Keeping Bexley Safe

BEXLEY COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Nargiza December 2016

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Associate Standing Together Against Domestic Violence
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1. Preface 5
1.1 Introduction 5
1.2 Timescales 6
1.3 Confidentiality 7
1.4 Equality and Diversity 9
1.5 Terms of Reference 10
1.6 Methodology 12
1.7 Contributors to the Review 14
1.8 The Review Panel Members 16
1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community 17
1.10 Involvement of Perpetrator and/or his Family 20
1.11 Parallel Reviews 21
1.12 Chair of the Review and Author of Overview Report 24
1.13 Dissemination 25

2. Background Information (The Facts) 26
2.1 The Homicide 27
2.2 Background Information on Victim and Perpetrator (prior to the timescales under review) 28

3. Chronology 30
3.1 Chronology from year to year (timescales under review) 30

4. Overview 54
4.1 Summary of Information from Family, Friends and Other Informal Networks: 54
4.2 Summary of Information from Perpetrator: 59
4.3 Summary of Information known to the Agencies and Professionals Involved 60
4.4 Any other Relevant Facts or Information: 62

5. Analysis 64
5.1 Domestic Abuse/Violence: 64
5.2 Analysis of Agency Involvement: 73

6. Conclusions and Lessons to be Learnt 105
6.1 Conclusions 105
6.2 Lessons To Be Learnt: 105

7. Recommendations 109
7.1 IMR Recommendations (Single Agency): 109
7.2 Overview Report Recommendations: 110

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Appendix 1: Domestic Homicide Review Terms of Reference 113
Appendix 2: Single Agency Recommendations and Action Plan 123
Appendix 3: DHR Recommendations and Action Plan 128
Appendix 4: Glossary 134

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"Let my daughter's sacrifice be the last one to stop this domestic violence. It [the DHR] *is very good because you keep people alert and try to prevent these things happening*".

Bekzod (Nargiza's father)

"*This happened in* [our] *family but I don't want this to happen to anyone from any background*".

Dilnura (Nargiza's sister)

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1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This DHR report examines agency responses and support given to Nargiza, a resident of the London Borough of Bexley, prior to her murder at home in December 2016. Nargiza was a national of a Central Asian Republic who had Leave to Remain (LTR) in the United Kingdom (UK). Nargiza was normally resident in the UK, although shortly before her homicide she had returned to Bexley after a stay of several months in her country of origin[1].

1.1.3 Marat, the alleged perpetrator, was Nargiza's husband. He was also a national of the same Central Asian Republic, had LTR and was normally resident in the UK. Following Nargiza's homicide, Marat was arrested and charged with murder. He spent a short period in a local hospital where he received treatment for self-inflicted injuries before he was subsequently remanded to prison and admitted to the healthcare wing. Marat died by suicide while in prison at the end of December 2016. There has therefore been no criminal trial in this case.

1.1.4 The review will consider agencies contact/involvement with Nargiza and Marat from January 2008, when Nargiza first arrived in the UK, to the date of Nargiza's homicide.

1.1.5 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there

[1] See 1.3.5 for an explanation of terminology relating Nargiza and Marat's country of origin.

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were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

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

1.1.7 This review process does not take the place of the criminal or coroner's courts, the independent review into Marat's death, nor does it take the form of a disciplinary process.

1.1.8 The Review Panel expresses its sympathy to the family, friends and colleagues of Nargiza for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

1.2.1 The Bexley Community Safety Partnership (CSP) commissioned this DHR, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004 ('the statutory guidance'). This is the first time that the CSP has commissioned a DHR. After consultation with local partners at an Extraordinary CSP Board meeting on the 4th January 2017, the Home Office were notified of the decision to conduct a DHR in writing on 9th January 2017.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent Chair for this DHR on 9th January 2017. The completed report was handed to the Bexley CSP in April 2018.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to conduct a DHR. The DHR took longer than this for a number of reasons, including arranging the first panel

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meeting so that all agencies could attend and the criminal trial. However, the main reason for the timeframe being extended was to enable contact with, and engagement by, Nargiza's family who lived abroad and for whom the translation of documents was necessary. This contact included meeting with Nargiza's family when they were able to travel to the UK (in August 2018), and then time for the translation of interview transcripts so the family could approve these (in September 2018). It also allowed for the translation of a draft Overview Report and time for the family to consider and respond to its contents (between November 2017 and January 2018). Engagement with Nargiza's family is described in 1.9 below. Lastly, in February and March 2018 attempts were made to engage with the Marat's family, with these described in 1.10 below.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is publicly available only to participating officers/professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance to the statutory guidance. The specific date of death has been removed, as has the gender of the children.

1.3.3 To protect the identity of the victim, the perpetrator, family members and friends, the following pseudonyms have been used. These pseudonyms were chosen by the Independent Chair of the review (hereafter 'the chair')[2]. A selection of names common in Central Asia were identified, cross referenced with the names of family members identified by the Metropolitan Police Service (MPS) during their murder enquiry and, if the names were the same or similar, excluded. This allowed the chair to be minimize the

[2] Nargiza's family were first invited to select pseudonyms, and then offered the chance to confirm that the pseudonyms suggested by the chair were acceptable. They chose not to take either offer up.

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potential risk of causing offence or hurt to family or friends. The subjects of this review are there referred to as:

- The victim: Nargiza
- The perpetrator: Marat
- The children: Child C (resident in the UK), Child A and Child B (both resident with paternal family in Nargiza and Marat's country of origin)[3]
- Other family members – Nargiza's father (Bekzod) and sister (Dilnura)
- Friends – Dilnoza, Feruza and Gulsara.

1.3.4 As per the statutory guidance, the chair and the Review Panel are named, including their respective roles and the agencies which they represent. Agencies who otherwise played a role by submitting information are also identified. The exception to this are the two General Practices (GPs) where Nargiza, Marat and Child C were registered during the period reviewed. These are referred to as the 'medical centre' (see 1.7.1) and 'the health centre' (see 1.7.2) respectively, as both were near to Nargiza and Marat's place of residence and their location information could potentially be used to identify them.

1.3.5 Additionally, specific references to Nargiza and Marat's ethnicity and / or country of origin have been avoided. This is based on a request from Nargiza's family who asked that the Overview Report only identify the region, rather than the specific country of origin. Therefore, references to Nargiza and Marat's ethnicity and country of origin have been generalised, with references to a 'Central Asian Republic[4]' or their 'country of origin' as appropriate. On a small number of occasions, a reference is either made directly to ethnicity or country or origin, or documents published by Non-Governmental Organisations (NGOs) that refer to their country of origin are

[3] Letters have been used for the children in order enhance their anonymity,

[4] The Central Asian Republics are the countries of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

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cited. In these cases, the chair has recommended to the CSP that these references are redacted when the Overview Report is published.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.4.2 Equality and diversity issues were included in the Terms of Reference and were also discussed explicitly at each Review Panel meeting. At the first meeting of the Review Panel, based on the information available from an initial scoping exercise, the following protected characteristics were identified as requiring specific consideration:

- Race (Nargiza was a national of a Central Asian Republic, as was Marat)
- Religion and Belief (Nargiza was a Muslim, as was Marat)
- Sex (Nargiza was Female, Marat was Male).

1.4.3 In addition, the Review Panel agreed to consider:

- The immigration status of both Nargiza and Marat and whether this had any impact on their confidence to engage with services, ability to access services or the engagement of services with either Nargiza and Marat
- Whether so-called ‘honour’ based violence and abuse was a potential factor.

1.4.4 Lastly, during Review Panel discussions it became apparent that agencies had differing perspectives about Nargiza and Marat’s English language skills, as both spoke English as a second language. Consequently, it was agreed that this would also be considered.

1.4.5 Given these issues, attempts were made to identify specialist services that could to be part of the review and share their expertise even though they had not been previously aware of the individuals involved. These attempts included:

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- Seeking to identify whether there were any organisations or groups in the London Borough of Bexley that could provide advice to the Review Panel - at the time the DHR was undertaken, there were not established organisations or groups that could perform this function
- Seeking to identify an organization or group which supported people from Nargiza and Marat's country of origin, or more broadly, Central Asian Republics – a number of small groups were identified in London, but it was not possible to establish contact with them
- Other steps included: research into Nargiza and Marat's country of origin, drawing on reports published by Non-Governmental Organisations (NGOs); an interview with a Journalist from that country; and the involvement of a STADV specialist from the Safety Across Faith and Ethnic (SAFE) Communities Project[5].

1.4.6 Sex should always require special consideration. Recent analysis of domestic homicide reviews; reveals gendered victimisation across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.[6] This characteristic is therefore relevant for this case; the victim of the homicide was female, and perpetrator of the homicide was male.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1.** This review aims to identify the learning from Nargiza's and Marat's case, and for action to

[5] For more information on the Safe Project go to https://www.standingtogether.org.uk/blog-3/blog-post-title-one-g9jmw

[6] In 2014/15 there were 107 female and 50 male domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* "(June 2016), p.69.

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be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from the London Borough of Bexley, as the victim and perpetrator were living in that area at the time of the homicide.

1.5.3 As Nargiza and Marat also had contact with agencies in the London Borough of Lewisham, agencies in that area were contacted for information. The local Violence Against Women and Girls (VAWG) Programme Manager acted as a point of contact for the borough, representing the Safer Lewisham Partnership, and was invited to participate in the Review Panel. Other agencies from Lewisham also supported the review, as described in 1.7.2 and 1.8.1 below.

1.5.4 Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.5 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the review would be from January 2008 (when Nargiza first arrived in the United Kingdom) to the date of the homicide. Agencies were asked to summarise any relevant contact they had had with Nargiza or Marat (who had been resident in the United Kingdom earlier than 2008) outside of these dates. Agencies were also asked to consider their contact with the wider family, including Child C (resident in the United Kingdom) and Child A and Child B (resident in a Central Asian Republic).

1.5.6 Key Lines of Inquiry: The Review Panel considered both the ‘generic issues’ as set out in the statutory guidance and identified and considered the following case specific issues:

a) Analyse the communication, procedures and discussions, which took place within and between agencies
b) Analyse the co-operation between different agencies involved with Nargiza and / or Marat [and wider family]

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c) Analyse the opportunity for agencies to identify and assess domestic abuse risk
d) Analyse agency responses to any identification of domestic abuse issues
e) Analyse organisations' access to specialist domestic abuse agencies
f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues
g) The extent to which the following protected characteristics or issues had an impact on the case:
    - Race (Nargiza was a national of a Central Asian Republic, as was Marat)
    - Religion and Belief (Nargiza was a Muslim, as was Marat)
    - Sex (Nargiza was Female, Marat was Male)
    - Immigration status
    - so-called 'honour' based violence and abuse
h) Given the limited contact with services in this case, consideration of what might have helped or hindered engagement in services by Nargiza (during Review Panel discussions, it was identified that this should include considering language, see 1.4.4 above).

1.6 Methodology

1.6.1 Throughout the report, the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and is included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

"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

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sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

1.6.2 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.6.3 This review has followed the statutory guidance. On notification of the homicide, 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) for all organisations and agencies that had contact with Nargiza or Marat. A total of 27 agencies were contacted to check for involvement with the parties concerned with this review. 16 agencies returned a nil contact, eight agencies submitted IMRs and chronologies, and six agencies provided a summary of their involvement only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology written by the chair.

1.6.4 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery in the agency concerned. The IMRs received were comprehensive and enabled the Review Panel to analyse contact with Nargiza and Marat, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Although all IMRs were of good quality, the IMR

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prepared by the Lewisham and Greenwich NHS Trust (LGT) identified a range of learning for the Trust, and the author was commended by the Review Panel for the quality and transparency of the analysis.

1.6.5 Three IMR authors made recommendations for their own agency. These IMRs recommendations are noted within this report and all the IMRs submitted have identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the Terms of Reference for this review. Agencies also shared updates about the actions being taken to progress these single agency recommendations. Additionally, the Review Panel has made additional recommendations for some agencies.

1.6.6 *Documents Reviewed*: In addition to the eight IMRs, documents reviewed have included Witness Statements taken by the MPS as part of their enquiries, the Independent Investigation Report of the Prisons and Probation Ombudsman, a Board Level Inquiry Report commissioned by the Oxleas NHS Foundation Trust, as well as the STADV Case Analysis and the Home Office DHR Case Analysis.

1.6.7 *Interviews Undertaken*: The Chair of the Review has undertaken a face to face interview with Nargiza's father, Bekzod, and one of her sisters, Dilnura, as well as correspondence by email subsequently. This is described in 1.9.1 to 1.9.6 below. Additionally, contact was sought with friends and colleagues of Nargiza and this is described in 1.9.7 below. The chair is very grateful for the time and assistance of those who have contributed to this review both directly (by speaking with the chair) and indirectly (by giving permission to share witness statements given to the MPS during their murder enquiry).

1.6.8 It has not been possible to interview the perpetrator, given his death, and contact with his family is described in 1.10 below.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

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- Bexley Clinical Commissioning Group (CCG)
- Bexley Women's Aid (BWA)[7]
- Darent Valley Hospital Emergency Department
- Health Centre (a GP surgery in the Royal Borough of Greenwich)
- London Borough Bexley Adult Social Care
- London Borough of Bexley Community Safety Partnership (CSP)
- London Borough of Bexley Education Services
- London Borough of Bexley Housing Services
- London Borough of Lewisham Adult Social Care
- National Probation Service (NPS)
- South London and Maudsley NHS Foundation Trust (SLaM)
- Victim Support.

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

Agency	Contribution
Greenwich CCG	Summary of involvement
Guy's and St Thomas NHS Foundation Trust (GSTT) (Nargiza's employer)	Chronology and IMR
Lewisham and Greenwich NHS Trust (LGT)	Chronology and IMR
Lewisham CCG	Summary of involvement
London Ambulance Service (LAS)	Chronology and IMR
London Borough of Bexley (Children Services)	Summary of involvement
London Borough of Lewisham (Children Services)	Summary of involvement
London Borough of Lewisham (Multi-Agency Risk Assessment Conference)	Referral form, meeting minutes and action log
Medical Centre (a GP surgery in the London Borough of Lewisham)	Chronology and IMR

[7] Provides support and refuge to women and children experiencing domestic violence in the London Borough of Bexley.

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Metropolitan Police Service (MPS)	Chronology and IMR
Oxleas NHS Foundation Trust (health visiting)	Chronology and IMR
REACH[8]	Chronology and IMR
Refuge[9]	Chronology and IMR
UK Visas and Immigration	Evidence and Enquiry Request Pro Forma

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

- Alison Blakely – London Ambulance Service (LAS)
- Ben Voss – MPS (Specialist Crime Review Group)
- Caroline Brown – Lewisham and Greenwich NHS Trust (LGT)
- Daniel Bygrave – Victim Support
- Jane Wells – Oxleas Trust
- Judith Clark – Bexley CCG
- Julie Carpenter – LAS
- Lucie Heyes – London Borough of Bexley (Children Services)
- Nola Saunders – London Borough of Bexley (Housing)
- Peter Bodley – MPS (Bexley)
- Sally Luck – NHS England
- Tom Brown – London Borough of Bexley (Adult Social Care)
- Toni Ainge – London Borough of Bexley (Communities)
- Emma Leathers – London Borough of Bexley (Community Safety)
- Sharon Wood – London Borough of Bexley (Children Services)
- Tracy Thorne – Bexley Women's Aid (BWA)
- Mala Karasu – Guy's and St Thomas NHS Foundation Trust (GSTT)
- Ade Solarin – Safer Lewisham Partnership

[8] REACH is a domestic abuse service based in the A&E department of St Thomas' Hospital, which is part of GSTT.
[9] Refuge provides an IDVA service in Lewisham for victims of domestic violence.

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- Tania Marsh – Refuge
- Graham Hewett – Lewisham CCG.

1.8.2 *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.

1.8.3 Unfortunately, it was not possible to identify representation from a service that had expertise in Black, Asian and Minority Ethnic (BAME) issues. The steps taken to address this gap, in particular to draw on external expertise, are addressed in 1.4.5 above. This gap in terms of BAME specialist provision also led to a recommendation which is discussed in 5.2.86 below.

1.8.4 The Review Panel met a total of three times, with the first meeting of the Review Panel on the 7th April 2017. There were subsequent meetings on 19th June 2017, the 8th September 2017. The Overview Report was agreed electronically thereafter, with Review Panel members providing comment and sign off by email.

1.8.5 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

Family

1.9.1 The Bexley CSP, the chair and the Review Panel acknowledged the important role Nargiza's family could play in the DHR.

1.9.2 The family of Nargiza are resident in a Central Asian Republic. For this reason, the Bexley CSP and the chair discussed how best to notify Nargiza's family of the decision to conduct a DHR. In consultation with the MPS Family Liaison Officer (FLO) – who had established a trusting relationship with the family and therefore had an open challenge for communication – a letter of introduction was sent by email in March 2017. This letter explained the purpose of the DHR, introduced the chair and

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outlined how the family could choose to be involved, including the method of contact (face, to face, by phone, email or Skype) and opportunities for involvement (including input on the Terms of Reference, as well as participating in the DHR itself and reading / commenting on a draft copy of the Overview Report). The letter was accompanied by the Home Office DHR leaflet for family members. The letter and leaflet were in English because the MPS FLO advised that, based on her contact to date, the family would prefer to receive correspondence in English and then arrange for this to be translated locally. Later that month the MPS FLO confirmed that the family had received and translated the letter.

1.9.3 At that time, the family chose not to contact the chair and therefore did not contribute to the Terms of Reference. However, the chair sought to establish contact with the Family, working with the FLO. In July 2017, it was confirmed that members of Nargiza's family would be travelling to the UK to have contact with Child C and participate in Family Court proceedings relating to their future care. These family members were:

Known in the review as	Relationship to Victim	Means of involvement in review
Bekzod	Father	Interview / reviewed report
Dilnura	Sister	Interview / reviewed report

1.9.4 The chair subsequently met with Bekzod and Dilnura on the 4th August 2017 at a Police Station in London, with this meeting arranged through the MPS FLO who also attended to make introductions and provide support. A translator was present. At the meeting, it was agreed that a translated copy of the interview transcript would be shared with the family for their approval and this was duly done.

1.9.5 The family have been updated regularly, with communication being undertaken by email through the MPS FLO and directly through the translator, and later via the chair. The same interpreter was used throughout this process, as the family had established a good working

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relationship with them. This was initially funded by the MPS as part of their enquiries and later by the London Borough of Bexley.

1.9.6 The family also had the opportunity to review the draft Overview Report. Given the size of the document, this was translated before being sent to the family electronically in November 2017. The family were invited to review and comment on the draft Overview Report and were offered the opportunity to speak with the chair. They provided feedback in January 2018, confirming that they were content with the Overview Report as they felt they had shared everything they had wanted to when they met the chair earlier in the year. The chair also explored whether the family would like to provide a Pen Portrait of Nargiza, but the family chose not to take this up. For this reason, where relevant, the Overview Report contains verbatim quotes from the interview with Nargiza's family to try and represent Nargiza's experience through the eyes of her family.

1.9.7 On sharing the Overview Report, the chair also explicitly asked Nargiza's family about any concerns that they might have about any engagement with Marat's family. In January 2018, Nargiza's family confirmed that they had no concerns about contact with Marat's family.

1.9.8 When the report was handed to the CSP, the chair sent a final email to Nargiza's family, providing an update on the review process and introducing a named contact at the CSP whom they could contact for any further information on the review process, receive a copy of the report, or be updated in relation to publication or discuss the next steps in terms of any action plan.

Friends

1.9.9 From the outset, the Review Panel decided that it was important to take steps to involve the friends and work colleagues. During their enquiries, the MPS took statements from friends and colleagues. A letter was sent from the chair to these witnesses via the MPS on the 18th July 2017 and followed by with a telephone call on the 7th August 2017 to confirm receipt.

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Where consent was given to share a witness statement, this information was incorporated into the report.

Known in the review as	Relationship to Victim	Means of involvement in review
Dilnoza	Work colleague / friend of Nargiza	Responded to police letter and gave consent to share witness statement. Agreed to participate in the review. Contact details passed to chair, who was unable to make contact
Gulsara	Work colleague of Nargiza	No response received to police letter, but later contacted the chair directly. Following a conversation via telephone and email, gave consent to share witness statement but did not want to participate further in the review
Feruza	Work colleague of Nargiza	Responded to police letter and gave consent to share witness statement. Did not want to participate further in the review
Colleague 1	Work colleague of Nargiza	No response received to police letter and therefore witness statement not used.
Childminder	Childminder	Response to police letter. Declined to share witness statement and did not want to participate in the review

1.10 Involvement of Perpetrator and/or his Family

1.10.1 The Review Panel discussed whether to involve the family of the perpetrator, given Marat's death. This statutory guidance suggests that DHRs should consider approaching the family of the perpetrator as they may have relevant information to offer. The Review Panel considered whether Marat's family should be approached, in light of the potential for conflict between Nargiza's and Marat's family as a result of care

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proceedings (see 1.11), and specifically because of the request by Nargiza's family that the report was anonymised to region (see 1.3.5). Initially the Review Panel felt it should err on the side of caution, but following feedback from Nargiza's family, as noted in 1.9.7 above, it was agreed that an approach would be made to Marat's family. In making this decision, the London Borough of Bexley sought legal advice.

