore ensures that were she ever to disclose the abuse, her credibility would be questioned …'*.

7.11 The children were not seen as victims of domestic abuse or coercive control; relationships and risks were not adequately assessed.

7.12 Professional understanding about many of the religious and cultural practices unique to the Sikh and Panjabi community is an area for development. Gaining insights into many of the subtle nuances of the belief systems, cultural norms and practices will greatly assist practitioners when working with children, adults and families.

7.13 Family members have commented on how many of the cultural norms may be different dependent on whether individuals originate from India and have re-located in the UK, or whether individuals are born in the UK as second, or subsequent generations. For those individuals that re-locate to the UK and who maintain strong family ties with family in India, beliefs and cultural norms, particularly in respect of the roles men and women assume in the family structure, are likely to be stronger and more enduring. For those born and raised in the UK, these beliefs and norms may be more diluted and less rigid. This has been reported in this case by family members, as Adult A was born in the UK as a second-generation child and is reported as having softer and more flexible views on many issues, whilst still maintaining a strong moral and cultural code. Adult B re-located to the UK, and maintained strong links to family in India, often appearing to take direction from family in India with thoughts of returning one day. These links are reported as being highly influential on his attitudes, behaviours and conduct. If agencies and professionals are to work effectively with victims of abuse, children and families these issues need to be identified, and considered during every single contact; they form the very fabric and DNA of how a Sikh and Panjabi family may function on a day-to-day basis.

8.0 Lessons to be Learned

8.1 This DHR has captured the following lessons to be learnt:

a. It is often very difficult for victims of domestic abuse to leave an abusive relationship; this can be made all the more difficult if the victims have parenting and caring responsibilities to their children who live in the same house. All professionals need to be aware of the often-conflicting demands and dilemmas faced by victims and support them to find a safe route out of an abusive relationship. In this particular case, the impact of Covid-19 made separation even more challenging.

b. For those victims that do make attempts to leave an abusive relationship, it can often be the riskiest time. Despite family members being aware that threats had been made, there was little indication that events would result in Adult A being suddenly killed. It is also a potentially high-risk act for caring family members of the victim to share information with professionals, if concerns for their own safety at this critical time, are apparent.

c. Children that live in households where there is domestic abuse and coercive control are victims too, through witnessing or experiencing abuse[8] - all of which can have a significant impact on both their short- and long-term health, welfare and safety. Statutory guidance[9] refers to this *'… non-physical forms of domestic abuse like coercive control have a significant impact on children and professionals focused on physical acts of violence may fail to understand the daily experience of victims and children, how it is affecting them, and the level of risk posed by perpetrators …'.* All professionals that work with children and young people need to remain alert to indicators of harm or abuse, and the likely impact of living with childhood adversity. Children being viewed as victims of domestic abuse is now something that is enshrined in legislation[10] under the Domestic Abuse Act 2021.

[8] Nicky Stanley, Khatidja Chantler, Rachel Robbins, Children and Domestic Homicide, The British Journal of Social Work, Volume 49, Issue 1, January 2019, Pages 59–76, https://doi.org/10.1093/bjsw/bcy024

[9] Domestic Abuse, Statutory guidance, July 2022, p. 53, Home Office, HM Government.

[10] Domestic Abuse Act 2021, section 3 – children as victims of domestic abuse.

d. Non-fatal strangulation can be a pre-cursor to attempted homicide; it is vital to consider this as a significant risk factor and there is new legislation, under the Domestic Abuse Act 2021 to address this.

e. Coercive control can be exercised in many different forms; as well as the more overt examples seen in this case such as the use of CCTV, restricting access to money and freedom, control may also have been exercised by Adult B refusing to use contraception, or limiting Adult A's access to any form of contraception. It is considered a crime under the Serious Crime Act 2015.

f. All forms of inequality are mutually reinforcing and must therefore be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another. The intersect of being a woman, being the victim of domestic abuse, having (or being reported/labelled as having) mental health difficulties, and being a member of the Sikh and Panjabi community is highly likely to significantly undermine efforts by a victim to end an abusive relationship.

g. Due to cultural norms and associated codes of honour, identifying, assessing and intervening in cases of abuse in the Sikh and Panjabi community may require professionals to work differently and consider alternative options when following procedural pathways.

