Wandsworth
Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Executive summary
Case of Adult 'Tamseela'

Died: November 2018

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August 2022

EXECUTIVE SUMMARY

This summary outlines the process taken by the Domestic Homicide Review Panel (the Panel) established on 30 January 2020 under section 9 Domestic Violence, Crime and Victims Act 2004 by the Community Safety Partnership in Wandsworth, independently chaired by Gerry Campbell MBE, to review the homicide of 'Tamseela' caused by injuries inflicted in November 2018 by her husband 'Nadim'.

The statutory DHR process began with a meeting on 30 January 2020 of all agencies that potentially had contact with the victim and the perpetrator prior to the death of Tamseela. Agencies participating in the Review were:

i. DHR Independent Reviewer and Chair of the Panel
ii. DHR Independent Reviewer and Support for Panel Chair
iii. NHS England (NHSE) Independent Reviewer
iv. Wandsworth Council's Housing Options
v. Refuge
vi. Victim Support
vii. NHS South West London Clinical Commissioning Group, Wandsworth-Safeguarding adults (CCG)
viii. Metropolitan Police Service (MPS)
ix. South West London and St George's Mental Health NHS Trust
x. Wandsworth Council's Mental Health Social Care Team
xi. Asian Women's Resource Centre
xii. Niche Consultancy (specialising in mental health services)
xiii. Wandsworth Council Community Safety Team

The process ended when the Panel approved a final version of the review report at a meeting on 1 August 2022.

The principal essence of this Review was to establish how well the agencies worked both independently and together, and to examine what lessons could be learnt for the

future. Agencies were asked to review all contact from the ***point of their first contact*** with Tamseela and Nadim to the date Nadim assaulted Tamseela resulting in her death. This timeframe was set to gather and analyse contact between agencies and the individuals concerned with this Review that may have had an effect on the family. Those agencies who had contact were required to complete Individual Management Reviews (IMRs) for submission to the Panel. The terms of reference was shared with the victim's family at an early stage of the DHR process and it was subsequently agreed by the Panel.

The criminal investigation, Criminal Justice proceedings against Nadim and Coronial proceedings touching on the death of Tamseela have now all concluded. In April 2019 Nadim appeared at Croydon Crown Court and pleaded guilty to manslaughter on the grounds of diminished responsibility, which was accepted. He was sentenced to a Section 37[1] Hospital Order with restrictions under Section 41[2]. Psychiatrists agreed that Nadim was suffering from severe depression with psychotic symptoms, and he was sentenced under section 37 of the Mental Health Act 1983 to a Hospital Order with Section 41 special restrictions that are 'without a time limit'. Nadim's sentence means that a court decided that instead of going to prison Nadim should be in hospital for treatment of a serious mental health problem. A Section 37 is called a "hospital order". The judge decided that due to concerns for public safety Nadim needs to also be subject to a Section 41, which is known as a "restriction order". Section 41 of the Mental Health Act 1983 states that a person cannot be discharged from hospital unless the Ministry of Justice or a Tribunal says that person can leave, and their discharge may be subject to certain conditions.

The HM Coroner's Court Inquest took place over 2 days in September 2020 and was presided over by Dr Shirley Radcliffe. The Inquest, which was attended by Tamseela's sister, one of her nephews and the DHR Chair took place virtually via Microsoft Teams.

[1] **Section 37 Mental Health Act (hospital orders).** After conviction in the criminal courts, the court may by order authorise admission to, and detention in, a specified hospital. The court may also place the subject under the guardianship of a local social services authority or another person approved by a local social services authority.

[2] **Section 41 Mental Health Act.** Restriction Order means the Secretary of State decides when you can be given leave and when you can leave hospital. If it is agreed that you can leave hospital, conditions will be attached to your discharge.

The Inquest concluded with a verdict of Unlawful Killing.

Background information (The Facts)

In early November 2018 Nadim was discharged from the care of the Wandsworth Home Treatment Team (HTT) following a mental health episode and continued to live with Tamseela. This was the last time that Aleena (Tamseela's sister) spoke to Tamseela. Tamseela was out of the house at the time shopping. Tamseela's sister Aleena and her nephew Hussain made several attempts at different times to call her. On 12 November at 8.14pm Nadim called Aleena back using Tamseela's phone to say that she had gone to an Islamic woman's meeting and that she would be back later. Aleena called again a few times but was told by Nadim that she was either cooking, praying or sleeping and to call back the following day. Aleena became increasingly concerned so she asked her sons Hussain and Tariq to drive her to Tamseela's address to check on her wellbeing; she was extremely worried knowing the situation with Nadim's mental health.