1.10.2 Subsequently, a letter to Marat's family was prepared and translated in February, before being sent by the chair to Marat's sister in March 2018. A response was received. Correspondence in English by email was possible, so several options for contact were discussed, before it was agreed that the chair would send a list of questions and, once the family had considered these, they would either respond in writing and / or a telephone interview would be set up. The questions were translated and sent, and arrangements were made to secure a translator for a telephone interview if required. Unfortunately, no acknowledgment of the questions, or a response to a subsequent follow up, was received. As a result, there is limited additional information about Marat in the report.

1.10.3 When the report was handed to the CSP, the chair sent a final email to Marat's sister, providing an update on the review process and introducing a named contact at the CSP whom she could contact for any further information on the review process, receive a copy of the report, or be updated in relation to publication.

1.11 Parallel Reviews

1.11.1 *Coroner*: There are two inquests that have been conducted in parallel to this DHR:

- The first was into the death of Nargiza. This opened at the South London Area Coroner's Court on the 28th December 2016 and adjourned
- The second was into the death of Marat. This opened at the Inner South London Coroners Court on the 5th January 2017 and adjourned.

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1.11.2 Reflecting the statutory guidance, to ensure that relevant information was shared without incurring significant delay in the DHR, it was agreed that a draft copy of the Overview Report would be shared to help inform both Inquests. This was done on the understanding that a final copy of the Overview Report and supporting documents could only be made available after they had been reviewed by the Home Office Quality Assurance Panel.

1.11.3 *Criminal trial*: A criminal investigation was conducted by the MPS Homicide and Serious Crime Command, which led to Marat being charged with the murder of Nargiza. Reflecting the statutory guidance, the chair invited the Senior Investigating Officer (SIO) to the first panel meeting so they had an opportunity to express any views on the content of the Terms of Reference. As Marat died in custody before he could be tried, the criminal justice process came to an end.

1.11.4 *Marat's death in custody*: There were three organisations involved in reviews of Marat's death while in custody (the MPS, the Prison and Probation Ombudsman and the Oxleas NHS Foundation Trust). As Marat's death occurred after Nargiza's homicide, these reviews are out of scope, however the Chair of the Review considered how they might dovetail with the DHR. This is as follows:

1.11.4.1 As Marat died in custody, the *MPS Prison Investigation Team* reviewed the case. A representative of this team attended the first Review Panel meeting to establish if there was any overlap. It was agreed that there was none, and the team did not participate in subsequent meetings. No additional information was identified, beyond what was already included in the MPS IMR.

1.11.4.2 *The Prison and Probation Ombudsman*: The Ombudsman completed an independent investigation into Marat's death[10]. The chair received a copy of the report and spoke with the investigator on the 2nd August 2017. The findings were not relevant to the

[10] The Ombudsman carries out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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DHR, however the report provided additional information on Marat's mental health. This is noted in 4.4.

1.11.4.3 *Oxleas NHS Foundation Trust*: The Trust was the health provider in the prison and, as Marat's death occurred while he was on the health care wing, a Board Level Inquiry was completed. The chair received a copy of the report. The findings were not relevant to the DHR, however the report provided additional information on Marat's mental health, as well as some background information on Marat's financial circumstances and employment in 2016. This is noted in 4.4.

1.11.5 *Care proceedings in respect of Child C*: Nargiza's youngest child, Child C, was living with Nargiza and Marat the time of the homicide. Having been taken into protective custody by the MPS, their care became the responsibility of the London Borough of Bexley. During the review, Child C was a Looked After Child, subject of an Interim Care Order, and there were ongoing court proceedings to decide where they should be living on a long-term basis. At the time of writing, these were expected to conclude in March 2018.

1.11.6 The Review Panel was conscious of this parallel process, and the chair received two summary reports from the London Borough of Bexley Children Services during the course of the review. The latter report included a summary of a Fact-Finding Hearing[11] by Her Honour Judge Atkinson, which was held in October 2017. This is relevant because no criminal trial was held. This found that:

- Child C's mother [Nargiza] was killed by her father [Marat]

[11] The threshold for finding facts is different in the Family Court in comparison to the Criminal Court. The threshold for determining a fact in a criminal court is 'beyond reasonable doubt'. The threshold for determining a fact in the Family Court is 'on the balance of probabilities'. The threshold in Family Courts is therefore lower.

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- Prior to her death [Nargiza] had suffered regular domestic violence at the hands of [Marat]
- There is no evidence that [Nargiza] was radicalised
- [Marat] took his own life whilst in prison.

1.11.7 With reference to Nargiza's oldest children (Child A and Child B), they were living in a Central Asian Republic at the time of the murder and were in the care of Marat's family at the time the report was written.

1.11.8 As Child C has been a Looked After Child in the care of the London Borough of Bexley, a copy of this Review should be attached to their record should they come looking for information in the future.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The chair and author of the Review is James Rowlands, an Associate DHR Chair with STADV. James Rowlands has received Domestic Homicide Review Chair's training from STADV. James Rowlands has co-chaired and authored one previous DHR and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.12.2 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

1.12.3 STADV has been involved in the DHR process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

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1.12.4 *Independence*: James Rowlands has no current connection with the London Borough of Bexley or any of the agencies involved in this case. James has had some limited contact with Bexley 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.

1.13 Dissemination

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Bexley CSP Board. Once agreed, they will be sent to The Home Office for quality assurance.

1.13.2 Once accepted and agreed by Home Office the final report will be shared with the London Borough of Bexley Local Safeguarding Children Board, Safeguarding Adults Board and Health and Wellbeing Board.

1.13.3 The recommendations will be owned by Bexley CSP and captured within the Bexley Action Plan. The Domestic Abuse and Sexual Violence Manager will be responsible for disseminating the recommendations and feeding back the progress.

1.13.4 The final report will also be shared with the London Borough of Lewisham, via the VAWG Programme Manager, for dissemination and the Safer Lewisham Partnership will own any relevant recommendations.

1.13.5 The report will be published once complete in line with Home Office Guidelines.

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2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to Nargiza**	**Age at time of Nargiza's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Nargiza	Victim	29	Ethnic group from Central Asia	Muslim	Partner of a person who is present and settled in the UK	N
Marat	Husband	34	As above	Muslim	Permanent resident, Indefinite Leave to Remain	N
Child C	Child	1	As above	Muslim	British national	N
Child A	Child	7	As above	Muslim	National of a Central Asian Republic	N
Child B	Child	6	As above	Muslim	National of a Central Asian Republic	N
Bekzod	Father					
Dilnura	Sister					
Sister 2	Sister					
Sister 3	Sister					
Dilnoza	Colleague / Friend					
Feruza	Colleague / Friend					
Gulsara	Colleague					
Friend 1	Colleague / Friend					
Babysitter	Friend					

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2.1 The Homicide

2.1.1 *Homicide*: Nargiza died in December 2016 at the home she shared with Marat; this was privately owned and had been purchased in June 2016. Police Officers from the MPS attended the address after receiving a call from a friend who had contacted them with concerns about Nargiza's welfare. Police Officers forced entry to the property, as they could hear a child crying (subsequently identified as Child C). Nargiza was found lying on a bed. It was apparent that Nargiza had been dead for some time (as part of the MPS investigation, Marat's time of death was estimated as having been at some time over the previous two days). Marat was lying next to Nargiza and had several self-inflicted wounds to his wrist; he was initially unconscious but was woken by Police Officers and treated for his injuries. The LAS attended and pronounced Nargiza's life as extinct. Marat was assessed and, as his injuries were minor, he was left in the care of the MPS.

2.1.2 Child C was in a distressed state in a cot in the living room. They were placed in police protection and taken to hospital, before being passed into the care of the London Borough of Bexley.

2.1.3 *Post Mortem*: On 15th December 2016, a Post Mortem examination of Nargiza was conducted by a Home Office Pathologist at Princess Royal Hospital Mortuary. The cause of death was given as manual compression of the neck.

2.1.4 *Criminal trial outcome*: The alleged perpetrator, Marat, was charged with the murder of Nargiza in December 2016. However, there has been no criminal trial as Marat, who had been remanded to prison, died by suicide at the end of the same month. The Post Mortem examination gave the cause of death as hanging.

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2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background Information relating to Victim*: Nargiza was the oldest child of a large family; she is survived by number of sisters and brothers, as well as her parents. Nargiza was born, raised in, and a citizen of, a Central Asian Republic.

2.2.2 At the time of her death, Nargiza was 29 years old. She had first come to the UK in 2008 on a Student Dependent Visa and, after several attempts, was granted LTR as the spouse of Marat in 2014. Nargiza was a Muslim and was not known to have a disability. Nargiza had lived with Marat in the London Borough of Lewisham until June / July 2016, when she moved to the London Borough of Bexley. Nargiza had trained as a health care professional in a Central Asian Republic. In the UK, she secured work as a Catering Assistant in GSTT, starting in 2012 as a member of bank staff before securing a full time roll as a Food Service Assistant in 2015. She continued to be employed by the GSTT until her death. At the time of her homicide Nargiza had secured LTR until September 2017.

2.2.3 *Background Information relating to Perpetrator*: Marat was the youngest of eight children; he is survived by four sisters, two brothers and his father. Marat was born, raised in, and a citizen of, a Central Asian Republic.

2.2.4 At the time of Nargiza's homicide and his own death, Marat was 34. He had first come to the UK in 2004 on a Student Visa, which was extended several times until he was granted Indefinite LTR in 2014. As part of their enquiries, the MPS established that Marat had been employed as a Chef. Marat is reported to have lost his job in August 2016.

2.2.5 *Synopsis of relationship with the Perpetrator*: Marat and Nargiza met in May 2008 when she was in the final year of her a degree at university (studying as a health professional). They married in July 2008. The marriage was arranged but there is no evidence that this was a Forced Marriage. Nargiza and Marat's families met in order that Marat could propose, with Nargiza agreeing to the marriage. Nargiza's father told the

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MPS during their enquiries that the decision to marry was Nargiza's. He said *"she liked him. I was not convinced but chose not to go against Nargiza's wishes"*. In August 2016, Marat announced he was divorcing Nargiza, although they were later re-married in November 2016.

2.2.6 *Members of the family and the household*: At the time of Nargiza's death, Child C lived with Nargiza and Marat. They were aged one. There were two further children (Child A and Child B) who were resident in a Central Asian Republic in the care of family members.

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3. Chronology

3.1 Chronology from year to year (timescales under review)

Background information up until 2013

3.1.1 Marat applied for an Entry Visa to the UK in July 2004. From this date, through to October 2013, he applied on seven occasions to extend his LTR. This was linked to his education. Various conditions applied, usually restrictions about No Recourse to Public Funds and no employment as doctor/dentist in training.

3.1.2 Nargiza met Marat in May 2008 in a Central Asian Republic, where she was in the final year of her university degree. They were introduced through Marat's sister, who had been Nargiza's teacher at university and had suggested to Marat that Nargiza would make a "*good wife*".

3.1.3 Nargiza and Marat were married in July 2008. This was an arranged marriage.

3.1.4 Shortly after the wedding, Marat returned to London, and Nargiza sought to join him, applying for Entry Clearance as a Student Dependent. This was refused in October 2008, but a subsequent application in November 2008 was approved. Conditions applied including No Recourse to Public Funds (NRPF).

3.1.5 In 2009, Nargiza was named as a dependent on Marat's application for LTR, with this granted for a period of two years. A further application was made in September 2011 and was granted, running through till November 2013. Again, conditions applied (including NRPF).

3.1.6 In August 2009, Nargiza and Marat's first child was born (Child A) in Ealing Hospital, which is provided by the London North West Healthcare NHS

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Trust[12]. Two months later, Child A was taken to Nargiza's country of origin and thereafter, lived with the parental grandparent's, being cared for by Marat's sister. Nargiza's family in her country of origin had regular contact with Child A. Nargiza's father (Bekzod) described both the care arrangements, as well as Nargiza's return to London, as normal and allowing Nargiza and Marat to work in London and send money to their family. However, while Bekzod said that "*Nargiza gave us no cause for concern"*, he was not sure what job she was doing and also noted that *"…it was Marat's idea to send Child A to …* [Nargiza's country of origin] *… so that he and Nargiza could work and earn money"*.

3.1.7 In May 2010, Nargiza and Marat travelled back to their country of origin for the first time since 2008, returning for a family wedding. Nargiza's father describes Nargiza during this visit as *"…happy with no complaints"* although she told him she missed Child A. Nargiza and Marat returned to London in July 2010.

3.1.8 In December 2010, Child B was born in in Lewisham Hospital. There were limited notes available to the review in relation to contact at this time (this period pre-dated the current IT system in use at LGT). The circumstances appear to be that after discharge Nargiza and Child B were passed into the care of the Community Midwifery Service, then to the Health Visiting Service (an introductory letter had previously been sent to Nargiza from the Health Visiting service inviting her to contact them and, after the birth of Child B, a referral was made). However, the case was only open to the Health Visiting Service for one day and no contact was made.

3.1.9 This limited contact may have been because Child B only remained with Nargiza and Marat until May 2011 when they were taken by Nargiza to her country of origin. After a stay or one or two months Nargiza returned to

[12] This was identified at a late stage in the review. A request was made to the London North West Healthcare NHS Trust to identify what if any information was held. The trust was able to confirm that there was limited information recorded on the electronic record. Given the time elapsed since this contact with Nargiza, it was agreed that no further archive search would be made as this would further delay the review and would not have been proportionate to any likely benefit, not least because of the more recent learning for another health trust in the review.

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London to work, leaving Child B in the care of her parents. Bekzod described Nargiza as *"…very upset about leaving her child, but she painted a happy picture so I did not believe she was unhappy or there were any problems"*. He added however, that *"Marat had called her and told her to leave the children … and come back to work".*

3.1.10 Nargiza and Marat visited their country of origin again in November 2011, living with Child A, Child B and the maternal grandmother, until February 2012. Bekzod describes Nargiza as being *"…not happy to be leaving her two children*". His account suggested that Marat's mother persuaded Nargiza to return to London, although Nargiza had also spoken to her own mother and another family member about taking the children with her. This led to meeting between Nargiza's mother, Nargiza and Marat, where it was agreed that the children would remain with Marat's family. Despite these circumstances, Nargiza's father said that during this time *"…the two families were getting on well and we* [Nargiza's family] *were happy with this decision. I did not detect any problems*".

3.1.11 Having returned to London, Nargiza began working as a Food Services Assistant in GSTT, starting in November 2012 as a member of bank staff.

3.1.12 In October 2013, Nargiza was named on a new application by Marat as a dependent. This was refused in November 2013, with Nargiza initially lodging an appeal in December 2013, with this later withdrawn in July 2014.

2014

3.1.13 On the 13th June 2014, Nargiza made what appears to be her first disclosure of domestic violence, speaking with a friend (see 4.1.11 below)

3.1.14 She also told her manager at GSTT (this was Gulsara, see 4.1.28). With her consent, Nargiza was referred to (and met with) REACH on the same day. Nargiza disclosed a history of domestic violence and abuse by Marat since 2008. This included physical, sexual, emotional and financial abuse, isolation and the use of male privilege. Nargiza also talked about how Marat used her immigration status and her children (this was a reference to

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Child A and Child B, for whom Nargiza wanted Marat to secure visas). Nargiza said that when she raised these issues, Marat would respond with physical violence.

3.1.15 At referral, REACH's records note that Nargiza had "*good English".* A Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) was completed, with a score of 12.

3.1.16 When asked about what she would like to do, Nargiza stated that she would like to leave the relationship, but that Marat continued to refuse to sign the immigration papers that would enable her to apply for Indefinite LTR. As an additional complication, all her documents were with the Home Office for an Appeal for LTR which was due to be heard on 8th August.

3.1.17 REACH staff explored safety options with Nargiza, including an offer of on-site accommodation as she had NRPF. Nargiza refused this offer, stating that if she did not return home tonight she believed that Marat would phone his brother (who had custody of the Child A and Child B in Nargiza and Marat's country of origin) and order him to hide or harm the children.

3.1.18 Additionally, Nargiza stated that she believed that Marat was applying for Indefinite LRT that week which would make her application easier (see 3.1.54 below, which describes the contact with the Home Office in August and September 2014). REACH staff advised Nargiza to contact the Home Office to see if she could apply for Indefinite LTR if she separated from her husband. Nargiza was also advised to contact the Home Office to ask why her application to stay in the UK had been refused. She was given information about a legal aid immigration solicitor.

3.1.19 REACH had a discussion with Nargiza about reporting to the MPS, but this was declined, with Nargiza stating that she would only make a report if there was a guarantee that Marat would not be deported.

3.1.20 REACH also considered making a referral to local Multi-Agency Risk Assessment Conference (MARAC). As Nargiza was a resident of the London Borough of Lewisham at the time, this would have meant making a referral to the Lewisham MARAC. Although the score of the DASH RIC was 12, the staff member felt that there were grounds to refer the case on

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professional judgement. There was a plan to do this in the next two weeks (after the next scheduled meeting with Nargiza). However, no referral was subsequently made.

3.1.21 After the meeting, Nargiza's manager was updated about the outcome. They were asked to contact either REACH or the in-house Police Officer if Nargiza did not turn up for scheduled shifts without phoning in.

3.1.22 On the 13th June, Nargiza attended a Police Station to report that Marat had assaulted her and drawn on her back (how and with what not detailed) after she declined to have sex with him. Nargiza reported that, after she declined him a second time, he hit her again and ejected her from their shared room. Nargiza provided a statement. After making this report, Nargiza stayed with a friend (Babysitter) as she was fearful of Marat's reaction.

3.1.23 On the 14th June, Marat was interviewed under caution but was not arrested. Marat denied any assault, stating that he had "*cuddled*" Nargiza as she had been upset at missing her sister's wedding and that later she had left the property having "*moaned"* at him.

3.1.24 Later that day Nargiza also came to the Police Station (after Marat had been interviewed) but made no further disclosures. An appointment was made with Nargiza for the 15th June, so an interpreter could be present. Later that day, MM called the MPS to ask them to be present with Nargiza when she collected her belongings from the address she shared with Marat. An appointment was arranged for the 16th June.

3.1.25 On the 15th June, Nargiza attended the Police Station again and detailed being assaulted by Marat but explained she had not previously disclosed this to anyone. A further statement was obtained in English due to the interpreter being unable to produce a statement in Nargiza's first language. Nargiza told Police Officers that she had two children who were living with her sister-in-law in her country of origin.

3.1.26 On the 15th June, REACH tried to call Nargiza using a phone that Nargiza kept, and only used, when at work. Nargiza did not answer the phone but a voicemail message was left. Nargiza was advised REACH would attempt to

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make contact again the following weekend (this time was chosen because Nargiza had told REACH that she would be on annual leave during the week but was working extra shifts at the weekend).

3.1.27 On the 16th June, there were several different contacts:

- The LAS received a 999 from Marat who reported experiencing chest pains. Marat also said that he had experienced anxiety attacks previously. Marat declined to be conveyed to hospital for further assessment and was left at home with advice to call back if his condition worsened.
- The Refuge IDVA Service in Lewisham received a referral by email from the MPS for Nargiza (this included the information that Nargiza had made a report following a physical assault and had agreed to the referral).
- Marat attended a Police Station and was interviewed under caution but was not arrested. Marat denied the further allegations.
- Her friend (Babysitter) called the MPS ahead of the appointment to confirm that Police Officers would be attending to support Nargiza in collecting her property. Police Officers arrived shortly after this call, met with Nargiza and attended the address. Marat declined to let them in, stating that was not the arrangement he had made with the Officer in Charge (OIC). Marat then contacted the OIC and said that Nargiza had been ringing and texting him, but he had ignored her due to being fearful that she may make another allegation.
- The OIC made a referral to the Lewisham MARAC on the 16th June based on professional judgement. The referral form noted that "*she* [Nargiza] *stated to police she has never told anyone before about this, as she is so scared of what he would to do to her*" and "*due to the suspect controlling everything she* [sic] *finding it hard to establish herself*". The OIC identified that the victim was hoping to get help with housing and emotional support.

3.1.28 On the 17th June, the Refuge IDVA Service made the first of several attempts to contact Nargiza, using the telephone number of a friend (Babysitter), with further attempts on the 19th, 21st, 22nd and 23rd June with no response.

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3.1.29 On the 17th June, Nargiza came into the Emergency Department at St Thomas' Hospital, part of GSTT, contacting REACH for an unplanned meeting. Nargiza said she had not gone home after the initial meeting with REACH on 13th June, staying instead at her friend's (Babysitter) house. Nargiza also stated that she had made a report to the MPS, and that Police Officers had spoken to Marat, but had told Nargiza they could not arrest him as she did not have any visible injuries.

3.1.30 Nargiza was advised by REACH to contact the Home Office to tell them that she had separated. A referral was made to an immigration solicitor on the same day, and an appointment was made. Nargiza stated that she would not mind if the Home Office told her to return home, as long as Marat stayed in the UK. A further meeting was arranged for the 21st June.

3.1.31 On the 17th June, Marat contacted the MPS stating he was concerned for Nargiza following a conversation with her mother who had said that she had not heard from her daughter since the previous day. Marat advised that he was not to have contact with Nargiza.