h. In areas where there is a strong and diverse population comprising of different racial, ethnic, religious and cultural constituents, service design and delivery that counteracts the cumulative effect of intersecting discrimination will be important. Empowering and involving local communities to design and deliver support services for victims and perpetrators of domestic abuse may be a productive approach to strengthening the local offer.

i. Programmes of support targeting victims of domestic abuse may be helpful and empowering to those victims; however, if victims return to live with ongoing abuse and control or develop relationship with new partners, the target for intervention also needs to include the perpetrators of abuse. The need to engage perpetrators is doubly important if there are strong and embedded cultural norms which narrate

how intimate partner relationships should function, and which undermine any notion of equality.

j. Female victims of domestic abuse may experience seeing male professionals (in whatever capacity or discipline) a barrier to sharing or disclosing abuse.

k. Where English is not the first language of any service user, the offer of an interpreter should always be made and the outcome recorded.

l. The use of chronologies may assist all professionals, but in this case GPs, to take a more holistic view about frequent attendances; it can be a tool to help with opening a conversation or dialogue about other issues that may be causing difficulty or worry.

m. Failure to attend appointments may be an indicator of safeguarding related issues. Prior to closing cases due to failure to attend (or was not brought in the case of children or those that lack capacity) there may be merit in reviewing all case history and exercising professional curiosity about the possible reasons for failing to attend.

n. Professionals need to remain mindful that victims of domestic abuse may experience mental health difficulties, but these difficulties might also be a symptom of the abusive circumstances in which they are living. Disentangling these factors, whenever possible, through professional curiosity, probing and sensitive assessment, will be helpful to offering targeted support. Perpetrators of domestic abuse and coercive control may use a victim's mental health as a way of distracting attention away from themselves, thereby undermining the credibility of the victim.

8.2. In addition to the lessons detailed above, through their own analysis and reporting, individual agencies have identified a number of other lessons from reviewing their agencies contact with Adult A and family.

9.0 Conclusions

9.1 This Domestic Homicide Review has examined the contact and involvement with a woman and mother who was killed in September 2021 by her husband and father to

the children. The perpetrator later went on to take his own life whilst detained in prison and awaiting trial.

9.2 The review has benefitted from reports from a number of agencies that had contact with the victim but also the perpetrator; the contributions of family members has also been helpful.

9.3 The review has found that there were a number of factors which, when combined, made it very difficult for the victim to protect herself from domestic abuse and coercive control; but also protect her children from the damaging effects of witnessing and living with the abuse. Factors included the intersect of gender, culture and faith, being subject to domestic abuse and coercive control to the point of it undermining self-confidence and the ability to act independently and being labelled as having mental health difficulties as a means of undermining any credibility.

9.4 The review has identified a series of lessons to be learnt, as well as making recommendations to improve local practice.

10.0 Recommendations

10.1 Single agencies that have contributed to this review have identified a series of recommendations for themselves.

10.2 In addition to the these, the following multiagency recommendations are made for Safer Wolverhampton Partnership:

1. Ensure the learning from this review is disseminated to all agencies and services that are likely to encounter domestic abuse.

2. Gain assurance about the level of resourcing and usage of interpreting services available in the area for all agencies and services.

3. Ensure all schools in the local area are participating in Operation Encompass, the Police led initiative of informing schools of domestic abuse related incidents attended by officers, where children of school age might be present, so as to support welfare-based interventions if needed.

4. Where information is obtained which suggests local religious leaders may be using charms or other idiosyncratic practices to ‘ward off evil spirits’, consideration should be given to a timely, sensitive yet robust assessment being undertaken by the relevant agencies i.e., children’s/adults’ services, Police, to ensure there is no evidence of child/adult abuse or exploitation of any sort. Following assessment, and dependent on the outcome, educative intervention should be provided with continued oversight.

5. Given the particular circumstances of this case in respect of child abuse, the Partnership should seek assurance that the correct procedures and pathway are applied to cases (similar to those identified in this case) where there is reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

6. Map and raise the profile of support services that are available for victims of domestic abuse. Raising the profile should include targeting campaigns involving Gurdwara’s, Asian TV channels, community centres, bus and travel billboarding sites, GP Practices, local supermarket notice boards.

7. Further efforts should be made to reach out to all local Gurdwara’s, which are established as charitable entities with responsibilities outlined under the Charity Commission, to support the creation, implementation, embedding and regular review of safeguarding policies and procedures. Engaging Gurdwara leaders in the process will be critical to success.