Aleena remained in the car whilst Hussain and Tariq called Nadim on his mobile phone and went to the front door. Nadim greeted them and said that their Aunt Tamseela was sleeping. Hussain entered the flat and looked in the bedroom to check on Tamseela while Tariq waited with Nadim by the entrance door. Hussain found Tamseela lying on the bed covered completely with a light brown blanket. He pulled the blanket from her head and saw that she was badly injured. He tried to find a pulse, but her body felt cold to the touch. He began to shout and scream that his aunt was dead, and that Nadim had killed her. Family members detained Nadim at the door. Aleena remained outside of the address. They then all walked out towards the front garden area of the address from where they called Police. Nadim said nothing and made no attempt to leave the scene.

On 13 November 2018 a post-mortem examination was conducted at St Georges Hospital, Tooting, London. This revealed that Tamseela had suffered extensive assault injuries including 'defensive injuries'. It was concluded that the cause of death was likely to be due to an assault with a blunt instrument potentially causing her to fall unconscious.

A number of lessons have been learned by the Southwest London and St George's Mental Health Trust (the Trust) because of this incident, but they were not causative. The key lessons include:

- Two members of the HTT staff did not appear to know that they should have been selecting self-administered not witnessed on JAC (the Trust's electronic prescribing system) instead of self-administered.
- There was no system in place for HTT staff to be aware of when the patient's medication was due to run out and when it should be ordered.
- Had the HTT team been able to access information from IAPTUS they would have been aware that the patient's depression was not getting better, which could have influenced their clinical picture of the patient.
- Some of the HTT team members were not aware that they could have conversations with families and carers even when a patient has withheld consent to enable them to listen to families rather than pass on any information without the patient's permission. The Trust reports that the HTT staff have had further training on Information Governance and Safeguarding Adults.
- Guidance on how to access translation services to be made available on the Trust's Intranet.

The Metropolitan Police Service (MPS) had two contacts with Tamseela and one with Nadim individually during the scope period of this review. The incidents of crime involving Tamseela as a victim were recorded and where possible investigated proportionately under the circumstances and in line with the current and relevant MPS policy and guidance (Home Office Crime Reporting Standards[3]). There were no concerns of Domestic Abuse (DA) between Tamseela and Nadim known or reported to police at any time, nor were there any concerns of such abuse between Tamseela and her former husband MS. The MPS response to such incidents, in particular in relation to support for BAME women in this case can therefore not be commented upon.

[3] Create a CRIS where initial investigation or information is sufficient to determine or to believe that a notifiable offence has been committed.

In relation to the Mental Health Episode with Nadim he was identified by Police as being a vulnerable Adult at Risk[4] and a Police Merlin report was created, and the appropriate risk assessments applied in line with current Multi-Agency Safeguarding Hub (MASH) guidance. This information was correctly supervised and shared with Social Services within the correct time frame which was good practice. No recommendations for the MPS have been made from their analysis.

Given the UK national prevalence and impact of DA, preventing and tackling it is everyone's business. Given this prevalence, the DHR Reviewers advocate community driven solutions within a whole system approach to sustainably tackle DA. Communities and individuals must be motivated and want to change their attitude and behaviour and drive that change. Specifically, family members, friends, work colleagues, employers, educators, neighbours, faith communities of perpetrators and victims of DA as well as other members of the public are well placed to be 'Active Bystanders', that is to take positive action when they see the signs or 'red 'flags' of abuse, see the abuse as a problem and are then motivated to do something about it.[5] Such positive action can be safely and effectively intervening, which can also involve calling the police.[6] An 'Active Bystander' Programme is an effective prevention and intervention approach to tackling DA. The work of the Australian Human Rights Commission has identified 3 forms of prevention long the continuum of an abusive relationship:[7]

[4] Metropolitan Police Service definition for vulnerability for all adults.
Vulnerability may result from an environmental or individual's circumstance or behaviour indicating that there may be a risk to that person or another. Those who come to notice of the police as vulnerable will require an appropriate response and should include appropriate multi-agency intervention especially where they come to repeat notice of police. Additional factors to vulnerability may include mental health, disability, age or illness.