3.1.32 Nargiza subsequently contacted the MPS seeking that they facilitate contact with Marat due to him having refused to engage with her about her collecting her belongings. An hour later Nargiza made a further call to the MPS requesting that Police Officers attend with her to collect her belongings, which Marat had left outside his property. This call was linked to the previous calls and the control room sought to contact Nargiza to clarify if they needed to attend.

3.1.33 The OIC submitted this incident for review but held that the investigation could not proceed due to the absence of corroborative evidence.

3.1.34 On 20th June, Nargiza informed Police Officers that she had returned to live with Marat.

3.1.35 Nargiza met with REACH on the 21st June and said that she had decided to give Marat another chance. She described him as apologetic and that he had been scared after Police Officers had visited him. She also said he had admitted to his family how badly he had treated Nargiza and had promised to change. Nargiza gave examples of his 'changed' behaviour

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(e.g. he had arranged Skype contact between Nargiza and her children and had promised to apply for a Visitor's Visa).

3.1.36 Nargiza also told staff that she that had previously decided to make an application to stay in the UK under the domestic violence concession rule and that the immigration solicitor had, as agreed, contacted her about her application. However, she had not attended the appointment.

3.1.37 She also told staff that the Home Office had advised her that her application to stay in the UK under the domestic violence rule may take up to a year and that they had not offered to fund accommodation for her during this time. Nargiza had stated that she feared that she would lose contact with her children in those circumstances.

3.1.38 Nargiza requested that REACH provide a letter for the Home Office, advising them of her return to Marat. It was agreed that this would be completed and that Nargiza would pick it up in the next few days. Additionally, the REACH worker agreed to contact the immigration solicitor to notify them why Nargiza had not attended the appointment.

3.1.39 REACH attempted to contact on Nargiza on the 23rd June; her phone went to voicemail and a message was left asking for a call back. A further attempt was made on the 26th June. Nargiza answered the call and stated that she was on holiday outside of UK and would be back by the weekend. She agreed to make contact on her return to arrange to pick up the letter to the Home Office.

3.1.40 On the 25th June, the MPS investigation was closed by a supervisor.

3.1.41 On the 2nd July, Nargiza rang REACH and asked if the Home Office letter could be posted to her as she was off sick from work. She said this would be safe as Marat would not be around.

3.1.42 On the 6th July, three missed calls were made by Marat to REACH, complaining about the content of the Home Office letter. Staff at REACH contacted Nargiza to discuss the phone calls from Marat. Nargiza was unaware that these calls had been made. Nargiza asked for the contents of the letter to be changed to state that "*everything was OK and that they were happy*". Nargiza was informed that this was not possible and was

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asked about her safety. Nargiza asked to meet that day but no staff were available. However, Nargiza was offered overnight accommodation on hospital premises if she felt unsafe to go home. Nargiza refused this offer and said that she had only wanted to meet for a chat. Nargiza was unable to give a date and time to meet during that week, stating that she did not know her shifts. Nargiza agreed to ring on the 8th July to arrange a meeting. She did not subsequently make this call.

3.1.43 On the 8th July, the Refuge IDVA Service contacted Nargiza who stated that she had reconciled with her partner and that things had improved. As Nargiza declined support, the call was very brief; the staff member relied on the referral information as provided by the MPS, did not have an opportunity to ask Nargiza which other services she may have been engaged with, and prioritised providing safety information. Nargiza was verbally provided with information about the Refuge IDVA service, the telephone number for the National Domestic Violence Helpline, as well as some information on domestic violence support. At this point, the referrer (the MPS) was not informed that contact had been made but that Nargiza had declined the service.

3.1.44 Marat and Nargiza were discussed at a Lewisham MARAC meeting on the 23rd July.[13] The following agencies were recorded as being present:

- Hyde Housing Association
- Lewisham & Greenwich Healthcare NHS (LGT)
- Lewisham HOC (Housing Options Centre)
- Lewisham Homes
- London Borough of Lewisham Adult Safeguarding

[13] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. Together, the meeting writes an action plan for each victim. They work best when everyone involved understands their roles and the right processes to follow. http://www.safelives.org.uk/practice-support/resources-marac-meetings

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- London Borough of Lewisham Adult's Social Care
- London Borough of Lewisham Attendance & Welfare
- London Borough of Lewisham Children's Social Care
- London Borough of Lewisham Community Safety
- London Borough of Lewisham MARAC Coordinator
- Metropolitan Police Service (MPS) and MARAC Chair
- Phoenix Community Housing
- Refuge IDVA Service
- SLAM
- Victim Support.

3.1.45 REACH was neither present nor aware of the MARAC meeting – they did not routinely receive the agenda for the MARAC in Lewisham, so did not know that Nargiza's case was being discussed.

3.1.46 The record of the meeting is reproduced below:

Figure 1. Lewisham MARAC minutes

Brief summary of recent incident and history; clarify fact and opinion

Date of most recent incident	12/06/2014
IDVA	None
Reasons for referral	Professional Judgement
Victim	• Currently staying with friend at [XXX] • Declined IDVA support • Self harms
Perpetrator	• [Marat], [DOB], husband • Denies DV allegations
Children	• Two children living in [Central Asian Republic]

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3.1.47 With reference to the Lewisham MARAC minutes, the Refuge IDVA Service IMR notes that it is unclear what information was presented other that the victim's name, address and alleged perpetrator details. It is not evident from the Lewisham MARAC minutes whether there was any consideration given to the information in the OIC's referral.

3.1.48 The action log records that a flag on the address was already on the MPS crime recording system ('CRIS') for both Nargiza's place of normal residence (at the time, in the London Borough of Lewisham), as well as a temporary address where she was staying with a friend (Babysitter) in another borough.

3.1.49 A single action was agreed for 'all agencies to flag'.

3.1.50 On the 24th July, Nargiza came to the Emergency Department at St Thomas' Hospital for an unplanned meeting with REACH. She said that she and Marat had decided to divorce and that she would be going home to her country of origin as soon as she got her passport from the Home Office. Nargiza also said that she had resigned from her post in GSTT with immediate effect. Nargiza was offered further support from REACH until her flight home but declined this. No further contact was made between REACH and Nargiza after this date.

3.1.51 Over the 27th and 28th July, Marat made three calls to the MPS. Initially he reported that Nargiza had taken a hard drive from his room. He then reported that Nargiza had refused to talk to him, that she was sitting outside crying and that he believed she was going to falsely report that he had hurt her. In his last call, he said that Nargiza had taken items and when he told her that Police Officers were coming she had thrown herself on the floor claiming he had hurt her.

3.1.52 On the 28th July, Police Officers attended and spoke (separately) with Nargiza and Marat. No allegations of crime were made by either party. A CRIS report was created and then closed on the 4th August after a review by the Community Safety Unit (CSU).

3.1.53 REACH also closed Nargiza's case on the 21st August. There appears to have been no update provided to Nargiza's manager at this point.

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3.1.54 On the 27th August, Marat applied for Indefinite LTR. On the same day, Nargiza also applied for LTR in the UK as the spouse of a settled person.

3.1.55 In September, the Home Office decided to consider curtailing Nargiza's LTR.

3.1.56 On the 1st October, Marat's application for Indefinite LTR was granted. This meant there were no longer any restrictions on his length of stay in the country or employment.

3.1.57 On the 10th October, Nargiza's LTR was curtailed, with this due to end in February 2015.

2015

3.1.58 In February 2015, the Home Office re-considered the decision to curtail Nargiza's LTR and in March, Nargiza was granted LTR as a dependent of Marat (until September 2017). As before, this was on condition of NRPF.

3.1.59 Nargiza became a fulltime member of staff at GSTT in April 2015, continuing in her role as a Food Service Assistant. This contract had an end date of September 2017 in line with her visa (she would be employed by the GSTT until her death).

3.1.60 In June, Nargiza went on maternity leave, and in the same month Child C was born at St Thomas' Hospital.

3.1.61 The Health Visitor Team from LGT contacted Nargiza on the 17th June and a new birth visit was arranged for the 25th June.

3.1.62 On the 18th June, a Community Midwife visited Nargiza and Child C at home. Child C was unwell and was subsequently admitted to the Children's Emergency Department at University Hospital, Lewisham, where she received treatment before being discharged home on the 24th June. It is noted in the LGT IMR that there is no routine screening for domestic violence and abuse in the Children's Emergency Department.

3.1.63 On the 25th June, the pre-booked new birth visit takes place. The Health Visitor completed a New Birth Visit Health Needs Assessment and a Genogram, but the Family Profile Record was not completed. The Health Visitor recorded that Nargiza said that her husband was "*supportive*" and

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that she had friends locally. A range of information is listed as having been discussed, with at least 6 leaflets / booklets, as well as details of the Health Visiting Team and baby clinics, being provided. A 6-8 week follow up visit was also booked.

3.1.64 On the 3rd July, Nargiza registered at The Medical Centre in Lewisham[14]. There are three contacts with Nargiza between the 9th July and the 28th July for post-natal checks. At the final contact Nargiza was asked about social support and the following note is included in the electronic record: "*husband very supportive", "good rapport*". Nargiza went onto be seen regularly at The Medical Centre, attending with Child C for minor childhood conditions, immunisations and routine health care.

3.1.65 On the 29th July, the LGT Health Visitor completed an 8 week follow up home visit as planned. Nargiza was seen with Child C and Marat. Nargiza reported to the Health Visitor that she was coping well and "*adjusting to motherhood*". Nargiza told the Health Visitor that she had had no feelings of low mood and was "*getting out and about*" and her husband was "*supportive*". No record was made of any contribution by Marat to the consultation. At this visit the Health Visitor identified a risk factor as "*limited family support*", although they were positive about Nargiza's abilities as a mother with protective factors listed as: "*nurturing parenting skills, active listening by mother towards health professionals and accessing local services*".

3.1.66 On the same day, Nargiza contacted the MPS to report problems with another tenant. Nargiza was advised to address the issue with her landlord.

3.1.67 In August, Nargiza had routine contacts (relating to Child C) with The Medical Centre.

3.1.68 On the 29th September, Nargiza and Child C were seen at the clinic for the planned 3-4-month visit, where Nargiza was observed by a Staff Nurse to

[14] Prior to this registration the only other contact with primary care identified by the review was a single attendance by Nargiza at a walk-in clinic in Lewisham for a possible insect bite in February 2012.

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be "*happy and co-operative and receptive to advice*", while Child C was "*alert and smiling*".

3.1.69 On the 4th October, the MPS received a report about Marat, relating to noise disturbance, from their landlord. However, as the tenant involved did not provide a statement the report was closed.

3.1.70 During October, Nargiza was in contact with Medical Centre on three occasions; these contacts related to Child C and, on one occasion, a prescription for Nargiza.

3.1.71 On the 3rd November, Nargiza attended the Community Health Centre, was seen by a Health Visitor in relation to a concern about Child C and was given advice. On the same day Nargiza attended The Medical Centre and asked for advice on the same issue.

3.1.72 In November, Marat returned to her country of origin. Initially he lived in his family's home but following arguments (cause unknown) with his sisters, he moved into a flat with Child A and Child B. Nargiza's father (Bekzod) told the Police that this argument was because Marat's sisters wanted to adopt Child A and Child B, which neither Nargiza or Marat wanted. Bekzod told Police that Nargiza discussed this with him, had told him that Marat was going to get visas to bring the children to the UK and that this made her *"very happy".*

3.1.73 In December, there are a further three appoints with The Medical Centre and, as previously, these were routine .

2016

3.1.74 On the 5th January 2016, Nargiza attended The Medical Centre and had a planned review for a prescription and consultation about another medical issue. There was a follow up consultation by phone the following day relating to an immunization. There were a further six contacts with The Medical Centre in relation to Child C or other routine visits, including being weighed for the Health Visitor Clinic.

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3.1.75 In this month, Nargiza was also invited to arrange an appointment with the Health Visiting Team for a 7-11 month developmental review for Child C. This was booked for the 29th February.

3.1.76 Nargiza and Child C attended as planned for the 7-11 month developmental review; in the notes Nargiza is described as "*observed to be happy and co-operative*".

3.1.77 On the 10th March, the LAS attended the home address as Child C had a high temperature. Subsequently Child C was conveyed to the Children's Emergency Department at Lewisham Hospital and was diagnosed with an infection, prescribed antibiotics and discharged home. The LGT Health Visitor Team received a Notification of Attendance and Child C was also seen at The Medical Centre for a follow up on the 18th March.

3.1.78 During this time Bekzod later told the MPS that he became aware that Marat was having problems getting visas for Child A and Child B. At this point Marat returned to London, leaving the children in the care of Nargiza's family.

3.1.79 On the 4th April, Nargiza called the LGT Health Visitor Team. Nargiza said she was in crisis and reported that her home was not safe for the family as a door had been removed and had not been replaced. The record is not clear about which door was missing and the circumstances at the time. Nargiza was advised that the Health Visitor Team could not negotiate housing issues and was told to contact landlord, housing department and local MP to follow this up.

3.1.80 On 5th April, Child C was weighed at the Health Visitor Clinic. There is no record of any follow up conversation in relation to the phone call that was made the previous day.

3.1.81 On the 5th May, Nargiza attended The Medical Centre and saw the Practice Nurse for a routine medical matter; later that day Nargiza had a GP telephone consultation and she was informed that Child C's previous infection had cleared up.

3.1.82 On the 6th May, Nargiza attended The Medical Centre reporting pelvic pain during intercourse, the onset having coincided with Marat's return from

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being away (it is not clear from the record whether the onset was after four months, or whether it began after Marat had been away for four months). There is no note of Marat being present in the consultation. However, he was seen on the same day by the same GP. In both contacts advice and follow up treatment was given.

3.1.83 On the 12th May, Nargiza was seen again because of a headache. She reported a minor head injury that she said had been caused by falling against a wall the previous evening. Bruising above the ear was noted.

3.1.84 On the 17th May, Nargiza attended for a further appointment, and reported further pelvic pain. Advice and follow up treatment was given.

3.1.85 On the 13th June, the Health Visitor Team at LGT received information that Nargiza had moved from Lewisham with Child C (this information was recorded on the LGT chronology as being provided by the Lewisham Multi-Agency Safeguarding Hub (MASH)). The Health Visitor Team Administrator recorded that the client had moved to temporary address in another borough where she was staying with a friend.

3.1.86 Nargiza had been due to return to work at GSTT on the 20th June 2016 but extended her maternity leave by one week, saying that Child C was unwell. Nargiza also took a week's annual leave saying that she and Marat were trying to arrange a mortgage.

3.1.87 In June, Nargiza and Marat purchased and then moved to a new property in Bexley.

3.1.88 There were further contacts with The Medical Centre on the 22nd, 26th July and 11th August; these were routine and related to Child C.

3.1.89 In early August, Nargiza travelled back to her country of origin, bringing Child C.

3.1.90 Marat remained in the UK and (this information was not known to agencies until after his death) it is believed that in August 2016 he lost his job.

3.1.91 Nargiza stayed in her country of origin until the start of November. This is consistent with Nargiza's employment record at GSTT, which includes a note on the 30th August that she was on leave. However, Nargiza appears to have stayed longer than she had intended or agreed (her employment

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record states she overstayed by 43 days and she told her manager at GSTT that Child C had been sick and so could not travel, although as noted below it appears her father had been sick rather than Child C).

3.1.92 This period appears to have been the trigger for a dispute between Nargiza and Marat (who was still in London). Nargiza's father (Bekzod) told the MPS that Marat did not want Nargiza to visit him when he was ill and did not want Nargiza to bring the children with her when she visited. Although Nargiza did visit her father, she only did so after asking Marat's family members for permission (Marat was reportedly not answering her calls at the time) and was escorted by one of his sisters. When she arrived at her family home, Bekzod later told the MPS that Marat rang. He is reported to have said to Nargiza *"Where are you? I didn't give you permission to go over to your family"*. Nargiza is described as being upset during the visit with Marat consistently ringing. Bekzod described Marat's contact at this point as *"…being abusive and unreasonable".*

3.1.93 Although Nargiza returned to Marat's family home, Bekzod told the MPS that Marat contacted his own parents by phone, telling them *"…to take Nargiza's phone, and any money she had and to send her and the 3 children back over to [her parent's] house as he had divorced her'*. The following day she came back to her parent's home and was accompanied by Child A, B and C.

3.1.94 The chronology in this period is unclear, but during this time Marat spoke to Bekzod about a divorce, saying he wanted this because Nargiza had visited Bekzod when he was sick.

3.1.95 During this period, Nargiza spoke to her father. Bekzod told the MPS that "*she began to open up to me*" and described a range of behaviours she had experienced from Marat. These included being sent out to work, beating her, taking control of her money and isolating her from friends. She also said that when she rang her family, Marat would listen in and tell her when to hang up. Nargiza's father summarized this as "…*he stayed in control of her life making her work and taking her money*".

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3.1.96 On the 5th September, Nargiza, Marat and Child C were removed from The Medical Centre's list after a change of address notification (a search of the NHS spine was unable to confirm who made this change).

3.1.97 On the 30th October, the family attended a 'reuniting commission'. Based on Bekzod's account this included representative from both Nargiza and Marat's family, as well as some local civic leaders. Marat participated via an internet service. At this meeting, Marat remained adamant that he wanted a divorce.

3.1.98 Marat is reported by Nargiza's father to have continued to control Nargiza's finances in this period, stating to police that when Nargiza tried to withdraw money from her account it had been emptied. Marat also reportedly threatened Nargiza about the property owned in London, saying that he would "*…make her bankrupt and get her into serious debt if she didn't come back to London".*

3.1.99 In November, Nargiza returned from her country of origin. A chronology of events for this month is presented side by side for both Marat and Nargiza for ease of reading:

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Nargiza	Nargiza's family	Marat
Nargiza returned to London on the 4th November, telling her father that she wanted to sort the situation out and that she had worked hard for the last five years and "…*didn't want to end up with nothing*". In London, Nargiza stayed with a friend. Nargiza told her father that she had talked to Marat's GP who had told her "…*he was suffering from depression and was not well*". Nargiza also told her father that Marat was turning up at her work place, calling her to try and get her to change her mind and then started to say he would arrange a visa for Child C. Nargiza's father reported to the MPS that "*Nargiza felt that this was a trick to get her to reconsider and thought he was emotionally blackmailing her*". .	Nargiza left Child A, B and C in the care of her father in her country of origin, although he told the MPS that on the 4th November that Marat's sisters took the children. From Nargiza's father's account, it appears that this may have been the result of a report to the local authorities in that country. He states that Marat had reported Nargiza and Child C missing. Nargiza's father received regular calls from Marat, asking where Nargiza was. Marat is also reported to have said that Nargiza was to blame for the divorce, stating that she had "…*fallen into Islamic Extremist Groups and was not choosing the right direction*'. Nargiza's father rejects this explanation. The time frame is unclear, but during this month, Marat's behaviour changed. Nargiza's father said that Marat contacted his sisters and told them he had changed his mind about getting divorced. He also contacted Nargiza's father and his wife to apologise and tell them he loved Nargiza. In this same period, Nargiza's father was visited by several of Marat's family members asking him and his family to forgive Marat. Nargiza's father	On the 7th November, Marat informed United Kingdom Border Agency (UKBA) that he had separated from Nargiza and that she had returned to her country of origin. On the 8th November: • Marat called the MPS. He said that Nargiza had left him in August and returned to her country of origin[15] but had now returned to the UK. He explained that he had talked to her on the phone the previous week, but she had not answered his calls since then and her place of work had said she had not returned. The incident was closed as no action was required. • Toward the end of that same day, a 999 call was received by the LAS, from Marat who reported experiencing chest pain, abnormal breathing, was at home alone and had a history of depression. On arrival Marat explained that he been drinking and feeling depressed, had recently separated from his wife and not seen his children for a long time. Marat was intoxicated but otherwise all observations were within normal parameters and he declined to be conveyed to hospital. He was left at home with

[15] Year not recorded, but this is likely to refer to the period described above.

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	described how "*everyone was saying let the families be complete and think about when the girls get married. They need a father to give a blessing at their wedding…*". Nargiza's father says he agreed with this sentiment at the time, although he later told the MPS that he regrets that, calling this "…*the biggest mistake of my life*' Nargiza's father talked with Nargiza on several occasions about whether she would reconcile with Marat. Nargiza was determined that Child C would live with her and wanted to bring Child A and Child B to the UK as well. Nargiza's father told the police that Nargiza had said that if Child C was there then "…*hopefully [Marat would] not raise his hands in Child C's presence*". She also told him that she would return to Marat if "…*he agreed to allow her to spend her own money, to talk to her family and to have no restrictions on her life*".	the advice to ring back if his condition deteriorated. On 12th November: • Marat called the MPS to report that he had been subject to a cyber-attack and that his computer no longer worked. Marat then stated that he did not feel safe, as he was being chased and that he believed someone would either kill or kidnap him because he was divorcing his wife. Marat said that his wife wanted to send him back home and then bring their children to the UK to be with her. He also said that his wife was scared of him, that she had said that they could kill each other, but he did not believe she would kill him because she loved him. Marat provided Nargiza's details and place of work. Marat explained that he had contacted immigration to advise that Nargiza no longer lived with him. Marat said he had talked to Nargiza the previous day and that she had told him she wanted a divorce and to live separately. • Police Officers attended Marat's address. They requested LAS attend due to Marat seemingly suffering with paranoia and depression but were advised that Marat had already contacted LAS and that LAS were unable to attend (although they later did so, see below). Marat told the Police Officers that he was low not suicidal, that he had not previously self-harmed, that he was not on medication or under the care of a mental health team. When asked about his comment

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		about his wife killing him he said that he was not serious, it was more a reference to the fact that they could not live together. At 05:59 Marat was provided with advice about the charity MIND and then left Marat to wait for LAS. • A MERLIN was generated. As Marat had not given consent for information to be shared, and Police Officers did not consider the incident to be of sufficient concern to override this, the following was recorded: "*Consent refused, no reason found to override this. No safeguarding or vulnerabilities seen*"[16]. • On that same morning LAS also received two 999 calls at 05:35 and 05:51. In the first, Marat reported he was depressed and that he was feeling dizzy. The second was from the MPS reporting that Marat was depressed possibly suffering from paranoia and depression. • An ambulance was dispatched at 06:32, arriving at the address at 06:54. On arrival the ambulance staff documented that Marat felt depressed and that he had requested an ambulance so he could talk. Marat explained that he was going through a divorce and separation from his children. Marat reported that he had no desire to self-harm and did not feel suicidal but might want to drink more alcohol. The ambulance staff advised against drinking

• [16] At the same day, the MERLIN was received by the Bexley MASH. It would have been discussed on the morning of the 14th November. However, given the rationale noted on the MERLIN, the referral would not have been accepted and there is no record of Marat on the adult social care database.

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		more alcohol. All observations were within normal parameters. Marat declined to be conveyed to hospital and agreed to contact his own doctor. Marat was left at home with the advice to ring back if his condition deteriorated. • Marat contacted the MPS again later that day but cleared the line almost immediately. When the operator rang back Marat asked if he could speak to his wife to rescue their marriage and that he no longer wished to get divorced. The operator advised that should he wish to resolve matters with his wife, and if his wife felt the same, they should attempt to do so.
On the 19th November Nargiza returned to her country of origin, re-married Marat on the 20th November (this was done while Marat was still in the UK) and returned to the UK on the 22nd. Before returning to the UK Nargiza agreed that Marat's sister could continue to care for Child A and Child B. GSTT employment records note that Nargiza was given three days of unpaid special leave as her child was sick, before returning to work on 24th November.		On the 22nd November Nargiza entered the UK; as a consequence, UKBA contacted Marat and he advised them that he had reconciled with Nargiza. Nargiza was subsequently allowed entry to the UK.

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3.1.100 At the start of December, Nargiza registered with a Health Centre in the London Borough of Greenwich. When registering, a new patient is advised to book a health check within 48 hours. On the 7th of December, a letter was sent (with a follow up phone call) to invite Nargiza for a review; there was no response received.

3.1.101 On the 2nd December, the Oxleas Health Visiting Service received a notification from the Health Centre that Nargiza and Child C had moved into the area. A routine introductory letter was sent to Nargiza and a request was made for the Health Visiting records from LGT Health Visiting Team.

3.1.102 On the 7th December, a phone call was made by the Oxleas Health Visiting Service to Nargiza to arrange a visit but there was no answer. A letter of appointment was sent to for the Health Visitor to undertake a home visit on 14th December.

3.1.103 Bekzod called Nargiza on the 11th December. He asked her how things were, and she said that "…*everything was fine".*

3.1.104 Early on the 12th December Bekzod told the MPS that Marat called him (the day marked a family occasion). Bekzod asked about Nargiza and Child C, and Marat said they were sleeping. Marat then told him he had a present, and the call ended shortly after. Marat made a further call later that day, again talking about a celebration.

3.1.105 Marat also called Nargiza's mother, saying that he had organized a celebration to mark the family occasion. He also called Nargiza's sisters (Sister 2 and 3):

- Marat and Sister 2 argued, with Marat ending the call saying, "*I'm a God, you are my creatures, I'm gonna take revenge from all of your relatives from beginning to end*". Sister 2 did not tell anyone about this call at the time because she did not want to spoil the family occasion.
- Marat's call with Sister 3 included a discussion about Nargiza and Child C, who he said were at school and work. The call concluded with Sister 3 asking Marat how things were, and he is reported to have answered "*we are very happy like Romeo and Juliet*".

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3.1.106 On 12th December, Nargiza's friend (Babysitter) called MPS reporting concerns for Nargiza after she had been contacted by the childminder who told her that Nargiza had not collected Child C. Her friend (Babysitter) then detailed that this was at odds with a text message she had received earlier in the day which stated that Nargiza was not attending work due to her baby being sick. Her friend (Babysitter) attempted to ring Nargiza without success, and she established that Marat had collected Child C. MM explained that her concerns were due to Nargiza having suffered domestic abuse.

3.1.107 Police Officers attended Nargiza and Marat's address and, due to their concerns, forced entry where they found Nargiza dead.

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4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

Family

4.1.1 Both Nargiza's father (Bekzod) and one of her sister (Dilnura) talked about Nargiza's achievements at university, her part in their lives as a daughter and a sister, as well as her love for her children.

4.1.2 Talking about Nargiza's marriage to Marat, Bekzod explained how Nargiza and Marat met, and their family's role in the marriage. Bekzod was clear that Nargiza was not forced into the marriage, saying this was Nargiza's decision, although he also said that at the time he had not been convinced by Marat (saying "*I saw his behaviour and I did not like him but Nargiza liked him so I said let it be"*).

4.1.3 After the marriage, Bekzod said he was not aware of any problems or issues in the relationship, explaining that Nargiza did not give any indication about negative or difficult experiences with Marat.

4.1.4 Dilnura talked about how:

"They were happy. In the beginning, we didn't see anything. We used to visit her in-laws when she was staying there, and they looked happy, it seemed perfect".

4.1.5 Nargiza talked for the first time about Marat's behaviour during her return to her country of origin in late 2016. Bekzod explained this as follows:

"The first thing is that she loved her children. Because of her children she would swallow everything. She would also think of my and her mother's position... She thought about the impact on her parents if she got divorced and what people would say. She thought it would be shameful for her parents for her to divorce and come back to them.

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She thought she would be happy in the future. I still wonder how she kept all these problems to herself".

4.1.6 Describing Marat's behaviour in the second part of 2016, Bekzod talked of: Marat's announcement of a divorce; disputes over the care of the children in her country of origin; as well as Marat later threatening Nargiza with the mortgage on the home and also taking money from her bank account. Bekzod summarized this as:

"Marat ignored her and said he would cause problems. Nargiza went back to London in November and Marat emotionally blackmailed her".

4.1.7 During the interview with Bekzod and Dilnura, there was a discussion about 'Mahalla's', a local body that comes together to manage civil issues. As Marat had said he would divorce Nargiza, the family had gone to the Mahalla. Both Bekzod and Dilnura described this process as fair to both sides of a dispute:

"They organise the meeting and ask all of the adults from both sides to come to see who is involved. The chairman then makes a conclusion."

4.1.8 Although the Mahalla did not lead to any outcome – Marat maintained he was going to divorce Nargiza regardless – Bekzod talked about how Marat's behaviour later changed, describing how in the following months: *"Marat came back begging as he had no wife and his family didn't have the children anymore".*

4.1.9 Dilnura also talked about this change in behaviour, explaining that "*my sister started hoping for a better life as Marat was promising and begging forgiveness".*

4.1.10 Bekzod also felt that Nargiza had wanted to return to the UK because "*she had done a lot there*", including both buying a home, getting a job and her

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wish to bring all three children to the UK to live with her and to be educated.

Friends and Other Informal Networks

4.1.11 Dilnoza first met Nargiza in 2013, when they both worked in GSTT[17]. Dilnoza said that Nargiza had talked to her about the abuse she experienced from Marat. She described the following:

- Not letting Nargiza pray at home
- Beating Nargiza when he was drunk
- Forcing Nargiza to have sex with him, and later making her sleep on the floor
- An occasion (during a pregnancy) when Marat would not take Nargiza to the hospital and would not let her have access to food.

4.1.12 Dilnoza also recalled an incident sometime in 2014 when Nargiza had left a number of voicemails in a state of panic and asking her to come to work. Dilnoza had not initially recognized the number. She said that Nargiza later told her that this was a phone that she kept secretly at work, so she could call her family, as Marat would not let her do so. (this is likely to be the phone that REACH also used to speak to Nargiza, see 3.1.26).

4.1.13 Dilnoza said that she could see that Nargiza had bruises on her arm and Nargiza also told her she also had bruises on her chest. Nargiza told Dilnoza she had been beaten by Marat and locked out of their shared flat, meaning she had to sleep outside overnight.

4.1.14 In response to this incident, Dilnoza encouraged Nargiza to speak with her supervisors (this appears to have been the trigger for Nargiza's disclosure to her manager on the 13th June 2014, see 3.1.14)

4.1.15 Dilnoza also spent time with Nargiza following this incident, and described how Nargiza tried to ask for her clothing / property but Marat replied that he

[17] The MPS took a witness statement from Dilnoza as part of the murder investigation, so this information was not known to the MPS before Nargiza's death.

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did not want to talk to her (it is not clear from the witness statement provided to the MPS whether Nargiza had described this to Dilnoza, or whether Dilnoza was in fact present) and then later refused to let her collect her property when she went to their home (this appears to refer to the 16th June 2014 when Police Officers met Nargiza and attended the address to prevent a Breach of the Peace).

4.1.16 Of note, Dilnoza also said that Nargiza had been concerned about her immigration status – Nargiza told her that Marat had called her mother and said that she would be deported.

4.1.17 Nargiza subsequently returned to Marat (likely to be around the time she called the MPS to say she had done so on the 20th June 2014, see 3.1.34). Nargiza explained she had done so because Marat had apologized and said he would not beat her again.

4.1.18 In October or November 2016, Dilnoza spoke with another friend (Babysitter), who had called her for advice after speaking with Nargiza. Nargiza had told her that Marat's family had her money and her children's passports and "*she didn't know what to do or where to go*".

4.1.19 Another colleague and friend, Feruza, also worked with Nargiza at GSTT[18].

4.1.20 Feruza was originally introduced to Nargiza because they were both from the same Central Asian Republic. Feruza had limited contact with Nargiza in 2014 and 2015 but met again in June 2016 when Nargiza was in the hospital discussing her return from maternity leave. Feruza spoke with Nargiza at work towards the end of October (it is likely that this was after the 4th November, when Nargiza returned to the UK, see 3.1.99).

4.1.21 This was the first time Nargiza talked about issues with her husband, talking about Marat's threat to get a divorce and also how Marat told her that "*he was going to cancel her visa, so she couldn't get back to the UK*" and that Marat had also taken all the money from her bank account.

[18] The MPS took a witness statement from Feruza as part of the murder investigation, so this information was not known to the MPS before Nargiza's death.

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4.1.22 In her statement Feruza also told the MPS that Nargiza had talked about Marat's behaviour and he:

- Had access to Nargiza's bank accounts and would control her money
- Had access to Nargiza's emails and did not like it if she talked to her relatives too much and that he would always listen to her conversations (there is a further reference in Feruza's statement to the hidden phone that is noted above)
- Did not allow Nargiza access to a smart phone as he did not want her to have access to social media
- Would lock Nargiza out of their room
- Would hit Nargiza "*lightly*" on the head and once or twice had put a pillow over her head and punched her through it
- Did not like Nargiza speaking to other people from their country of origin and did not like her to socialize.

4.1.23 Feruza also told the MPS when giving her statement that on one occasion when she was due to meet Nargiza, this was cancelled because "*her husband wouldn't let her out*", and during other meetings Nargiza would be receiving texts from Marat.

4.1.24 During this period, Feruza talked to Nargiza's about her previous contact with the MPS. Nargiza told her that the police *"didn't help … because she hadn't had any bruises"* and that when she had tried to collect property from their home "*her husband showed the police the rental agreement which was in his name only so they told Nargiza they couldn't do anything to help*" (this is assumed to be a reference to contact in July and July 2014, after Nargiza's report to the MPS, see 3.1.22 above).

4.1.25 During meetings with Nargiza in November, Feruza was also told about how Marat's behaviour changed so he began "*begging*" Nargiza to come back, but that Nargiza also told her that he "*kept coming to the hospital to wait … when she finished work*". As this was the period when Nargiza was living with a friend, Feruza said that Nargiza "*ended up spending the whole night in his car with him talking as she didn't want him to know where she*

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was living and she was afraid he would follow her home". Nargiza also told Feruza that Marat's family was calling her to try and persuade her to return to Marat.

4.1.26 Nargiza spoke with Feruza when she made the decision to return to Marat. Feruza said that Nargiza returned to Marat because he had agreed to everything Nargiza had asked, including that Child C could come back to the UK and that she could have access to her money and phone. However, it appears Nargiza was still concerned about Marat. Feruza told the MPS that she asked about welfare benefits for children and did not want Marat to know about these payments as he would take them for himself.

4.1.27 Nargiza also confided in Gulsara[19] – her manager at GSTT who facilitated a referral to REACH (see 3.1.14) – disclosing that Marat had beaten her, kicked her out of the house and controlled her finances. Marat also told Gulsara that Marat listened in on her phone calls and she had to hide a phone so that she could contact her parents. Gulsara felt that "*Marat completely controlled her* [Nargiza]".

4.1.28 Gulsara also described how she was suspicious of a number of texts and emails that she received from Nargiza during the time she knew her. These often related to periods of sickness or leave, and she felt that they "…*didn't sound like Nargiza"*. Gulsara sought to reach out to Nargiza after these contacts, although she also reported that on at least two occasions Marat responded telling her not to do so any more.

4.2 Summary of Information from Perpetrator:

4.2.1 Given Marat's death, the Review Panel was unable to interview him, which limited the extent to which it was possible to understand his background, experiences and choices. As a result, most of the information about Marat is drawn from the MPS as part of its enquires, and professional contact

[19] The MPS took a witness statement from Gulsara as part of the murder investigation, so this information was not known to the MPS before Nargiza's death.

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with Marat which was largely after his arrest and during the period he was on remand.

4.2.2 As noted in 1.10 above, contact was attempted with Marat's family, but this was not successful in securing their involvement with the review.

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 A range of agencies had contact with Nargiza. Broadly this contact was related to the following themes:

- Health
- Immigration
- Employment
- Domestic violence and abuse.

Health

4.3.2 Nargiza had extensive contact with health services, principally her GP at The Medical Centre and Health Visiting Services, with some contact with hospital staff. In most cases this contact was related to her own or Child C's health and can broadly be described as consisting of routine consultations, or responses to specific health needs.

4.3.3 However, there are some points of contact where issues have been identified in relation to practice: there were weaknesses in the assessment of the family's circumstances, in particular at a New Birth Assessment and when Nargiza disclosed a head injury to her GP, and when she sought help from Health Visiting Services about a missing door.

Immigration

4.3.4 Both Marat and Nargiza's immigration status was subject to change, with Nargiza having to repeatedly apply for extensions for her LTR. Immigration status appears relevant to Nargiza's experience of domestic violence, for both herself, but also her children. Her options in relation to help and support were potentially limited as Nargiza had NRPF.

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Employment

4.3.5 Nargiza was employed by GSTT and based on accounts from her family, her job was important to her. Critically, it also enabled Nargiza to access support from REACH during 2014.

Domestic violence and abuse

4.3.6 June 2014 appears to have been a significant period in Nargiza's life, marking the first occasion when a disclosure is recorded as having been made to any services. It is also the period when Nargiza attempted to separate from Marat.

4.3.7 In this period three agencies had contact with Nargiza in relation to the domestic violence and abuse.

- GSTT was aware of Nargiza's experiences, first in its role as her employer and then through the support offered by REACH, a domestic abuse service based in the A&E department of St Thomas Hospital. This appears to have been the first time that Nargiza both disclosed and then substantively engaged with a service in relation to her experience of domestic violence and abuse, with REACH undertaking both an assessment and having a range of contact during June and July 2014
- The MPS also had extensive contact with Nargiza, although this was episodic. The first occasion was in June 2014 when Nargiza attended a Police Station to report domestic violence and abuse. During this and subsequent contact, she talked about her experiences. Nargiza's first report to the MPS was on the same day that she first approach GSTT
- The MPS also had further contact with Nargiza, in relation several attempts to collect belongings in June 2014. These do not appear to be have been resolved
- Nargiza had further contact with another domestic abuse service, speaking with the Refuge IDVA Service in Lewisham. However, this contact, which was triggered by the referral to the July 2014 MARAC in Lewisham, was limited to one phone call in which she declined support.

4.3.8 However, by the end of June 2014 Nargiza was reporting to the MPS and REACH that she would be returning to live with Marat. Nargiza later

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reiterated this to the Refuge IDVA service during their limited contact with her.

4.3.9 There was a MARAC meeting on the 23rd July 2014. The MARAC was not aware of the information known to REACH and only one action – for all agencies 'to flag and tag' – was agreed.

4.3.10 In contrast, the contact with Marat was more limited, although these contacts are related to:

- Health
- Domestic violence and abuse.

4.3.11 Marat had only one recorded contact with health services in his own right, attending for a consultation with his GP. However, it is of note that Marat was present in at least one of Nargiza's contacts with health services and it is not clear from the record of consultations / appointments held by health services whether he was present in other sessions. The LAS also had contact with Marat in 2016.

4.3.12 The MPS also had contact with Marat in relation to Nargiza's report, including interviewing him as part of their enquiries although he was not subsequently charged. The MPS also had contact with Marat following Nargiza's attempts to retrieve belongs in 2014 as well as other contact when Marat was in a state of distress in 2016.

4.4 Any other Relevant Facts or Information:

4.4.1 The Prisons and Probation Ombudsman Investigation Report described how Marat received a Mental Health Act assessment on the 19th December 2016. This assessment concluded that Marat did not have a mental illness and that he was not depressed, although that during his time on remand staff reported that he was at times confused, disorientated and experiencing high levels of anxiety.

4.4.2 The report also noted that Marat communicated with staff in English and declined an interpreter.

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4.4.3 The Board Level Inquiry by The Oxeas NHS Foundation Trust included background information on Marat's financial circumstances in 2016, which was not otherwise known to the Review Panel. It is noted that Nargiza and his family experienced a number of problems with their accommodation resulting in them living in inadequate conditions until June 2016, when a mortgage was secured on a flat.

4.4.4 The report also noted that, at some time after August 2016, Marat lost his job.

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5. Analysis

5.1 Domestic Abuse/Violence:

5.1.1 Marat died by suicide after being charged and remanded to prison, but before a criminal trial could conclude. Therefore, the allegations against Marat have not been proven in a Criminal Court, although the Review Panel noted the Finding of Fact in the Family Court. As a result, in light of the government definition of domestic violence and abuse, and considering the information gathered by the MPS murder enquiry, shared by agencies in their IMRs (in particular the MPS and REACH), as well as provided by family and friends, the Review Panel concluded that Nargiza was a victim of domestic violence and abuse from Marat.

5.1.2 Tragically, Nargiza's death means that it will never be possible to know the full extent of her experiences. However, drawing together the information available, it is likely Nargiza was subjected by Marat to:

- *Physical abuse*: such as being beaten and hit
- *Coercion, threats and intimidation*: Nargiza herself talked about her experiences, which agencies like REACH and the MPS (as part of a MARAC referral) recognized as coercive and controlling. More broadly, Marat used Nargiza's immigration status (this is discussed further below as an example of 'abuse of process'). He also harassed and stalked Marat (both Nargiza's father and one of her friends talked about how Marat waited for Nargiza outside her workplace during their separation and how Nargiza stayed with him all night because she feared being followed to her address)
- *Emotional abuse and isolation*: Nargiza told friends/colleagues that her contact with both her family abroad and friends in the UK was monitored, and that she was prevented from praying or from leaving their shared home. The reports of Nargiza's hidden mobile phone, used to speak to family and at work, also indicates the lengths she had to go to avoid Marat's monitoring of her contact with other people. What information is available also suggests that Marat may have used Nargiza's faith: one friend (Dilnoza) told the MPS that Nargiza said that

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Marat would not let her pray at home, while Marat is reported to have told Bekzod that his daughter had *"fallen into Islamic Extremist Groups"* (presumably to discredit her, although there is no evidence to suggest that this was the case)

- *Sexual violence*: Nargiza told REACH she experienced sexual abuse from Marat, also describing to a friend how she was forced to have sex with Marat (raped)
- *Use of children*: by all accounts Nargiza was a dedicated and loving mother and wanted to be re-united with Child A and Child B. However, there are examples of how Marat used this to control Nargiza, particularly with reference to immigration and threats. These are discussed below.

5.1.3 Different forms of violence and abuse usually operate together, or in parallel, and can be used by a perpetrator to create a web of violence and abuse. Such behaviours are underpinned by coercive control, which restricts a victim's autonomy and space for action, because coercive control "*play[s] off the restrictions on autonomy, marriage choices, education, career options and comportment at home or in public that continue to characterize communities".*[20]

5.1.4 With this in mind, it is important to consider Nargiza's experience of domestic violence and abuse as described above, and how this might have been compounded by her personal circumstances and different identities (for example, her sex, race and nationality).