[5] Public Health England, Bystander interventions to prevent intimate partner and sexual violence: summary (December 2020) accessed via https://www.gov.uk/government/publications/interventions-to-prevent-intimate-partner-and-sexual-violence/bystander-interventions-to-prevent-intimate-partner-and-sexual-violence-summary

[6] Public Health England, Bystander interventions to prevent intimate partner and sexual violence: summary (December 2020) accessed via https://www.gov.uk/government/publications/interventions-to-prevent-intimate-partner-and-sexual-violence/bystander-interventions-to-prevent-intimate-partner-and-sexual-violence-summary

[7] Australian Human Rights Commission, Part 4 Bystander interventions in violence prevention accessed via https://humanrights.gov.au/our-work/part-4-bystander-interventions-violence-prevention

(i) 'Primary prevention. Before the violence has occurred to prevent initial perpetration or victimisation.

(ii) Secondary prevention. Once the problem has begun to deal with the short-term consequences of violence, to respond to those at risk and to prevent the problem from occurring or progressing.

(iii) Tertiary prevention. Responding afterwards: *Tertiary* prevention

a. Long-term responses *after* violence has occurred to deal with the lasting consequences of violence, minimise its impact and prevent further perpetration and victimisation.'

As part of an Active Bystander Programme, it is of fundamental importance that community members are equipped with the knowledge of recognising the signs and what the Reviewers call the 'red flags' of DA. In addition, community members must also be advised what to do next; such as calling the police, signposting the victim and / or the perpetrator to specialist support services. That said, Bystander Programmes don't operate in isolation and complement other schemes and initiatives such as an Employers' Initiative and a Safe Spaces Scheme. An example of a more focussed Employers' Initiative and complementary Safe Spaces Scheme can be found in the London Borough of Hillingdon.[8]

Further to the aforementioned, and germane to the circumstances of this DHR, the perpetrator's employer and the perpetrator and victim's faith community played a vital role. Faith leaders have an equally vital role alongside a Bystander approach to raise awareness and understanding of gender equality and tackling inequalities, human rights abuses and criminality and using religious scripture to effectively reinforce educational and preventive messaging.

Wandsworth Council and its local statutory partners must work alongside faith leaders and faith communities as critical gateways in accessing otherwise 'failed to reach' minority communities who are exposed to domestic violence and abuse, where the risks are high, and their experiences of violence are often intersecting and overlapping

[8] More information about the Workplace Safespaces scheme can be found by visiting https://workplacesafespace.org/about

(Thiara, 2012). The US academic Kimberle Crenshaw states that structural intersectionality describes the multiple layers of oppression experienced by women of colour due to both their race and gender (Crenshaw, 1991).

Research shows that the level of disclosure for black and minority ethnic (BME) victims of DA is far lower than that of the general population (Walby & Allen, 2004), exposing victims to repeat offending and greater risk and harm. There are many causes for this including exposure to honour based violence, multiple perpetrators including family and community members, immigration status, no recourse to public funds and in a quarter of cases the requirement for an interpreter, all of which act as barrier(s) to accessing information or the assistance of support services.[9] BME communities cite the reason for not reporting abuses nor asking for the support they need is for fear of bringing shame and dishonour upon their families and community and / or the fear of being misunderstood by services. [10]

Faith Leaders are important role models in BME and other communities as a source of pastoral care and spiritual support and guidance for victims of DA as well as to the wider congregation. In addition, places of worship have ~~also~~ long been places of safety, security and refuge. Such an approach can be best complemented and balanced by secular based specialist support organisations. Furthermore, It is recognised that abusers may 'weaponise' their religion and justify their abusive behaviour by reference to scripture.[11] The Panel recommends that Wandsworth

[9] https://safelives.org.uk/practice_blog/supporting-bme-victims-–-what-data-shows

[10] Safelives, Breaking the Silence within Communities and Service Providers (May 2017) accessed via https://safelives.org.uk/practice_blog/breaking-silence-within-communities-and-service-providers

[11] Leveraging faith to Help End Domestic Violence: Perspectives from Five Traditions, Social Work & Christianity, Vol. 44, No. 4 (2017), 39–66 Journal of the North American Association of Christians in Social Work accessed via http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=6&sid=ce5a996a-f357-4f7b-a461-e250ab4fc4c2%40sessionmgr4006

Council further develops its inclusive engagement approach with local faith communities to improve awareness of preventing and tackling DA and mental health.