5.1.5 Several reports published by Imkaan[21] provide a way to frame this using an intersectional approach, which considers *"… the different ways that violence is perpetrated and experienced, with recognition that BME girls and women's experience of gender inequality inevitably intersect with 'race'*

[20] Evan, S (2008) *Coercive Control: How Men Entrap Women in Personal Life*, Oxford: OUP. p238

[21] Imkaan is a London based Black and 'minority ethnic' women's organisation. We are the only UK based, national second tier women's organisation dedicated to addressing violence against Black and 'minority ethnic' (BME) women and girls. For more information go to http://imkaan.org.uk

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inequality and may also intersect with other sites of oppression which include class, sexuality, age, disability, caste, belief and religion"[22]*.*

5.1.6 With this in mind, the Review Panel used an intersectional perspective to consider how Nargiza's personal circumstances and different identities may have affected her experiences, the needs and the risks she faced, as well as service responses. The latter are considered further in section 5.2, while the following analysis relates to: *economic and financial abuse; immigration status; children and family;* and *the beliefs and attitudes of Marat*.

Economic and financial abuse[23]

5.1.7 The cross-government definition of domestic violence refers to 'financial abuse'. Although there is no nationally agreed definition of economic and financial abuse, these can be defined as:

- *Economic abuse*: involves tactics used by abusers to affect a women's economic self-sufficiency (e.g. the use of accommodation or property, access to education or training, or sabotage to work efforts)[24]
- *Financial abuse:* involves tactics like making all the financial decisions, reducing a woman's ability to acquire, use, and maintain money, and/or forcing her to rely on him for all of her financial needs. Financial abuse can include financial control (e.g. demanding to know how money is spent), financial exploitation (e.g. spends money needed for household bills, build up debt under partner's name), and financial sabotage (e.g. does things to stop a partner from going to working / college)[25].

5.1.8 Nargiza experienced economic abuse, when she was ejected / locked out of her accommodation (i.e. denied access to accommodation), as well when Marat's successfully attempt to thwart her retrieval of property.

5.1.9 Nargiza also experienced financial abuse, with Nargiza telling family and friends that Marat had control of her money. Marat was also able to use

22 Larasi, M. with Jones, D. (2017) *Tallawah: a briefing paper on black and 'minority ethnic' women and girls organising to end violence against us.*, London: Imkaan

23 With thanks to Surviving Economic Abuse (SEA) for advice in relation to economic and financial abuse.

24 Judy L. Postmus, Sara-Beth Plummer, Sarah McMahon, N. Shaanta Murshid, Mi Sung Kim (2012) 'Understanding Economic Abuse in the Lives of Survivors', *Journal of Interpersonal Violence,* 27(3), pp. 411 - 430.

25 Adams, A., Sullivan., C., Bybee. D and Greeson, M. (2008) 'Development of the Scale of Economic Abuse', *Violence Against Women,* 14(5), pp. 563-588.

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financial abuse when he was not in physical proximity and during periods of separation: when Nargiza returned to her country of origin in late 2016, she said that Marat emptied her bank account and had made threats about debt relating to their home's mortgage.

5.1.10 Taken together, this economic and financial abuse could be used by Marat to exercise control. For example, they would have affected Nargiza's options and her financial autonomy and may have made her feel that she had to return to the UK in late 2016. This would have been exacerbated by her immigration status and NRPF, which is discussed below.

5.1.11 It is worth noting that both economic and financial abuse can be very hard to detect – in Nargiza's case no one appears to have known about this until she made a disclosure to REACH in 2014, and later to a friend and her father. The difficulty in identifying economic or financial abuse is an important reminder of the potential role of organizations that have not traditionally taken a role in the coordinated community response E.g. banks and building societies.

The absence of a nationally agreed definition of economic and financial abuse is problematic, as it means that professionals (and other institutions such as banks and building societies) may not be able to name, identify and respond to these types of abuse. The Review Panel therefore made the following recommendation:

Recommendation 1: The UK Government to review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate economic and financial abuse

Immigration status[26]

5.1.12 Initially Nargiza's status was as a dependant of Marat (who was on a student visa), but after 2014 she had LTR as the spouse of a settled person. This was granted for a period of 30 months and would have ended

[26] With thanks to Imkaan for advice in relation to intersectionality and specialist BME led provision. http://www.imkaan.org.uk

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in early 2017 when she would have had to apply for a renewal for a further 30 months before making an application for Indefinite LTR. During this time, she had NRPF.

5.1.13 Marat was able to use Nargiza's immigration status as a means of control, using it as both a threat (relating to his continued support of Nargiza, as she was his dependent), but also as an 'incentive' (by saying he would bring the children to the UK).

5.1.14 Marat's ability to use of her immigration status would have been increased because Nargiza had NRPF. Nargiza had to make repeated applications to the Home Office, naming Marat. Marat would have been aware of this and could have used these applications as a regular reminder of his power over her. Additionally, Nargiza immigration status severely restricted her options to access help and support. For example, if she had wanted to find a place of safety, it is likely that Nargiza would not have been able to access refuge as she had NRPF. This is certainly something she was concerned about, telling REACH that she would not have access to money if she left Marat. (While REACH (through GSTT) is to be commended for its willingness to offer short term accommodation to Nargiza, this would not have been a long-term solution).

Children and family

5.1.15 Nargiza had strong links to her country of origin, where both her family (and that of Marat) lived. Her two oldest children lived there, residing at different times with paternal and maternal family, and she also spent time in the country shortly before her homicide.

5.1.16 As with her experience of economic and financial abuse, and immigration status, Marat was able to use children to limit Nargiza's autonomy, and to maintain power and exercise control. As noted above, Marat used the promise of bringing their children to the UK, but Nargiza was also concerned about direct risk to her children. When she spoke to REACH in 2014 she told them she was worried that Marat would phone his brother and order him to hide or harm them.

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5.1.17 Nargiza did not talk to her family about her experiences until late in 2016. It is not possible to know why she did not do so, but it is reasonable to assume this may have been influenced by her concerns or fears about attitudes around gender roles, relationships and domestic violence. For example, Nargizas father, Bekzod, suggested a sense of shame may have been the reason why Nargiza felt unable to talk about her experiences.

5.1.18 Conversely, the manner by which Marat was able to unilaterally initiate a divorce, and the subsequent convening of a meeting of the local body known as a 'mahalla', is indicative of his relative power, and Nargiza's lack of status compared to Marat.

5.1.19 The 2015 report on by the United Nation's Committee on the Elimination of Discrimination against Women (CEDAW) about Nargiza's country of origin noted the:

> *"… persistence of deep-rooted patriarchal attitudes and stereotypes concerning the roles and responsibilities of women and men in the family and in society, which discriminate against women and perpetuate their subordination within the family and society and which, among other things, are reflected in women's educational and professional choices, their limited participation in political and public life, their unequal participation in the labour market and their unequal status in marriage and family relations. The Committee recalls that such stereotypes are also root causes of violence against women…"*[27].

5.1.20 The same report noted the prevalence of domestic violence, expressing concern that this is considered a 'private matter' and that cases are taken mainly to local bodies known as 'the mahalla' for reconciliation. This is echoed in a report from the Uzbek Bureau on Human Rights and Rule of Law – a Uzbek NGO – which notes that domestic violence is common, and is often described as:

[27] Committee on the Elimination of Discrimination against Women (2015) *Concluding observations on the fifth periodic report of Uzbekistan*, Geneva: United Nations. p4.

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> *"family conflict, meaning it is "perceived by people as something private, normal and natural like the notion of family itself. This combination blears the extent of domestic violence in Uzbek society, perpetrators are assured it is normal, while victims see no way out of it".*[28]

5.1.21 These reports provide a useful context which can be used to consider how customs and beliefs may have affected Nargiza's view of her options, which her father suggested may have been a reason she did not talk about her experiences. However, this approach has limitations. Most immediately, it is not possible to speak with Nargiza to discover how she understood her situation. There is also risk that such an analysis inappropriately explains away Nargiza's lived experienced (and Marat's actions, up to and including the homicide), locating both in a particular culture, community and country. Instead the cultural context needs to be considered as one element that may have informed Nargiza's view of the violence and abuse she experienced, or the help and support she could access. Given that sex is a risk factor in domestic violence (see 1.4.6), it is important to note that while the specific customs and beliefs of Nargiza country of origin may be relevant to this case, they are just one example of how women's inequality operates within and across borders.

Beliefs and attitudes of Marat

5.1.22 As Marat is dead and has not been interviewed as part of this review, it is not possible to explore his beliefs and attitudes.

5.1.23 As discussed above in relation to Nargiza, it is also useful to consider how Marat's background, including customs and beliefs, may have influenced his behaviour. Indeed, it is important to recognise that these may have enabled him, particularly given the ease by which could initiate a divorce.

5.1.24 However, Marat is responsible for his own behaviour. But this will have been underpinned by attitudes towards Nargiza, which seem likely to have

[28] Uzbek Bureau for Human Rights and Rule of Law (2015) *Uzbekistan's Implementation of the CEDAW*, Tashkent: Uzbek Bureau for Human Rights and Rule of Law. p7.

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been negative. When interviewed by the MPS in June 2014 (when he was asked to account for an alleged assault which he denied) he described Nargiza "*moaning*" at him. Although it is not possible to know what Marat's intent was when he used this word, professionals who work with perpetrators of domestic violence and abuse would be alert to this as an example of how language could be used to minimize a victim's point of view, or to blame them for an incident. Other examples of attitudes would include Marat's reported control of money, control in terms of contact with others, as well as reported examples of a sense of entitlement around sex.

5.1.25 There are two further features of Marat's behaviour which give an indication of his sense of entitlement, and willingness to use a range of mechanisms to exact violence and abuse to maintain power and exercise control over Nargiza.

5.1.26 Firstly, it is striking how – in several different accounts given by Nargiza about Marat – he was described as "*supportive*". This description was recorded by different professionals, in particular, health professionals. This served to paint a picture which would, without knowledge to the contrary, suggest that domestic violence and abuse were not an issue. It is not possible to know whether Marat directly or indirectly made Nargiza feel she had to describe him in this way, but it is not uncommon for victim/survivors to try and manage their own safety when engaging with professionals by presenting an acceptable 'public face' to a relationship. There is an example of the length to which Marat was willing to go to protect this positive description of him – when he found a letter prepared for Nargiza he contacted REACH directly about this, while Nargiza herself later contacted the service asking them to change the content of the letter. It is reasonable to assume that such a request would almost certainly have been made under direction from, or in fear of the reaction by, Marat.

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5.1.27 Secondly, Marat demonstrated a capacity to abuse using 'abuse of process'. The cross-government definition of domestic violence does not refer to abuse of process and there is no nationally agreed definition. However, there is an emerging understanding of this type of abuse, which involves the use of different platforms to continue unwanted contact, undermine someone's credibility, exercise control or to demonstrate an abuser's own power. The most common examples include the use of the Civil and Family Court, but also allegations to the police[29]. In this case, Marat called the MPS on at least one occasion to allege Nargiza was missing, while he also successfully thwarted an attempt to retrieve property. Marat also used his knowledge of the immigration system, and Nargiza's dependence on him, to give meaning to his coercion, threats and intimidation and use of children as noted above. Based on the account of Nargiza's manager, Gulsara, it also seems likely that Marat was impersonating Nargiza in her communication around her work.

The absence of a nationally agreed definition of abuse of process is problematic, as it means that professionals (and other institutions such as banks and building societies) may be less able to name, identify and respond to perpetrator's use of different platforms to abuse. The Review Panel therefore made the following recommendation:

Recommendation 2: The UK Government should review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate abuse of process

5.1.28 Despite Marat's actions, Nargiza sought to create space for action, by finding ways to maintain her contact with family and friends. She also sought help in June 2014, although that attempt was ultimately not successful. These actions speak to her resilience in the face of Marat's violence and abuse. Her actions in the second half of 2016 also show how

[29] Waxman, C. and Fletcher, F. (2016) *Abuse of Process* http://www.voice4victims.co.uk/wp-content/uploads/2016/11/Abuse-of-Process-28th-November-report-FINAL-1.-pdf.pdf

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Nargiza's priority throughout this period of her life was her children, both in her care toward Child C and the decisions she took in relation Child A and Child B, including her ongoing hope to re-unite with them and bring them to the UK.

5.2 Analysis of Agency Involvement:

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference.

Analyse the communication, procedures and discussions, which took place within and between agencies.

5.2.2 There are examples of clear communication within and across the agencies involved in this case.

5.2.3 This includes within GSTT, when REACH responded pro-actively to Nargiza following her disclosure in June 2014 to her line manager, which meant she was referred to a specialist service on the same day.

5.2.4 Similarly, The Medical Centre had regular contact with Nargiza (and Child C) in 2015 and 2016 and responded promptly to a range of routine health care needs. There was also liaison with the LGT Health Visiting, as well as follow up after Child C had been discharged from home after two short admissions to hospital.

5.2.5 The MPS showed an awareness of communication between agencies, and local procedures in relation to domestic violence and abuse, with a Police Officer pro-actively making both a referral to the Lewisham MARAC (which is discussed further below) and notifying the local specialist domestic abuse service (the Refuge IDVA service) in June 2014.

5.2.6 However, there are occasions when intra or inter agency communication was incomplete, specifically when two specialist domestic abuse services failed to provide an update to a referring agency when their contact / engagement with Nargiza came to an end.

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5.2.7 The first example relates to intra agency communication within GSTT. Initially there appears to have been good two-way communication between Nargiza's manager and REACH, with a referral made on the day following Nargiza's disclosure of domestic violence and abuse. There was also clear communication back to her manager about what to do if she did not come into work. However, when Nargiza disengaged in 2014, REACH did not notify her manager, appearing to take at face value her statement that she had resigned (when in fact she remained in employment until the homicide).

5.2.8 There is no recommendation within the REACH IMR in relation to this. This was discussed by the Review Panel, which recognised that REACH's involvement combined the functions of both a specialist domestic abuse service *and* the responsibilities of an employer. This presents a number of challenges. For example, while it would not be appropriate for REACH to routinely share information about a member of staff without their consent, in this case it would clearly have been helpful for GSTT to have been aware that Nargiza was no longer engaged with REACH but was still at risk.

5.2.9 The Review Panel agreed that it would have been good practice for REACH to have discussed with Nargiza how she wanted the service to interact with her manager. This could have been completed at the point that Nargiza first contacted the service and reviewed subsequently. As part of any policy or procedure underpinning this, the Review Panel agreed that there should also be explicit consideration as to how and when an update could be shared without consent if a member of staff disengaged from REACH and where they (or others) were judged to be at risk.

5.2.10 The second example relates to inter agency communication between the Refuge IDVA service and MPS. In this example, Refuge did not tell the MPS that Nargiza had declined support. Current policy and good practice within Refuge is to contact the referrer if a victim cannot not be contacted, but this is not the case where someone is contacted but declines support. While this information was subsequently shared at the MARAC, it would

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have been best practice to inform the MPS that Nargiza had declined support as soon as possible. This has been recognized in Refuge's IMR, which recommended that full case information should be shared throughout the whole referral process even where the service has been declined by the victim.

Although it is not possible to know what the outcome of an update following case closure on these two occasions might have been, this serves as an important reminder for specialist domestic abuse services to ensure that they routinely provide an update when they close a case and know that another agency is involved. In relation to this issue, the Refuge IMR included a recommendation so the Review Panel only made a recommendation for GSTT:

Recommendation 3: GSTT to ensure that there is a clear policy and procedure in place to manage communication between REACH, members of staff who access the service and their managers. This should strike a balance between confidentiality and consent with the ability of REACH to seek information from or liaise with managers in high risk cases

Analyse the co-operation between different agencies involved with Nargiza and / or Marat [and wider family].

5.2.11 A referral to the Lewisham MARAC was made by the MPS – this was on the basis of professional judgement. The OIC's rationale for this decision was that this was Nargiza's first disclosure, her level of fear and experience of control and because she wanted to secure housing and emotional support. This was an example of good practice which triggered a multi-agency response.

5.2.12 Sadly, that multi-agency response had little impact and, in relation to this, the Review Panel identified three issues in relation to Lewisham MARAC:

- The quality of the minutes;
- The absence of information from REACH, and;
- The actions arising from the case discussion.

5.2.13 The quality of the Lewisham MARAC minutes at the time appears to have been poor, with the record providing scant evidence as to what information

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was discussed. It is not possible to identify whether the MARAC was aware of, or considered, the information provided by the OIC in their referral (that this was Nargiza's first disclosure, that the perpetrator was controlling and that her priorities were housing and emotional support), or by the Refuge IDVA service (that Nargiza had reconciled with Marat).

5.2.14 The Review Panel discussed this issue and agreed that recording practices at the Lewisham MARAC at time were not sufficiently robust.

5.2.15 The issues in this case are similar to the findings of a MARAC case audit that was completed in Lewisham in October 2016. This looked at a sample of MARAC cases and was completed by the VAWG Programme Manager. The report summarised the key issues arising as:

- "*Risks were not always identified, and when so, not properly recorded, and ultimately addressed in the action plan;*
- *In some cases, information was brought to the meeting, but not always shared verbally at the meeting. Some partners shared information after the meeting, which is not appropriate;*
- *The recording of minutes and actions needed to be revamped so that the information was simpler, clearer and easier to access, for MARAC partners*".

5.2.16 In response to these findings, there have been a number of changes to the Lewisham MARAC arrangement including: revising the referral form, introducing a new document to capture MARAC minutes / actions, as well as working with MARAC leads and the chairs to embed best practice.

5.2.17 The Review Panel therefore agreed that, as action has been taken to address the substantive issues identified in this case, that no additional recommendation(s) were necessary for the Lewisham MARAC.

5.2.18 The Review Panel felt it appropriate to consider how wider lessons could be learnt from this case and consequently also discussed practice at the Bexley MARAC.

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5.2.19 A review was recently completed by SafeLives[30], who observed a Bexley MARAC meeting on 20th December 2016. Their report identified a number of strengths locally, but also areas for development in relation to information sharing and action planning, and included a MARAC Development Plan with the following actions being proposed:

- "*Review and address barriers to identification and referral of high risk victims; including repeat cases.*
- *Ensure a clear referral pathway exists for victims and promote a single point of contact for victims ensuring services are not duplicated.*
- *Local groups that support people from diverse communities are trained to identify domestic abuse and high risk and are encouraged to engage in the MARAC*
- *The MARAC records outcomes… [and] monitors the effectiveness of the MARAC in identifying and safeguarding vulnerable adults and children at risk.*
- *Criteria / reason for referral and confirmation of consent is stated at the case presentation.*
- *Risks are explicitly identified on the research forms with information on last known sightings etc. and recorded in the minutes and the Chair encourages actions to address and reduce the risks*
- *Agency representatives' actions are specific and relevant to the risks identified at the meeting*
- *The MARAC routinely addresses the behaviour of the perpetrator in the action plan*".

5.2.20 These recommendations have been developed into an action plan, which is being overseen by the Bexley MARAC steering group. It was therefore agreed that that no additional recommendation(s) were necessary.

[30] SafeLives is a national domestic abuse charity and a key area of its activity includes guidance, tools and resources on how to run an effective MARAC. More information is available at http://safelives.org.uk

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However, the Review Panel noted that when progress against the action plan is reviewed it should include specific consideration to the learning from this case.

5.2.21 The most striking feature of this multi-agency activity is the absence of information from REACH while, in contrast, the Lewisham MARAC had an incomplete picture of the extent of the risk to Nargiza and her vulnerability.

5.2.22 As set out in the REACH IMR, the service had considered whether to make a MARAC referral. However, in practice there was a two-week delay. The rationale given was that the staff member was waiting for another appointment with Nargiza. This was because the risk level was judged to be just below the threshold to MARAC and, while it had been recognised that a referral could have been made on professional judgement, further information was being sought. Additionally, during this time, the REACH IMR indicates that the staff member was seeking to confirm the referral route to the Lewisham MARAC. However, despite further contact with Nargiza subsequently, no referral was made.

5.2.23 Considering first the decision not to refer immediately on professional judgement: given what Nargiza had disclosed, and then the subsequent contact with Nargiza (where she first indicated she was returning to Marat and then later that she and Marat were getting a divorce and she was returning to her country of origin), REACH should have made a referral to the Lewisham MARAC. That they did not do so was an omission. While the initial delay may have been appropriate in order to maintain a relationship and gather more information, a referral should have been made (without consent if necessary) after Nargiza disengaged from the service. Nargiza's report of her departure from both work and the country was not sufficient reason to discharge a duty to in these circumstances. This practice issue is not addressed fully in the REACH IMR.

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Ensuring that high risk cases are identified and referred to the MARAC process in a timely manner is a key part of local procedures to manage risk. While cases are often referred on the basis of visible high risk (the number of ticks on the DASH RIC) or escalation, professional judgement referrals provide an important safety net. Professional judgement should in particular be used in cases where a victim has disengaged. The Review Panel therefore made the following recommendation:

Recommendation 4: GSTT to conduct a review of decision making in relation to referral to MARAC within REACH, with particular reference to time frames, the use of professional judgement and how cases are managed when a victim disengages from the service

5.2.24 Regardless of if and when a referral should have been made, if REACH had been signed up to the Lewisham MARAC - and therefore in receipt of the agenda - the service would have identified that Nargiza had been referred and would have been able to share its extensive information. The Review Panel agreed that it was likely that this information would have changed the case discussion at the Lewisham MARAC, which may have meant the actions agreed would have been different.

5.2.25 Given that GSTT provides a range of services to the residents of Lambeth, Southwark *and* Lewisham, the fact that that REACH is not signed up to a Lewisham MARAC is a major gap in operational practice. There is no recommendation within the REACH IMR in relation to this.

Organisations that cross local authority boundaries may need to be linked to multiple MARACs. It is vital that they identify these MARACs and have robust pathways in place. The Review Panel therefore made the following recommendations:

***Recommendation 5: GSTT to review pathways to MARACs in London. In doing this, GSTT should prioritize pathways with those areas with the greatest number of patients. As a minimum this should include* Lambeth, Southwark *and* Lewisham.**

5.2.26 During its discussions, the Review Panel identified that LAS is not routinely made aware of the cases discussed at MARACs, including at both the

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Lewisham and Bexley MARACs. While this would not have made a difference in this case (Nargiza was discussed at the Lewisham MARAC in 2014 and the LAS had contact with Marat in 2016) this contact does illustrate the potential for LAS to have information that might be relevant to a MARAC discussion. This is a Pan London issue: at the time of writing this report, LAS reported that it only receives requests for information from six boroughs (Greenwich, Newham, the Tri-Borough (which is made up of Hammersmith & Fulham, Kensington & Chelsea and Westminster), with Lewisham beginning to make requests during the course of the review.

It would be best practice to have a pathway from the LAS to local MARACs in order to share information in high risk cases. This would require LAS to ensure it has a clear process for signing up to local MARACs, including the relevant operating and information sharing protocols, as well as the resources to manage any requests.

Recommendation 6: LAS to review how it can sign up to, and participate in, MARACs and disseminate guidance to MARACs in London

5.2.27 As there were two agencies that were not linked into the Lewisham MARAC, the Review Panel considered whether there should be a recommendation in relation to multi-agency engagement in the MARAC process. Nationally there is clear guidance about this issue within*'10 Principles of an effective MARAC'*[31] published by Safelives. Therefore, no further recommendation is made. However, this DHR serves as salutary reminder that local MARACs should have robust governance arrangements which are able to ensure that membership, attendance and engagement are regularly reviewed.

5.2.28 However, another element in facilitating multi-agency engagement with the MARAC process is ensuring that information is easily available. The REACH IMR identified that a staff member was seeking to confirm the

[31] SafeLives (2017) *10 principles of an effective Marac,* Available at: *http://www.safelives.org.uk/node/361* (Accessed: 29th October 2017).

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referral route to the Lewisham MARAC. With this in mind, the chair looked at the information available online about the Lewisham and Bexley MARACs:

- Lewisham MARAC – A dedicated webpage, which clearly identifies how to contact the MARAC. The local area also promotes MARAC briefing sessions. However, it is not possible to access any practice guidance, referral forms or best templates such as research forms etc[32]
- Bexley MARAC – There is no dedicated webpage.

Information on the local MARAC process should be accessible in order to facilitate multi-agency engagement. The Review Panel therefore made the following recommendations:

Recommendation 7: The Lewisham MARAC should further develop its online profile, to ensure that information and guidance on the MARAC process is as accessible as possible

Recommendation 8: The Bexley MARAC should ensure that information and guidance on the MARAC process is made accessible, including online and through the provision of local training

5.2.29 There was only a single action agreed at the Lewisham MARAC, which was to 'flag and tag'. It is not possible to respectively consider the quality of the MARAC action plan, given it was not clear what information was shared at the meeting, and the MARAC was not aware of the information that was known to REACH.

5.2.30 However, the Review Panel did consider what lessons could be learnt from this case, specifically noting that those MARAC cases with only routine actions like 'flag and tag' (which are effectively 'no action' cases as no further specific actions are agreed) are often those cases where a victim 'does not engage'. In such cases it may be that there are no obvious routes

[32] London Borough of Lewisham (2017) *Support networks for staff and professionals,* Available at: https://www.lewisham.gov.uk/inmyarea/publicsafety/domestic-violence/informationforprofessionals/Pages/support-networks-for-staff-and-professionals.aspx (Accessed: 29th October 2017).

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through which to intervene, perhaps because no agency is actively engaged within the victim (although this was not the case for Nargiza, who had engaged with REACH as discussed above, but this information was not available to the Lewisham MARAC). Yet in these circumstances a victim may be isolated and marginalised, facing a number of factors that hinder their ability to access services, or may be experiencing multiple disadvantage. Certainly, this was true for Nargiza, who was subject to a range of violence and abuse and was particularly vulnerable given Marat's use of economic and financial abuse, immigration status, children and family.

5.2.31 The risk of viewing victims through the prism of 'non-engagement' is that it places responsibility for accessing further help and support on that individual and serves to 'de-risk' agencies, rather than recognising that professionals should seek to identify other avenues for engagement, or at least seek assurance that a safety net is in place should a victim re-present.

5.2.32 For example, in this case it would have been appropriate to consider what other routes may have been available – could the Refuge IDVA service have made a further contact attempt, worked with the OIC to engage with Nargiza, or could the MARAC have identified another agency (such as a GP) as a route to offer help and support?

5.2.33 While learning relates to the Lewisham MARAC case discussion, this is relevant to the Bexley MARAC as well.

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It would be rare to see a case at a MARAC where every risk had been identified and addressed, including ensuring that the victim and the perpetrator are engaged with the relevant support/services and / or a safety net had been put in place. When a victim referred to a MARAC does not engage, professionals should routinely consider how to address risk and vulnerability, rather than these cases leading to no actions being taken.

Recommendation 9: The Lewisham MARAC should conduct an audit of 'no action' cases to identify whether this is an isolated case or whether there is any wider learning that could inform practice at the MARAC

Recommendation 10: The Bexley MARAC should conduct an audit of 'no action' cases to identify current practice and consider any wider learning that could inform practice at the MARAC

5.2.34 Depending on the outcome of these audits, each area may need to consider how it ensures there is the capability and capacity to respond to such cases. This could include relatively simple steps, such as creating or revising an Aide Memoire (possible actions for specific risk factors) to use as a prompt 'in room' to ensure that actions are being explored in response to each risk or need that is identified. If more structural issues are identified, then each area may need to consider how to enable a more in-depth discussion. This could include reviewing the time available for case discussion or considering other ways of managing complex cases (an example of how other areas bring additionality in the MARAC process is the MARAC + in West Sussex[33]).

Analyse the opportunity for agencies to identify and assess domestic abuse risk.

5.2.35 Nargiza's contact with health services may have been an opportunity for frontline staff to recognise the indicators of domestic violence and abuse and ask relevant questions.

5.2.36 During Nargiza's contact with the LGT there were several points when she could have been asked (or asked more effectively) about her experiences,

[33] https://www.westsussex.gov.uk/fire-emergencies-and-crime/domestic-abuse/multi-agency-risk-assessment-conferences-marac/

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which may have provided an opportunity for disclosure. These are identified in the LGT IMR.

5.2.37 Significantly, it is unclear as to whether staff at LGT was aware, during their contact with Nargiza in 2015, that she had been discussed at the Lewisham MARAC in July 2014. LGT are listed as having attended this meeting, where the only action was for all agencies to 'flag and tag'. If, during their contact in 2015 onward, staff had been aware that Nargiza had previously been considered a high-risk victim of domestic violence and abuse, this may have influenced their approach to assessments, including opportunities for enquiry. If Nargiza had disclosed abuse at this point, she would potentially have been within the period for re-referral to MARAC as a 'repeat' case i.e. where there was a further incident within one year. This is not considered in the LGT IMR.

5.2.38 Nargiza's record at LGT was not flagged to indicate that that she had been heard at a MARAC. LGT uses a system called 'iCare' for case management. 'iCare' has a flagging function that could indicate that someone had been referred to a MARAC and the actions that need to be taken by staff (e.g. to ask if the patient is currently experiencing domestic violence or if the victim feels safe). The content of a flag is a decision of the member of staff allocating the flag. Clearly it is not possible to know if staff would have approached Nargiza in a different way, or how she would have responded, however there is clearly learning for LGT in terms of standardising the use of 'flagging' to indicate that someone has been referred to a MARAC in the last year.

If professionals from LGT having contact with Nargiza had been aware that she had previously been referred to a MARAC, this may have enabled them to explore her experience of domestic violence and abuse in their contact with her.

Recommendation 11: LGT to review policy and procedure in relation to the use of MARAC flags so these are used consistently

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5.2.39 There were two occasions when Child C was admitted to the Paediatric Emergency Department at University Hospital Lewisham (in June 2015 and March 2016). However, the Paediatric Emergency Department does not undertake routine enquiry regarding domestic violence on admission. The current practice is for the triage nurse to ask the parent if family members are known to social services. This question is repeated on assessment.

5.2.40 These contacts would have been an opportunity to ask about domestic violence, either as part of routine or targeted enquiry. It is of note that there is inconsistency within LGT regarding this practice: there is routine domestic violence screening at another hospital in the trust (the Emergency Department at Queen Elizabeth Hospital) but not at University Hospital Lewisham. The National Institute of Clinical Excellence (NICE) guidance on domestic violence and abuse[34] recommends that staff in a range of departments (including antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services) should be trained to ask patients if they have experienced domestic violence, even where there are no indicators of such violence and abuse.

5.2.41 The LGT IMR included the following recommendations, which were welcomed by the Review Panel, on the basis their implementation was prioritised in relation to the Paediatric and Adult Emergency Departments, as well as the other departments noted in the NICE guidance:

- To roll out the set screening questions for domestic violence and abuse at University Hospital Lewisham
- For the Health Independent Domestic Violence Advisor (H-IDVA) to carry out specific training around risk identification and risk assessment of Domestic Violence and Abuse at both Adult and Paediatric Emergency Departments.

[34] NICE (2014) *Domestic violence and abuse: multi- agency working (PH50)*, London: National Institute of Clinical Excellence. [https://www.nice.org.uk/guidance/ph50]

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5.2.42 The H-IDVA service at the University Hospital Lewisham is provided by the local specialist service (Refuge) and there is a joint working protocol in place, setting out how referrals will be managed, and the support offered. This is positive and reflects the value of a specialist domestic abuse staff within a hospital, which have been evidenced by a recent SafeLives report[35], including opportunities for earlier identification. However, while the LGT recommendations were welcomed, the Review Panel noted that for these to be effective there needs to be sufficient H-IDVA capacity to enable a specialist response, and the existing care pathway should be reviewed to ensure it is fit for purpose.

It is best practice to have specialist domestic abuse staff co-located within a hospital setting, as is the case at the University Hospital Lewisham. When implementing the recommendations identified in the LGT IMR, health providers, the specialist domestic abuse service and commissioners should work together to ensure that the H-IDVA can meet demand.

Recommendation 12: LGT to work with Refuge and the relevant commissioners to ensure there is sufficient H-IDVA capacity, and a robust care pathway, within University Hospital Lewisham

5.2.43 There were concerning weaknesses in contact with Nargiza by the Health Visiting Service. The New Birth Visit conducted by the Health Visitor on the 25th June 2015 should have provided an opportunity for robust assessment of family health needs. These assessments are pivotal in uncovering need, safeguarding children and in determining levels of health intervention to be offered to children and their families by the Health Visitor. However, within the assessment:

- There was no information about Nargiza's first language recorded and it was not clear whether an interpreter was required / considered

[35] SafeLives (2017) *A Cry for Health: Why we must invest in domestic abuse services in hospitals*, Bristol: SafeLives.
[http://safelives.org.uk/node/935]

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- Nargiza was asked about domestic violence, drug and alcohol abuse and this is recorded on the assessment sheet (New Birth Visit Needs Assessment Form). Most responses were marked 'NP' (No Problem). The template in use is a 'tick box' template designed for rapid assessment – there is therefore no record of the type of questions used and the responses given, as there was no space to write additional information on the template itself
- It was not recorded which family members were present – if Marat had been present, his presence may have influenced the responses of Nargiza
- There was no family profile i.e. an assessment of how the family functioned and their attitudes towards each-other and if they were facing any challenges – this would have identified if there was any significant health or social factors present for any member of the family
- Nargiza reported no history of mental health problems and told the health visitor that she was currently feeling "*settled and well*"
- Nargiza told the Health Visitor that Child C had been admitted to St Thomas' for several medical conditions. The medical notes do not include any further information on these admissions (although there was a cross reference note on the mother's electronic record to check Child C's electronic record for medical conditions). However, there was no evidence to these conditions in the baby Child C's medical notes
- A genogram was completed but this did not record the other children of Nargiza, identifying Child C as an only child.

5.2.44 The electronic record provides some additional information about the visit itself. Nargiza identified and told the health visitor that her husband was "*supportive*" and she had friends locally. At the appointment, a range of information is listed as having been discussed, with at least 6 leaflets / booklets, as well as details of the Health Visiting Team and baby clinics being provided.

5.2.45 The New Birth Visit appears to have been superficial and there were weaknesses in the assessment. To some extent this is a systems issue – the design of the assessment sheet as a 'tick box' format is likely to both

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impede professional practice and ability to record any substantive response.

5.2.46 Additionally, the gaps in other areas of the assessment suggest that opportunities to explore Nargiza's needs were missed (albeit she may have chosen not to share some information, such as having other children, or her experience of domestic violence and abuse). As an example, the genogram and subsequent information highlighted that Nargiza appeared to be isolated and this was recognised by the Health Visitor. However, there is nothing to indicate any consideration to Nargiza's specific circumstances i.e. she was from a Central Asian Republic, or an awareness of her immigration circumstances. Professional curiosity about her specific circumstances may have enabled the Health Visitor, at both this visit and in subsequent contact, to offer more tailored information or options.

5.2.47 At the subsequent 6-8-week appointment (conducted on the 28th July 2015), Nargiza was seen with Child C and Marat was present. Nargiza is recorded as having told the Health Visitor that she was coping well and "*adjusting to motherhood*". Nargiza is recorded as describing Marat as "*supportive*", although there is no record of his contribution to the meeting.

5.2.48 On the 4th April 2016, Nargiza contacted the Health Visitor Service and expressed that she was in crisis and she was missing a door. From the records, it was not explicit which door was missing or why. However, Nargiza was advised that this was not something that the Health Visitor Service could assist with and signposted to other sources of support.

5.2.49 This was clearly a missed opportunity and should have been actioned: Nargiza had contacted a statutory service, with whom she had an established relationship, and sought support. While it may not have been evident at the point of contact as to why the door was missing, signposting was not an appropriate response. As a minimum, there should have been a real-time assessment as to whether Nargiza and Child C were at risk and this may have triggered a further home visit, a referral to the local MASH or a referral to an appropriate support service.

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5.2.50 The LGT IMR includes the following recommendations, which were welcomed by the Review Panel, to

- For the health visiting new birth assessment form to be re-developed to allow an in-depth assessment of the families [sic] health needs
- For families to be given information on domestic violence and abuse and how to get help at every opportunity
- To change practice to allow for the scope to engage professional curiosity if a client contacts the health visiting service with a problem or issue. For issues identified, an action plan must be completed
- Improvement in documentation from Guys and St Thomas's NHS Trust (GSTT).

5.2.51 Nargiza also had frequent contact with her GP, a Medical Centre in Lewisham, presenting with a range of different health needs. These could have indicated that there was underlying cause for her use of health services. Ensuring that frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse, is critical.

5.2.52 The Medical Centre IMR noted that During the Summer/Autumn 2016 administrative and clinical staff received IRIS (Identification & Referral to Improve Safety[36]) training, which increased awareness of domestic violence, and how to proactively enquire about this, in consultations where presentations might suggest domestic violence. The Medical Centre has since incorporated templates in the clinical system that triggers reminders to ask about domestic violence and abuse when a clinician enters symptoms or conditions that could be indicators, as well as information on referral pathways, including forms, patient information and templates for local domestic abuse services.

5.2.53 While the affected practice was in Lewisham and has taken steps to improve its response to domestic violence and abuse, the Review Panel additionally considered whether there were any wider implications for the

[36] For more information go to http://www.irisdomesticviolence.org.uk

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Bexley CCG and GPs in the borough. The Bexley CCG has reviewed the IRIS Project and has made the decision that the cost and time commitment to register and implement this will not be cost effective. However, work is ongoing to implement a process which ensures that victims of a domestic violence are referred to a support service and that disclosure of domestic violence in the patient's medical record is recorded. The action plan that has been developed includes: raising awareness with GP's and practice staff on the following: recognising indicators of abuse; knowledge of local procedures for reporting abuse and accessing advocacy; best practice from the recently RCGPs on recording risks of domestic abuse on GP records. From January 2018, a new process of information sharing between GPs and the MARAC will be piloted.

A range of effective interventions can make it easier for NHS services to play their part. This should include ensuring that GPs have access to training, support and a referral programme to support them asking about and responding to domestic violence and abuse. In this case, the affected surgery has adopted the IRIS project. The Bexley CCG has an action plan in place to address practice across GPs more widely.

Recommendation 13: The Bexley CCG to monitor the implementation of its local action plan to improve the response to domestic violence and abuse with GPs and undertake an evaluation to ensure that the local action plan is effective and leads to improved victim outcomes.

5.2.54 Both the MPS and LAS had access to information about Marat's behaviour and concerns that could potentially have indicated he was a risk. This included his use of alcohol, separation and fixation on Nargiza.

5.2.55 During November 2016, the MPS had brief contact with Marat. First on the 8th November (an Adult Come to Notice Merlin was completed but not shared as Marat did not give his consent to do so), and then on the 12th (Police Officers called LAS. The Police Officers clarified his state of mind and also the comments made by and regarding Nargiza). Both incidents were closed as 'no further action' was required.

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5.2.56 These were reviewed as part of the DHR and the MPS IMR describes these as in line with procedure. The calls were all linked by the MPS and Marat's number was highlighted as being from a 'repeat caller'.

5.2.57 For the LAS, contact occurred on the 8th November 2016 (Marat was drinking, reported feeling depressed, and separation having not seen his children for a long time) and then on the 12th November (Marat repeated these disclosures on the first of the two call outs that happened on that day).

5.2.58 The LAS IMR identified that staff followed National Clinical Guidelines to aid their decision making and the treatment provided (they offered to convey Marat to hospital and, when he declined, they provided advice).

5.2.59 The Review Panel considered whether there should have been a response to Marat's disclosures, to either the MPS or LAS. This is because Marat's disclosures (alcohol use, depression, separation, child contact) are indicators of domestic violence and abuse, featuring for example in the DASH RIC as questions 21, 6, 7.

5.2.60 During the Review Panel discussions, the MPS noted that no crimes were disclosed in these contacts.

5.2.61 The Review Panel accepted this but questioned whether, while existing procedures would have meant that 'no further action' was required, responding Police Officers should have been aware of Marat's reported history of domestic violence, specifically the MARAC in 2014. There is therefore merit in considering a different response, how the information could be used/shared and how to inform practice and activity.

5.2.62 The LAS representative noted that there have been positive developments in the LAS, including the development of a referral for patients who would like assistance around domestic abuse, as well as a Domestic Abuse Policy which includes the importance of notifying the MPS even when no consent has been gained. Staff also have training, with domestic violence included in a reviewed training package introduced following the Care Act 2014. However, they noted that there would be no way to link the incidents relating to Marat, given both the volume of calls received on a daily basis,

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and ambulance crews dispatched and mobilized to call outs based on address rather than a patient name. Additionally, while there are procedures in place to identify 'frequent' callers, the level of contact by Marat would not have triggered this process.

5.2.63 The Review Panel accepted that the LAS practice in response to Marat was consistent with clinic guidance, but again, noted the merit in considering what a different response could have been in light of his disclosures.

5.2.64 The Review Panel noted the increasing focus on the identification of those who use violence and abuse. Nationally the VAWG strategy[37] aims to "*embedded robust approach to tackling perpetrators through greater scrutiny of their motives and behaviour with a reduction in re-offending*". As contact with Marat above demonstrates, it is challenging for agencies to identify and respond to perpetrator behaviour, or behaviour that could be a cause for a concern, in a domestic violence context at an early opportunity. There are clearly practical considerations in developing practice in this area, and while it may not have led to a different outcome in this case, the Review Panel agreed that this should be explored further.

There is a need to consider whether practice, pathways and training in relation to the identification and response to perpetrators is sufficiently robust and develop proposals to address any gaps in the local response.

Recommendation 14: The Bexley CSP to develop a profile of perpetrators locally and review practice, pathways and training in response to this group

Analyse agency responses to any identification of domestic abuse issues.

5.2.65 In reviewing the chronology, there are several points where the MPS response – after domestic violence and abuse had been identified –

[37] Home Office (2016) *Strategy to end violence against women and girls: 2016 to 2020*, London: HM Government.

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illustrates the complexities of dealing with domestic violence and abuse that often involves a pattern of incidents.

5.2.66 The first of these is related to the management of a request for Police Officers to be present to prevent a breach of peace when Nargiza collected her belongings from the address she shared with Marat in June 2014. This was clearly significant for Nargiza, as she told at least two friends about this experience (Dilnoza and Feruza).