Adult Social Care should have also seen beyond the Police Merlin Report on 16 October 2018 to look beyond Nadim's mental health and the impact on Tamseela as carer in these circumstances, particularly considering her previous requests for support with her deceased husband eight years earlier. The Panel considered whether Adult Social Care would have had access to the previous information in relation to 2010.

Nadim and Tamseela's attendance at the GP surgery did not involve the use of independent interpretation services. Tamseela interpreted and spoke on behalf of her husband without investigation by the GP. Tamseela spoke to her GP in Urdu. Whilst the surgery has access to interpretation services, the absence of professional curiosity prevented the GPs from exploring Nadim's unhappy presentation and Tamseela's complaints regarding her new husband.

The GP surgery had also not identified that Nadim and Tamseela were not living together in October 2018.

The Panel has not identified any best practice in this Review. During the DHR process, it is noteworthy that the council has achieved DAHA accreditation and White Ribbon Status.

Conclusions from the Review

This Review has identified all the public bodies involvement with the victim, the perpetrator, and their family. The circumstances revealed in this Review reinforce the need for improvements in professional practice and service delivery by individual agencies and by the Community Safety Partnership. The recommendations below are, in the main, for the partnership as a whole but organisations have identified internal recommendations that mirror or otherwise complement these. It is suggested that the single agency action plans should be the subject of review through its governance, scrutiny, and review processes.

Recommendations

The recommendations below are, in the main, for the partnership as a whole but organisations have identified internal recommendations that may replicate or otherwise complement these. It is suggested that the single agency action plans should be the subject of review via the Review Action Panel, hence the first recommendation.

Recommendation 1: That relevant agencies report progress on their internal action plans to the relevant panel of the Wandsworth CSP's governance structure

Recommendation 2: That the learning from this review and other DHRs are embedded within and informs the action plan that underpins the new VAWG Strategy 2022-25

Learning Point – The learning from this review requires integration across the Borough's partnership's approaches to prevent and tackle DA and to ensure that a sustainable approach is taken to learning lessons from Tamseela's death.

Recommendation 3: That the Wandsworth CSP develops and enhances its higher level VAWG Strategic Group including its membership, which provides the governance and strategic direction of the partnership's approach to preventing and tackling domestic abuse

Learning Point - The Borough has initiated a VAWG Strategic Group, which is in its infancy. The Borough is seeking to develop the membership of this Strategic Group further. It is acknowledged that additional work needs to be undertaken to secure engagement and ~~the~~ buy-in from local partners. This recommendation is to be read in conjunction with the requirements under the Domestic Abuse Act 2021 regarding the development of a Local Partnership Board.

The VAWG Strategic Group is required to provide the necessary governance, oversight and provide clear direction to the partnership in its work to prevent and tackle domestic abuse and other forms of VAWG in a sustained way.

Recommendation 4: That the Wandsworth CSP conducts an Equalities Needs Assessment to better understand domestic abuse victimisation and inform commissioning of services, service provision, partnership activity, communication, and engagement strategies.

Learning Point – This review has highlighted the need to develop community engagement to raise awareness with, and to enable marginalized communities to identify DA and to access DA specialist services. The helpful contribution from the AWRC has placed the spotlight on the requirements for the borough to consider how this engagement can be achieved. The engagement with communities will also provide information and evidence of the barriers to reporting and in accessing services.

Recommendation 5: That the Wandsworth CSP develops a strategy, which vividly encapsulates the prevention, early intervention, partnership priorities and its approaches to tackling DA.

It is of note that Wandsworth Council has developed an updated VAWG Strategy 2022 – 2025, whilst this DHR was underway. A borough or local area should have one main VAWG or DA strategy, which unite the partnership organisations and their resources in talking violence and abuse in a consistent and unified way. A singular strategy provides for a common understanding and approach for the which stakeholders can be held accountable to.

Recommendation 6: That the South West London and St George's Mental Health Trust should ensure that retraining and /or the conduct of refresher training takes place for the WHTT staff on the JAC[12] guidance to ensure compliance with their medicine monitoring regime.

Recommendation 7: That the South West London and St George's Mental Health Trust staff do not document compliance with medication until:

[12] JAC is Electronic Prescribing and Medicine Administration

a. **they have checked compliance or asked the patient if they have taken their medication on each visit; and**
b. **clarified when further stock is due.**

Recommendation 8: That the South West London and St George's Mental Health Trust:

a. **review its communication processes with the primary healthcare trust to ensure smooth channels of communication; and**
b. **where staff experience difficulty logging onto IAPTUS, they should contact the service to request a print-out of the clinical record**

Recommendation 9: That the South London and St George's Mental Health Trust should ensure that clear guidance is provided to their staff detailing the policy in relation to the use of and access to interpretation services for patients.