5.2.67 Practice in these circumstances is set out within the MPS Domestic Abuse Policy. The section entitled "*Your duty of care to domestic abuse victims*" sets out that "*Where victims or perpetrators wish to retrieve property from a venue where domestic abuse has taken place or a shared property, consideration is to be given to a police officer accompanying them*".

5.2.68 On the 16th June 2014, a friend (Babysitter), called the MPS to establish the whereabouts of police in respect of a pre-arranged appointment. It appears that this was pre-emptive: this call was made ahead of scheduled appointment time and Police Officers arrived shortly thereafter.

5.2.69 When Police Officers subsequently attended, Marat declined to let them in. No further action was taken. Upon review of this decision, the Police Officers at the scene noted that Marat was listed solely on the tenancy agreement and therefore they had no lawful powers to enter.

5.2.70 The next day (the 17th June 2014) Nargiza made a further call to the MPS requesting that Police Officers attend with her to collect her belongings. This was not actioned. When the contact was reviewed, it appears that the Control Room had attempted to contact Nargiza seeking to clarify if Police Officers needed to attend as the property had been left outside, but that Nargiza did not respond.

5.2.71 Marat had contacted the MPS on the 17th June about concerns for Nargiza, and later - over the 27th and 28th July 2014 - he made three calls to the MPS, initially reporting that Nargiza had taken a hard drive from his room; then that Nargiza had refused to talk to him, and that she was sitting outside crying and that he believed she was going to falsely report that he had hurt her; and finally, that Nargiza had taken items and when he told her

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that police were coming she had thrown herself on the floor claiming he had hurt her.

5.2.72 On the 28th July 2014 Police Officers attended the home and spoke with Nargiza and Marat separately. No allegations were made by either party. A Book 124D and a DASH RIC was completed. Nargiza's response to all the questions was "No" and declined a referral to victim services.

5.2.73 A CRIS report was created, which documents the risk assessment. Officers also completed intelligence checks in line with the MPS Domestic Abuse Policy which identified the assault reported by Nargiza in June 2014. The officers then graded the risk as Standard. This was closed on 4th August 2014 following a review by the attending officer supervisor and then the CSU.

5.2.74 The CSU review considered the summary of the incident as provided by the reporting officer, the DASH question responses and also the previous reports relating to Nargiza and Marat. The officer would have reviewed the previous report, which documented the MARAC flag and the investigation.

5.2.75 The MPS reviewed this decision in the IMR submitted and were of the view that the appropriate grading (i.e. standard) supported the basis of the information provided/known at the time. The report author noted that with the benefit of hindsight, further risk factors can be identified, which would have raised the grading to medium. These include:

- Have you separated or tried to separate?
- Does he try to control everything you do and/or are they excessively jealous
- Do or say things of a sexual nature that makes you feel bad
- Are there any financial issues, and
- Previously in trouble with police.

5.2.76 Nargiza had been discussed at the Lewisham MARAC on the 23rd July 2014. As the contacts with Marat, and then Nargiza and Marat, were only a few days later, there was a discussion at the Review Panel as to whether this should have been considered a 'repeat' and therefore referred back to the MARAC.

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5.2.77 MPS practice in relation to the MARAC is that:

- A report is generated from the criminal intelligence database (CRIMINT), which details subject's details and the result of the meeting
- The crime report generating the referral to MARAC has a flag added confirming referral to MARAC and includes an update of the outcome of the discussion
- A spreadsheet is maintained by each borough's CSE of all MARAC referrals and cases, which officers research to identify previous referrals.

5.2.78 The MPS practice in relation to perpetrators, in order to link different contacts, is that Intelligence checks (a minimum 5 years) should be completed for all parties involved (whether victim, suspect or witness). The checks include PNC and IIP (CRIS, CAD, CRIMINT and MERLIN). The checks are MPS-wide and cover all incident types. The results of these checks are added to the relevant report and informs risk grading and subsequent action. These checks are then accessible to all officers competing subsequent checks.

5.2.79 The Review Panel discussed the MPS contact, in particular considering the decision to close the case on the 4th August 2014. However, as the report included no allegations, was reviewed but did not meet the criteria for referral to MARAC and an offer of a victim support service referral was declined, the Review Panel accepted that there was no further action that the MPS could have taken.

5.2.80 The Review Panel considered whether, regardless of the nature of the incident or the level of risk, there should have been a re-referral to MARAC. The MPS were clear that this contact would not have triggered a re-referral to MARAC. One reason that this is the definition of a repeat MARAC case.

5.2.81 SafeLives defines a repeat MARAC case as one which has been: "*previously referred to a MARAC and at some point in the 12 months from the date of the last referral a further incident is identified. Any agency may identify this further incident (regardless of whether it has been reported to the police). A further incident includes any one of the following types of*

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behaviour, which, if reported to the police, would constitute criminal behaviour:

- *Violence or threats of violence to the victim (including threats against property); or,*
- *A pattern of stalking or harassment; or,*
- *Rape or sexual abuse"*

Where a repeat victim is identified by any MARAC agency, that agency should refer the case to the MARAC, regardless of whether the behaviour experienced by the victim meets the local referral threshold of visible high risk, escalation or professional judgement." [38]

5.2.82 The Review Panel considered the requirement in the definition that the behaviour of the perpetrator should, if reported to the police, constitute criminal behaviour. The Review Panel felt that the definition is unclear which, critically, could lead to confusion as to whether a case should be re-referred to the MARAC.

The focus on a 'repeat' threshold as being at a specific point of time and which, if reported to the police, would constitute criminal behaviour, is potentially confusing. The definition should be reviewed in light of the increasing recognition that professionals should consider the harm caused by coercion or control, the cumulative impact on a victim and that a repeated pattern of abuse can be more injurious and harmful than a single incident of violence.

Recommendation 15: SafeLives to review the definition of a 'MARAC repeat'

Analyse organisations' access to specialist domestic abuse agencies.

5.2.83 There were examples of agencies accessing domestic abuse services, including REACH and Refuge, through internal or multi-agency pathways. These contacts are analyzed above. There is nothing in the information

[38] SafeLives (2017) *Definition of a "repeat" at Marac,* Available at: *http://www.safelives.org.uk/definition-repeat-marac* (Accessed: 29th October 2017).

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presented to the Review Panel to indicate that organizations were not aware of – or able to access information about – specialist domestic abuse services.

5.2.84 However, it is of note that as part of the review process, it was not possible to identity a specialist BAME led organisation (or even generic BAME led organisation) in the borough that could provide advice to the Review Panel (see 1.4.5).

5.2.85 Consequently, the Review Panel considered the question of provision of specialist BAME led services. A report by Imkaan[39] defines such organisations as "*independent, specialist and dedicated services run by and for women from the communities they seek to serve"*, which:

- "*Work in ways that are not only about individual women and girls' safety, and/or the safety of their children, but are also about BME women's autonomy, freedom and self-determination.*
- *Recognise the continuum of violence against women and girls and seek to offer support around every aspect of women's needs, ensuring a holistic, needs led response.*
- *Work across the spectrum of risk and need, understanding the fluctuating nature of risk and are adept at recognising 'hidden risk indicators.*
- *Are skilled in identifying indicators and experiences of specific forms of Violence Against Women and Girls (VAWG) that may be missed within a mainstream domestic violence organisation.*
- *In offering a range of services, are able to access women who may not even recognise their experiences as violence.*

[39] Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*, London: Imkaan. [http://imkaan.org.uk/resources]

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- *Create flexible and diverse support systems, sensitive to the fact that for many BME women, refuge and support services may be unfamiliar and/or stigmatized*".[40]

5.2.86 It is not possible to know whether, if Nargiza had been able to access a BAME led specialist organization, a better outcome might have been achieved. But it is reasonable to consider whether having access to a specialist BAME led organisation might have enabled Nargiza to access help and support in an environment where staff have the knowledge and expertise in providing support to those affected by various forms of violence in specific individual, family and community contexts. This may have included opportunities to access immigration related support, including advice around the domestic violence concession, or specific support tailored to her unique needs. This raises the question of whether specialist BAME provision should be available locally.

It important for a local authority to be aware of their local population, including the level of need and the requirement for specialist BAME led provision. However, for individual London boroughs, it is neither possible nor desirable for areas to work alone in this regard and, there are opportunities to work on a regional basis to ensure BAME led specialist services are accessible and / or sustained.

Recommendation 16: The Bexley CSP scopes the requirement for specialist BAME led provision in the borough

Recommendation 17: The Bexley CSP works with other bodies in London, including MOPAC, to ensure that there is sufficient specialist BAME led provision

[40] Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*, London: Imkaan. [http://imkaan.org.uk/resources]

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Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

5.2.87 Agencies have a range of policy, procedures and training in place in relation to domestic violence and abuse and these were described in each agencies' IMR.

5.2.88 The learning in this case – issues like coercive control, immigration status, ensuring that incidents are considered in context rather than as 'stand-alone' and other issues, as well as the equality and diversity issues noted below – is an important reminder that professionals need to be able to have the skills and confidence to respond appropriately to domestic violence and abuse.

5.2.89 During its discussion, the Review Panel considered how agencies should ensure that their workforce have access to appropriate training, through both provision of single training but also access to wider multi-agency training. The Review Panel also considered the role of bodies like the Local Safeguarding Children Board (LSCB) and Safeguarding Adults Board (SAB) in providing assurance around this issue.

5.2.90 Individual agency IMRs described the single agency training accessible to staff, and examples of some of the multi-agency activity undertaken locally to provide assurance around training was shared during the review, including a template of the Bexley Safeguarding Adults Board 'Safeguarding Adults at Risk Audit Tool 2017 – 2018'. This references domestic violence directly.

5.2.91 Additionally, the chair examined the multi-agency training locally, including the Safeguarding Adults Board '*Learning and Development Safeguarding Adults Training Programme 2017 – 2018'*[41] and a summary of the Local Safeguarding Children Board Training and Development plans[42]. The SAB

[41] Bexley Safeguarding Adults Board (2017) *Safeguarding Adults Learning and Development Safeguarding Adults Training Programme*

[42] Bexley Local Safeguarding Children Board (2017) *Training Programme*

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programme references domestic violence and abuse only once (a single Practice Development Workshop, which is primarily for staff responsible for overseeing or managing section 42 Safeguarding Enquiries), while the summary of LSCB activity does not directly reference domestic violence and abuse. In addition, there is limited information available specifically in relation to training around working with BAME communities or immigration issues (including an understanding of the implications of immigration status including 'no right to remain or 'no recourse to public funds') in the context of domestic violence.

The Bexley CSP should work with the LSCB and SAB to ensure that local single and multi-agency training is sufficient, is making a difference and builds in the voice of victims in relation to domestic violence and abuse.

Recommendation 18: The Bexley CSP should work with the LSCB and SAB to ensure that local single and multi-agency training is sufficient in relation to domestic violence and abuse. Referencing the learning specifically in this case, that would include training in relation to BAME communities and immigration issues.

The extent to which the following protected characteristics or issues had an impact on the case:

- *Race (Nargiza was a national of a Central Asian Republic, as was Marat)*
- *Religion and Belief (Nargiza was a Muslim, as was Marat)*
- *Sex (Nargiza was Female, Marat was Male)*
- *Immigration status*
- *so-called 'honour' based violence and abuse*
- *English as a second language*

5.2.92 Nargiza's experience of domestic violence and abuse, and the ways in which her different identities (including sex, religion and belief, race and nationally), as well as her immigration status, compounded her experiences or were used to abuse are discussed in 5.1 above.

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5.2.93 An additional issue considered by the Review Panel was if these factors affected how Nargiza sought help, and whether services considered her unique needs in their response.

5.2.94 As noted previously in 1.4.6, sex is a risk factor for domestic violence, including domestic homicide. Additionally, Nargiza's case demonstrates how sex can intersect with other aspects of someone's identities.

5.2.95 The intersection of these issues was noted at times. For example, when Nargiza was in contact with REACH, there was consideration of a range of factors, including having no NRPF and her immigration status, for which signposting to legal advice was provided. This referral for legal advice was appropriate as, if Nargiza had felt able to take this up, it may have enabled her to access information on her rights, including applying for the Domestic Violence (DDV) concession (to enable access to public funds) or Indefinite LTR as a victim of domestic violence. On the specific issue of provision, REACH (through GSTT) is to be commended for its willingness to offer short term accommodation to Nargiza as part of its attempts to provide her with increased options for safety, although this would not have been a long-term solution.

5.2.96 However, REACH did not make a referral to the MARAC as discussed previously; a referral should have been made in recognition of the risk and needs of Nargiza. Critically, to a very great extent these risks and needs – and Nargiza's ability to access help and support – were influenced by the intersection of her identities.

5.2.97 Conversely, the LGT Health Visitor contact with Nargiza did not fully consider her protected characteristics, as discussed in the analysis of agency involvement above. The LGT IMR recognises that this a weakness in practice in this case.

5.2.98 Nargiza spoke English as a second language, as did Marat. There is some discrepancy between agency records as to their respective language abilities. It is positive that at several points different services considered or used interpreting services, although in fact it appears that both Nargiza and Marat had a good level of English (for example, REACH and Nargiza's

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employer stated that her English was good. In contact with Marat, both MPS and later prison staff reported that he did not require the use of an interpreter).

5.2.99 Viewed collectively, it is of note that, even when Nargiza's identities were noted explicitly and proactive steps were taken, responses were largely issue specific. There is limited evidence of any broader reflection on how her identities intersected, and therefore whether additional action was needed in order to manage her risks and needs. Noticeably in this respect, agency records do not indicate any consideration of referral to, or engagement with, services that explicitly work with BAME women. This is addressed above relation to both service provision (see 5.2.83 onward) and training (see 5.2.87 onward).

Given the limited contact with services in this case, consideration of what might have helped or hindered engagement in services by Nargiza.

5.2.100 Nargiza sought emotional support through her informal network in relation to domestic violence and abuse, as well as the MPS. However, she also made a disclosure to her manager and was then referred to her employers 'in house' domestic abuse service.

5.2.101 While it is rare for a health trust to have a service like REACH, this is an illustration of the importance of employers and that their response to domestic violence can help victims access services; the national VAWG strategy[43] describes employers as having a critical role in both identifying abuse and developing robust workplace policies to support employees who may be victims of violence, abuse or stalking.

5.2.102 As part of the DHR process, Review Panel members were asked whether their agency had a specific staff policy relating to domestic violence and abuse. The range of responses from within this small sample of agencies was striking, although perhaps not surprising:

[43] HM Government (2016) *Ending Violence against Women and Girls: Strategic 2016 – 2020,* London: HM Government.

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Agency	Staff Policy
Bexley Clinical Commissioning Group (CCG)	There is no stand-alone workplace domestic violence policy, although in response to this review a draft policy has been developed
Bexley Women's Aid (BWA)	At the time of the review there was no stand-alone workplace domestic violence policy, although the document '*Domestic Abuse Polices 2017*' addressed staff experience. During the review a stand-alone policy has been developed and was implemented in October 2017.
Guy's and St Thomas NHS Foundation Trust (GSTT)	Being reviewed and to include a section on staff referrals and how these are managed
Lewisham and Greenwich NHS Trust (LGT)	There is no stand-alone workplace domestic violence policy, however the *'Domestic Violence and Abuse Policy'* addresses staff experience
Lewisham Clinical Commissioning Group (CCG)	No stand-alone workplace domestic violence policy
London Ambulance Service (LAS)	There is no stand-alone workplace domestic violence policy, however the '*Domestic Abuse Policy and Procedure*' addresses staff experience
London Borough of Bexley	There is no stand-alone workplace domestic violence policy. A Domestic Abuse Policy is being produced. This is due to be signed off in October 2018
London Borough of Lewisham	Internal Staff policy in place since 2013; a review began last year and a revised policy is in the process of being signed off
Metropolitan Police Service (MPS)	Has a stand-alone workplace domestic violence policy; this was last reviewed in July 2014
NHS England	Does not have a domestic abuse policy, and Human Resource and Safeguarding Policies do not address it, although there is information and established mechanisms in place for support of staff. In response to this review NHSE will take this issue through governance and safeguarding routes for consideration for inclusion into policy

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Oxleas Trust (health visiting)	There is no stand-alone workplace domestic violence policy; the '*Domestic Abuse Policies and Procedures*' addresses staff experience
Refuge	Has a stand-alone workplace domestic violence policy; this was last reviewed in January 2016

Local partnerships should ensure that their own member agencies have policies in place, as well as identify how they can individually and collectively promote the adoption of workplace policies within the public, voluntary and private sector.

Recommendation 19: The Bexley CSP should identify how it can support the raising of awareness of domestic violence and abuse across the public, voluntary and private sector by encouraging employers to develop robust workplace polices to support employees who may be victims of domestic abuse, violence or stalking

Recommendation 20: Representatives from organisations represented on the Review Panel that do not have a workplace policy to support employees who may be victims of violence, abuse or stalking to escalate this issue within their organisation so that a robust policy can be put in place

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6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 Nargiza's homicide is tragic; her family have lost a daughter and sister to homicide and she will be deeply missed. It is also impossible to forgot that three young children were robbed of an opportunity to grow up knowing their mother. That loss is made more difficult still as it is compounded by the death by suicide of their father Marat. Regardless of Marat's actions, the death of both their parents in these circumstances is a heavy burden.

6.1.2 Marat's suicide also means that the criminal justice process was unable to run its course, and so those affected by Nargiza's homicide have been denied the opportunity to see a determination of Marat's criminal guilt. While the DHR process cannot fill this gap, it can seek to illuminate past. The Review Panel hopes that this review goes some way to describing Nargiza's life and experiences, articulating what happened and describing the behavior of Marat, based on the information available, and so providing some closure to Nargiza's family, friends and others affected by the homicide.

6.1.3 The Review Panel in particular extends its thanks Nargiza's family for their participation.

6.2 Lessons To Be Learnt:

6.2.1 There has been a range of learning from this review – in particular about how a victim's personal circumstances and their different identities intersect, and can affect their experiences, as well as the help and support that they seek or are offered.

6.2.2 Throughout this review, it has been clear that Nargiza's risk and space for action were significantly influenced by her personal circumstances and different identities. She was, as an example, a diligent member of staff, a mother and daughter. She was also a victim of violence and abuse, trying to manage her immigration status and, in doing so, experiencing repeated

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contact with the Home Office while being dependent on Marat as her spouse for her LTR in the UK. Her interactions with services are likely to have been informed by these different issues, and as a result, there is learning about how agencies identify, understand and respond to a victim's unique needs.

6.2.3 Nargiza's experiences also show how pervasive different forms of violence and abuse can be. In particular Marat's use of financial and economic abuse, as well 'abuse of process', have led to recommendations of national significance to ensure that these forms of violence and abuse are better understood. Additionally, this learning is reminder that it is critical that agencies are able to recognize and understand how violence and abuse are perpetrated and can respond to someone's experience, and the risk posed by the perpetrator, in a multi-faceted way.

6.2.4 There is learning about how agencies work individually and collectively to protect victims of domestic violence and abuse. Significantly, there were omissions by two agencies in their response to risk. Firstly, in 2014 REACH did not refer to the Lewisham MARAC and then closed the case, relying on Nargiza's report that she was leaving both her work and the UK. It is not possible to know what the outcome would have been had REACH referred to the Lewisham MARAC, but given the striking difference between what was known to the service and the paucity of information available to the Lewisham MARAC at the time, it is reasonable to assume that agencies would have had the opportunity to be better informed and therefore potentially to work together differently in order meet Nargiza's needs. Secondly, in 2016, the LGT Health Visiting Service failed to respond to a report by Nargiza of a missing door and simply signposted Nargiza to other services. While the circumstances are unclear, and it is not possible to know what the outcome would have been if LGT had proactively responded to Nargiza's request for help, this was an occasion help was sought and an agency did not respond.

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6.2.5 The review has also identified learning relating to MARAC, both in terms of the importance of a clear record of meetings but also considering why 'no action' MARACs are problematic. There is a risk that MARACs which take no actions – because for example, a victim is 'non-engaging' – effectively 'de-risk' agencies, while leaving the risks and needs of victims unmet. Partnerships need to ensure that they understand these cases and identify how they can respond in order to keep victims at the centre of all that they do.

6.2.6 Additionally, there is learning about the identification and re-referral of MARAC cases. Again, Nargiza actively sought help from a service (the MPS) in 2014 to help her retrieve property from the home she shared with Marat. The MPS felt it could not take any action as no criminal offence occurred and did not re-refer to the MARAC because the incidents did not meet the definition of a 'MARAC repeat'. It is not possible to know what the outcome would have been had the definition been different and had the MPS therefore made a re-referral. However, a re-referral would have triggered a further opportunity for a case discussion, which may have enabled agencies to think again about how to help and support Nargiza. The current definition needs to be reviewed.

6.2.7 There has also be learning about how agencies communicate internally and with each other, including for specialist domestic abuse services and across different parts of the health sector (in this case, with reference to work in hospitals, general practices and the ambulance service).

6.2.8 Communication is of course only effective if staff understand their role, what they can do and how they should work together. The review has made recommendations around how the local partnership can be assured about training, both in relation to victims but also how staff can identify and respond to perpetrators sooner.

6.2.9 While there has been a range of learning, there have also been areas of good practice. The Police Officer who was dealing with Nargiza's case in 2014 rightly recognized her risk and referred her to the Lewisham MARAC, while the availability of a service like REACH is clearly positive,

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including the response to Nargiza's first disclosure by both her manager and REACH itself. Lastly, health providers had regular contact with Nargiza, providing a good response to her health needs.

6.2.10 Following the conclusion of the review, there is an opportunity for agencies individually and collectively to consider their response in light of the learning and recommendations. In order to make the future safer for others, this is a responsibility that all agencies share so that domestic violence really is everybody's business. As referenced at the start of this report, the family of Nargiza have talked about what will come about as a result of this DHR, and the Review Panel hopes that they feel the recommendations will bring about positive change.

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7. Recommendations

7.1 IMR Recommendations (Single Agency):

7.1.1 The single agency recommendations, made by the agencies in their IMRs are described in section 3 following the analysis of contact by each agency, and are also presented collectively in **Appendix 2**. These are as follows:

Medical Centre

7.1.2 Ensure new staff have access to Domestic violence IRIS Training.

7.1.3 A significant event analysis will be shared with Practice staff at The Medical Centre.

Lewisham and Greenwich NHS Trust

7.1.4 To roll out the set screening questions for domestic violence and abuse at University Hospital Lewisham.

7.1.5 For the Health Independent Domestic Violence Advocate (IGVA) to carry out specific training around risk identification and risk assessment of Domestic Violence and Abuse at both Adult and Paediatric Emergency Departments.

7.1.6 For the health visiting new birth assessment form to be re-developed to allow an in-depth assessment of the families [sic] health needs.

7.1.7 For families to be given information on domestic violence and abuse and how to get help at every opportunity.

7.1.8 To change practice to allow for the scope to engage professional curiosity if a client contacts the health visiting service with a problem or issue. For issues identified an action plan must be completed.

7.1.9 Improvement in documentation from Guys and St Thomas's NHS Trust (GSTT).

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Refuge IDVA Service

7.1.10 Full case information should be shared between both agencies throughout the whole referral process even where the service has been declined by the victim.

7.2 Overview Report Recommendations:

7.2.1 The Review Panel has made the following recommendations, which are also described in section 3 as part of the analysis and presented collectively in **Appendix 3**.

7.2.2 These recommendations should be acted on through the development of an action plan, with progress reported on to the Bexley CSP within six months of the review being approved by the partnership. In relation to the recommendations with national implications or for the London Borough of Lewisham, the Chair of the Bexley CSP should write to the Home Office and the Chair of the Safer Lewisham Partnership respectively once the review is approved.

7.2.3 **Recommendation 1:** The UK Government to review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate economic and financial abuse.

7.2.4 **Recommendation 2:** The UK Government should review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate abuse of process.

7.2.5 **Recommendation 3:** GSTT to ensure that there is a clear policy and procedure in place to manage communication between REACH, members of staff who access the service and their managers. This should strike a balance between confidentiality and consent with the ability of REACH to seek information from or liaise with managers in high risk cases.

7.2.6 **Recommendation 4:** GSTT to conduct a review of decision making in relation to referral to MARAC within REACH, with particular reference to

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time frames, the use of professional judgement and how cases are managed when a victim disengages from the service.

7.2.7 **Recommendation 5:** GSTT to review pathways to MARACs in London. In doing this, GSTT should prioritize pathways with those areas with the greatest number of patients. As a minimum this should include Lambeth, Southwark and Lewisham.

7.2.8 **Recommendation 6:** LAS to review how it can sign up to, and participate in, MARACs and disseminate guidance to MARACs in London.

7.2.9 **Recommendation 7:** The Lewisham MARAC should further develop its online profile, to ensure that information and guidance on the MARAC process is as accessible as possible**.**

7.2.10 **Recommendation 8:** The Bexley MARAC should ensure that information and guidance on the MARAC process is made accessible, including online and through the provision of local training.

7.2.11 **Recommendation 9:** The Lewisham MARAC should conduct an audit of 'no action' cases to identify whether this is an isolated case or whether there is any wider learning that could inform practice at the MARAC**.**

7.2.12 **Recommendation 10:** The Bexley MARAC should conduct an audit of 'no action' cases to identify current practice and consider any wider learning that could inform practice at the MARAC.

7.2.13 **Recommendation 11:** LGT to review policy and procedure in relation to the use of MARAC flags so these are used consistently

7.2.14 **Recommendation 12:** LGT to work with Refuge and the relevant commissioners to ensure there is sufficient H-IDVA capacity, and a robust care pathway, within University Hospital Lewisham

7.2.15 **Recommendation 13:** The Bexley CCG to monitor the implementation of its local action plan to improve the response to domestic violence and abuse with GPs and undertake an evaluation to ensure that the local action plan is effective and leads to improved victim outcomes.

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7.2.16 **Recommendation 14:** The Bexley CSP to develop a profile of perpetrators locally and review practice, pathways and training in response to this group**.**

7.2.17 **Recommendation 15:** SafeLives to review the definition of a 'MARAC repeat'.

7.2.18 **Recommendation 16:** The Bexley CSP scopes the requirement for specialist BAME led provision in the borough.

7.2.19 **Recommendation 17:** The Bexley CSP works with other bodies in London, including MOPAC, to ensure that there is sufficient specialist BAME led provision**.**

7.2.20 **Recommendation 18:** The Bexley CSP should work with the LSCB and SAB to ensure that local single and multi-agency training is sufficient in relation to domestic violence and abuse. Referencing the learning specifically in this case, that would include training in relation to BAME communities and immigration issues**.**

7.2.21 **Recommendation 19:** The Bexley CSP should identify how it can support the raising of awareness of domestic violence and abuse across the public, voluntary and private sector by encouraging employers to develop robust workplace polices to support employees who may be victims of domestic abuse, violence or stalking.

7.2.22 **Recommendation 20**: Representatives from organisations on the Review Panel that do not have a workplace policy to support employees who may be victims of violence, abuse or stalking to escalate this issue within their organisation so that a robust policy can be put in place.

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Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Nargiza and Marat following the death of Nargiza in December 2016. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Nargiza and Marat from 01/01/2008 (when Nargiza arrived in the United Kingdom) to the date of Nargiza's death (inclusive) and to summarise any agency involvement with Marat prior to this period.

2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6. To contribute to a better understanding of the nature of domestic violence and abuse.

7. To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

8. *The Independent Chair of the DHR will:*
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.

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d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. *The Review Panel will:*
   a) Agree robust terms of reference.
   b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
   c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
   e) Agree and promptly act on recommendations in the IMR Action Plan.
   f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
   g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
      - The purpose of the review has been met as set out in the ToR;
      - The report provides an accurate description of the circumstances surrounding the case; and
      - The analysis builds on the work of the IMRs and the findings can be substantiated.
   h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
   i) On completion present the full report to the Bexley Community Safety Partnership.
   j) Implement your agency's actions from the Overview Report Action Plan.

Bexley Community Safety Partnership ("the Community Safety Partnership") will:
   a) Be the lead CSP, with responsibility for the commissioning of the review process
   b) Translate recommendations from Overview Report into a SMART Action Plan.
   c) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
   d) Forward Home Office feedback to the family, Review Panel and STADV.
   e) Agree publication date and method of the Executive Summary and Overview Report.
   f) Notify the family, Review Panel and STADV of publication.

Lewisham Community Safety Partnership will:
   a) Be an associated CSP, with responsibility for supporting the review process.
   b) Nominate a Single Point of Contact to be a member of the Review Panel.

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c) Facilitate the engagement of other Review Panel members from Lewisham as appropriate.
d) Support the translation of any recommendations from Overview Report into a SMART Action Plan where they relate to Lewisham and takes responsibility for progressing these.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is: "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. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Nargiza and Marat (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).

12. The Review Panel identified the following protected characteristics of Nargiza and of Marat as requiring specific consideration for this case:
a) Race (Nargiza was a national of a Central Asian Republic, as was Marat)
b) Religion and Belief (Nargiza was a Muslim, as was Marat)
c) Sex (Nargiza was Female, Marat was Male)

13. The Review Panel will additionally consider the immigration status of both Nargiza and Marat and the impact this had on their confidence to engage with

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services, ability to access services or the engagement of services with either Nargiza and Marat.

14. As part of the initial scoping, so-called 'honour' based violence and abuse has also been identified as a potential factor in this case and further consideration will be given as to whether this was pertinent to this homicide.

15. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' – a person "who is or may need community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation". The conclusion is that neither Nargiza or Marat were 'Adults at Risk' based on the information known to professionals at the time. However, Bexley Adult Social Care will be represented on the Review Panel to ensure that issues in relation to Adults are Risk are considered.

16. *Expertise*: The Review Panel will invite specialist service(s) with expertise in work with the immigration status, faith and so-called 'honour' based violence as an expert/advisory panel member to ensure the Review Panel is able to appropriately consider these issues and to help understand crucial aspects of the homicide.

17. If Nargiza and Marat have not come into contact, and/or had limited contact, with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those members of the community from Marat and Nargiza's country of origin. The Review Panel will invite a specialist service(s) / community group to represent the voice of this community as an expert/advisory panel member.

18. The CSP/Chair of Review/other panel member will make the link with relevant interested parties outside the main statutory agencies.

19. The Review Panel agrees it is important to have an intersectional framework to review Nargiza and Marat life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

20. There is an inquest into the death Nargiza and the panel will ensure the DHR process dovetails with the Coroner Inquest.

21. Additionally, while Marat's death occurred after the death of Nargiza, the panel will note that the Prisons and Probation Ombudsman (PPO) is carrying out an

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independent investigation into Marat's death in custody, and that there will also be a Coroner Inquest. The panel will ensure that the DHR process dovetails with the investigation and the Inquest in relation to any information obtained that is relevant to the period under review as part of the DHR.

22. It will be the responsibility of the Chair of the Review to ensure contact is made with the chair of any parallel process.

Membership

23. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

24. The following agencies are to be on the Review Panel:
    a) Bexley Adult Social Care Services
    b) Bexley Children's Social Care Services
    c) Bexley Clinical Commissioning Group (providing the link to General Practice and will link with Greenwich CCG as required)
    d) Bexley Community Safety
    e) Bexley Crisis Intervention Team (including the link to the local Multi-Agency Risk Assessment Conference)
    f) Guy's and St Thomas' NHS Foundation Trust (acute trust and provider of REACH, a domestic abuse service based in the A&E department of St Thomas' Hospital, and employer of Nargiza)
    g) Local domestic violence specialist service provider - Bexley Women's Aid
    h) NHS England
    i) Oxleas NHS Foundation Trust (community health, mental health)
    j) Police (Critical Incident Advisory Team / Specialist Crime Review Group, Bexley Borough Commander Unit and (for first meeting only) Investigation Team and Prison Investigation Team
    k) Substance misuse services SLAM (Substance misuse services)
    l) Victim Support

25. Nargiza and Marat lived in another local authority area (Lewisham) prior to moving to Bexley. The Review Panel considered this and the following agencies are on the review panel:
    a) Lewisham & Greenwich NHS Trust
    b) Lewisham Adult Social Care Services
    c) Lewisham Children's Social Care Services
    d) Lewisham Clinical Commissioning Group (providing the link to General Practice)
    e) Lewisham Community Safety Partnership (providing the link to the local Multi-Agency Risk Assessment Conference)
    f) Local domestic violence specialist service provider -– Refuge

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26. As agreed in paragraph 16 and 17 above the following will be contributing to the review as experts: [the be confirmed]

27. In the first instance, the Chair and Police representative (Critical Incident Advisory Team / Specialist Crime Review Group) will be the panel member with responsibility to ensure good cross communication with the reviews identified in section 21 – 23 above]

Role of Standing Together Against Domestic Violence (STADV) and the Panel

28. STADV have been commissioned by the (local area) CSP to independently chair this DHR. STADV have in turn appointed their DHR Associate (Name of Chair) to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Administrator will provide administrative support to the DHR and the DHR Team Manager will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the STADV DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

29. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

30. Chronologies and Individual Management Review (IMRs) will be completed by the organisations known to have had contact with from 01/01/2008 (when Nargiza arrived in the United Kingdom) to 12/12/2016 (the date of Nargiza's death) (inclusive) and to summarise any agency involvement with Marat prior to this period.

31. Further agencies may be asked to complete chronologies and IMRs if their involvement with Nargiza and Marat becomes apparent through the information received as part of the review.

32. Each IMR will:
    - Set out the facts of their involvement with Nargiza and/or Marat
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

33. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed

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within the partnership which could have brought Nargiza and / or Marat in contact with their agency.

Key Lines of Inquiry

34. In order to critically analyse the incident and the agencies' responses to Nargiza and/or Marat, this review should specifically consider the following points:
    a. Analyse the communication, procedures and discussions, which took place within and between agencies.
    b. Analyse the co-operation between different agencies involved with Nargiza and / or Marat [and wider family].
    c. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d. Analyse agency responses to any identification of domestic abuse issues.
    e. Analyse organisations' access to specialist domestic abuse agencies.
    f. Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g. The extent to which the following protected characteristics or issues had an impact on the case:
        - Race (Nargiza was a national of a Central Asian Republic, as was Marat)
        - Religion and Belief (Nargiza was a Muslim, as was Marat)
        - Sex (Nargiza was Female, Marat was Male)
        - Immigration status
        - so-called 'honour' based violence and abuse
    h. Given the limited contact with services in this case, consideration of what might have helped or hindered engagement in services by Nargiza.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

35. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the relevant Community Safety Partnership on their action plans within six months of the Review being completed.

36. The Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report,

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for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

37. The review will sensitively attempt to involve the family of Nargiza in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Police Family Liaison Officer.

38. The Review Panel discussed the involvement of children in the DHR at the 1st Panel Meeting and have decided it is inappropriate for this review. The panel has considered the following factors; the one child who is resident in the UK was aged 1 year at the time of death, while two other children aged 7 and 5 at the time of Nargiza's death were resident in Central Asian Republic. However, Bexley Children's Social Care will be represented on the Review Panel and, as appropriate, can advise in relation to any issues relevant to the children.

39. It is not possible to invite Marat to participate in the review, given his death shortly after the death of Nargiza.

40. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

41. The Review Panel discussed involvement of other informal networks of Nargiza and / or Marat and agreed it was proportionate to the DHR to invite the friend of Nargiza to be involved in the DHR, as well as any friends of Marat where relevant. In the first instance the Police will provide a list of witnesses who have been interviewed as part of the criminal enquiry and request permission to share their statements with the Review Panel and the Review Panel will also consider whether to invite friends to participate directly in the DHR.

Media handling

42. Any enquiries from the media and family should be forwarded to the Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

43. The Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

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Confidentiality

44. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

45. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

46. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

Disclosure

47. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

48. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        - The review team should be informed about the existence of information relevant to an inquiry in all cases; and

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- The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
- partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   i) It is needed to prevent serious crime
   ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

49. Although a police criminal investigation was begun, the subsequent death of Marat has meant that this has ended. While the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case, and any material gathered in this DHR process could be subject to disclosure to the defense, if it is considered to undermine the prosecution case or assisting the case for the accused, this is therefore not an issue in this case. However, the DHR will need to ensure it dovetails to a number of parallel reviews as noted in paragraphs 20 - 22.

50. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

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Appendix 2: Single Agency Recommendations and Action Plan

Medical Centre

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Ensure new staff have access to Domestic violence IRIS Training	Local					
A significant event analysis will be shared with Practice staff at The Medical Centre	Local					

Guy's and St. Thomas NHS Foundation Trust

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
No recommendations were made.						

Lewisham and Greenwich NHS Trust

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the	Target Date	Date of Completion

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	i.e. local or regional			recommendation		and Outcome
To roll out the set screening questions for domestic violence and abuse at University Hospital Lewisham	Local					
For the Health Independent Domestic Violence Advocate (IGVA) to carry out specific training around risk identification and risk assessment of Domestic Violence and Abuse at both Adult and Paediatric Emergency Departments.	Local					
For the health visiting new birth assessment form to be re-developed to allow an in-depth assessment of the families health needs.	Local (Cross Border)					
For families to be given information on domestic violence and abuse and how to get help at every opportunity.	Local (Cross Border)					
To change practice to	Local (Cross					

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allow for the scope to engage professional curiosity if a client contacts the health visiting service with a problem or issue. For issues identified an action plan must be completed.	Border)					
Improvement in documentation form Guys and St Thomas's NHS Trust (GSTT)	Local (Cross Border)					

London Ambulance Service (LAS)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
No recommendations were made.						

Metropolitan Police

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
No recommendations were made.						

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Oxleas NHS Foundation Trust

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
No recommendations were made.						

REACH (Domestic Abuse Service)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
No recommendations were made.						

Refuge IDVA Service

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Full case information should be shared between both agencies throughout the whole referral process even where the service	Local (Lewisham)					

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has been declined by the victim.						

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Appendix 3: DHR Recommendations and Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1: The UK Government to review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate economic and financial abuse	National					
Recommendation 2: The UK Government should review the cross-government definition of domestic violence and abuse and any associated guidance to incorporate abuse of process	National					
Recommendation 3: GSTT to ensure that there is a clear policy and procedure in place to manage communication between REACH, members of staff who access the service and	Local (Cross Border)					

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their managers. This should strike a balance between confidentiality and consent with the ability of REACH to seek information from or liaise with managers in high risk cases						
Recommendation 4: GSTT to conduct a review of decision making in relation to referral to MARAC within REACH, with particular reference to time frames, the use of professional judgement and how cases are managed when a victim disengages from the service	Local (Cross Border)					
Recommendation 5: GSTT to review pathways to MARACs in London. In doing this, GSTT should prioritize pathways with those areas with the greatest number of patients. As a minimum this should include Lambeth, Southwark and Lewisham	Regional					
Recommendation 6: LAS to review how it can sign up to, and participate in,	Regional					

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MARACs and disseminate guidance to MARACs in London						
Recommendation 7: The Lewisham MARAC should further develop its online profile, to ensure that information and guidance on the MARAC process is as accessible as possible	Local (Lewisham)					
Recommendation 8: The Bexley MARAC should ensure that information and guidance on the MARAC process is made accessible, including online and through the provision of local training	Local					
Recommendation 9: The Lewisham MARAC should conduct an audit of 'no action' cases to identify whether this is an isolated case or whether there is any wider learning that could inform practice at the MARAC	Local (Lewisham)					
Recommendation 10: The Bexley MARAC should conduct an audit of 'no action' cases to identify	Local					

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current practice and consider any wider learning that could inform practice at the MARAC						
Recommendation 11: LGT to review policy and procedure in relation to the use of MARAC flags so these are used consistently	Local (Regional)					
Recommendation 12: LGT to work with Refuge and the relevant commissioners to ensure there is sufficient H-IDVA capacity, and a robust care pathway, within University Hospital Lewisham	Local (Lewisham)					
Recommendation 13: The Bexley CCG to monitor the implementation of its local action plan to improve the response to domestic violence and abuse with GPs and undertake an evaluation to ensure that the local action plan is effective and leads to improved victim outcomes	Local					
Recommendation 14: The Bexley CSP to develop a profile of perpetrators	Local					

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locally and review practice, pathways and training in response to this group						
Recommendation 15: SafeLives to review the definition of a 'MARAC repeat'.	National					
Recommendation 16: The Bexley CSP scopes the requirement for specialist BAME led provision in the borough	Local					
Recommendation 17: The Bexley CSP works with other bodies in London, including MOPAC, to ensure that there is sufficient specialist BAME led provision	Regional					
Recommendation 18: The Bexley CSP should work with the LSCB and SAB to ensure that local single and multi-agency training is sufficient in relation to domestic violence and abuse. Referencing the learning specifically in this case, that would include training in relation to BAME	Local					

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communities and immigration issues.						
Recommendation 19: The Bexley CSP should identify how it can support the raising of awareness of domestic violence and abuse across the public, voluntary and private sector by encouraging employers to develop robust workplace polices to support employees who may be victims of domestic abuse, violence or stalking	Local					
Recommendation 20: Representatives from organisations on the Review Panel that do not have a workplace policy to support employees who may be victims of violence, abuse or stalking to escalate this issue within their organisation so that a robust policy can be put in place.						

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Appendix 4: Glossary

Glossary of terms	
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic
BWA	Bexley Women's Aid
CCR	Coordinated Community Response
CCG	Clinical Commissioning Group
CRIS	(MPS) Crime Recording System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist
DHR	Domestic Homicide Review
FGM	Female Genital Mutilation
FLO	(MPS) Family Liaison Officer
GP	General Practice
GSTT	Guys and St Thomas' NHS Foundation Trust
H-IDVA	Health Independent Domestic Violence Advisor
IDVA	Independent Domestic Violence Advisor
ILR	Indefinite Leave to Remain
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety
LAS	London Ambulance Service
LGT	Lewisham and Greenwich NHS Trust
LTR	Leave to Remain
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MPS	Metropolitan Police Service
NICE	National Institute of Clinical Excellence
NGO	Non-Governmental Organization
NRPF	No Resource to Public Funds
OIC	(MPS) Officer in Charge
REACH	A domestic abuse service based in the A&E of St Thomas' Hospital which is part of GSTT
SAB	Safeguarding Adults Board
SIO	MPS Senior Investigating Officer
STADV	Standing Together Against Domestic Violence
UK	United Kingdom

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