Recommendation 10: That the South London and St George's Mental Health Trust should ensure that the Commissioned Interpretation Services are readily available to meet staff requirements in delivering a high-quality service to patients and their families. This may require contract or inclusion in contract monitoring methodology.

Recommendation 11: That the South West London and St George's Mental Health Trust review the implementation of guidance provided to staff regarding the conversations that can take place with family members regarding a patient; obtaining collateral information, where the patient has withheld consent.

Learning points – This review together with the NHSE root cause analysis has identified the requirements for change and learning within the South London and St George's Mental Health Trust. The absence of use of interpretation services for key appointments with Nadim is noteworthy, and the resulting reliance on Tamseela as interpreter with her limited English. Patients should have access to language interpretation services to enable a full and clear account of their symptoms and presentation to be shared with medical professionals. Additionally, the health care professionals should have access to such interpretation services so that they can more

effectively communicate with patients and family members as required to discharge their responsibilities. This should be detailed in the Trust policy and staff training conducted to increase understanding of why this is a priority. There are inherent risks in using family members as interpreters. Nadim's compliance with medication was not monitored and the lack of policy detailing the Trust's approach is apparent. The lines of communication across the Trust were not always clear resulting in a lack of connectivity of information.

Recommendation 12: That the Wandsworth Council Adult Social Service develops a staff practice guidance on the 'Needs of Carers' to empower staff to exercise professional curiosity to enable them to adopt a more holistic approach in their day-to-day practice.

Learning Point – The Police Merlin Report on 18 October 2018 was not prioritised or acted upon. Staff should have considered the impact of Nadim's mental health on his household members, namely Tamseela.

Recommendation 13: That the Wandsworth Community Safety Partnership enhances its engagement with the borough's BAME communities and older people and representative support groups to improve awareness of domestic abuse and accessibility to specialist support services.

Learning Point – This review has highlighted the need to develop community engagement to enable marginalised communities to access DA services. The helpful contribution from the AWRC has placed the spotlight on the requirements for the borough to consider how his engagement can be achieved. Communities should be informed that DA is a criminal offence, the referral pathways, and the red flags of presentation. Research has shown that marginalised communities including older people are less likely to recognise and report the violence and abuse that they are experiencing and less likely to access services.[13] This is further exacerbated if the older person is from a diverse cultural background. It is further recognised by the DHR Reviewers that BAME people are not a homogeneous group, and their experiences

[13] SafeLives Spotlight #1: Older people and domestic abuse accessed via https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

and identities differ widely. If this is not recognised, then victim's intersectional differences and needs will not be adequately or effectively addressed.

Recommendation 14: That the Wandsworth CSP works with the Borough's faith communities to review their safeguarding approaches notably in relation to marriage introductions and to raising awareness of preventing and tackling domestic abuse.

Learning Point – Faith organisations provide a vital role in communities including pastoral support. This review has highlighted the need to develop engagement with faith communities to access DA services. The helpful contribution from the AWRC has placed the spotlight on the requirements for the borough to consider how his engagement can be achieved. Communities should be informed that DA is a criminal offence, the signs and 'red flags' of abuse and the referral pathways to support services.

Recommendation 15: That the Wandsworth CSP considers adopting a local employers' initiative to increase the awareness of local employers and co-workers of mental health and domestic abuse including prevention, signs and 'red flags' and referral pathways.

Learning point – The perpetrator Nadim was employed at the mosque where he was a worshipper and a member of the security team. Whilst being so employed he displayed signs of mental illness. Evidence suggests that workplaces can offer safe places for victims/survivors of DA as well providing support to them and to perpetrators. Employers and co-workers provide an important role in supporting victims and survivors whilst also recognising the signs and red flags of abuse, and referrals to specialist organisations. Tamseela was unhappy in her marriage to Nadim and had disclosed so to her sister and possibly to another woman at the mosque. There is a role for a wider active bystander program to be implemented across the borough, which should encapsulate an employers' initiative.

Recommendation 16: That the GP practices and other healthcare providers involved in the DHR should audit their compliance with the National Institute for Health and Care Excellence guidance on *Domestic violence and abuse: multi-agency working (*Public health guideline [PH50]) and act on their findings.