Wandsworth
Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Overview report
Case of Adult 'Tamseela'

Died: November 2018

Authors: Gerry Campbell MBE and Neelam Sarkaria
August 2022

The Authors and the Domestic Homicide Review Panel would like to express their sympathy and their sincere condolences to the family for the loss of a loved sister and aunt. The Independent Chair and Authors of this review would like to thank the family, friends, professionals and others who contributed to this review. The Independent Chair would also like to thank the Domestic Homicide Review (DHR) Panel's members and the Authors of the individual agency reports for their valuable time and thoughtful deliberations, which have contributed to the findings of this review.

The DHR Panel would also like to extend its gratitude for the kind support of the Wandsworth Community Safety Team for providing key administrative support.

Abbreviations

A and E	**Accident and Emergency**
BAME	**Black, Asian, Minority Ethnic**
DA	**Domestic Abuse**
DAHA	**Domestic Abuse Housing Alliance**
HTT	**Home Treatment Team**
IAPT	**Improving Access to Psychological Therapies**
IDVA	**Independent Domestic Violence Advocate**
IMR	**Individual Management Review**
LAS	**London Ambulance Service**
MASH	**Multi-Agency Safeguarding Hub**
MH	**Mental Health**
MPS	**Metropolitan Police Service**
NHSE	**National Health Service England**
OT	**Occupational Therapy**
VAWG	**Violence Against Women & Girls**
WHTT	**Wandsworth Home Treatment Team**
WSPA	**Wandsworth Single Point of Access**

Contents

Please note, the Executive Summary is a standalone document to this report.

1. Preface

1.1 Introduction

1.1.1 This report of a Domestic Homicide Review (DHR) hereinafter referred to as 'the Review', examines the agency responses and support given to Tamseela (not her real name), a resident of Wandsworth prior to her death, which took place between specific dates in November 2018 resulting from an attack in her home by Nadim. The exact date of Tamseela's death has not been established, although during a mental health assessment at the police station following his arrest, Nadim stated that he attacked his wife. Tragically, Tamseela's deceased body was discovered later by her relatives at her home.

1.1.2 In addition to agency involvement, the review also examined the past to identify any relevant background or activity before the homicide, whether support was accessed within the community and whether there were any individual or structural barriers denying or preventing the relevant parties from accessing support. By taking a holistic approach the review sought to identify learning and appropriate and effective solutions to support making the future safer.

1.1.3 The review considered agencies contact/involvement with Tamseela and Nadim from the beginning or the first contact with statutory agencies up to the discovery of her body on. The review has included relevant facts from their earlier life in the background information.

1.1.4 These events led to the commencement of this review, which was commissioned by the Wandsworth Community Safety Partnership. The inaugural Panel meeting was held on 30 January 2020, which was supported by numerous meetings to actively consider the circumstances of Tamseela's death.

1.1.5 The key purpose for undertaking this review was to:

a) 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;

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse (DA) is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse;

and

f) highlight good practice.

One of the operating principles of this review has been to be guided by compassion, empathy, and transparency with Tamseela's 'voice' and that of her extended family at the heart of the process.

1.2 Timescales

1.2.1 The Wandsworth Community Safety Partnership (CSP), in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' (hereafter 'the statutory guidance') commissioned this review.

1.2.2 Gerry Campbell (supported by Neelam Sarkaria) was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review. The completed report was handed to the CSP in August 2022. It was subsequently submitted by the CSP to the Home Office Quality Assurance Panel.

1.2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended due to covid 19 pandemic. The initial meetings were held face to face and subsequent meetings online. This has not diminished the effectiveness of the Panel

and facilitated more meetings than initially anticipated over this period resulting in effective participation.

1.2.4 The first Panel meeting was held on 30 January 2020 to ensure agencies could attend.

1.3 Anonymity

1.3.1 In order to maintain anonymity, the various parties referred to in this review have been provided with alternative identities, also known as pseudonyms and which have been identified by the participants in the review or as in the case of the victim, the victim's sister. The use of pseudonyms also supports and empowers individuals to participate in the review.

- Victim - Tamseela
- Perpetrator - Nadim
- Victim's Sister - Aleena
- Victim's Brother-in-Law - Altaf
- Victim's nephew 1 - Tariq
- Victim's nephew 2 - Hussain
- Perpetrator's Cousin - Ali
- Neighbour 1 - Jenny
- Neighbour 2 - Joe
- Mosque/Nadim's employer representative - Sulman

1.4 Confidentiality

1.4.1 Details of confidentiality, disclosure and dissemination were discussed and agreed, between the Domestic Homicide Review Panel ('the Panel') members during the inaugural Panel meeting on 30 January 2020. The Panel agreed that all information discussed at its meetings was to be treated as confidential and not disclosed to third parties without the agreement of the Panel Chair and the responsible agency's representative

All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

1.4.2 The information communicated between agencies and the Panel was password protected.

1.5 Equality and Diversity

1.5.1 The nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation) as defined by the Equality Act of 2010 have all been considered within this review. The review identified that the relevant characteristics which applied to Tamseela include race, religion, and sex, and considered whether such characteristics resulted in a barrier to accessing services. In addition, consideration was also given to whether Tamseela's birth nationality (Pakistani) and culture were also factors.

1.5.2 Tamseela was female, of Asian Pakistani origin born in February 1956 into the Ahmadiyya faith (a sect of Islam). Her religion formed a key part of her lifestyle and the way she lived her life. Tamseela undertook charity work to support her faith community and followed the principles of Tahrik Jadid, which are detailed below.

1.5.3 Nadim was born in January 1952 and is Asian Pakistani too. He has also been raised in and practices the Ahmadiyya faith.

1.5.4 Tamseela and Nadim were known in the local Ahmadiyya Community.

1.5.5 The Asian Women's Resource Centre (AWRC) has provided a description of the Ahmadiyya Community (Appendix 3). The community describe themselves 'Muslims who believe in the Messiah, Mirza Ghulam Ahmad (1835-1908) of Qadian.' (www.alislamorg). According to Mirza Ghulam Ahmad he was the second coming of Jesus Christ and the last Mahdi, which is written in Qur'an too. The Ahmadiyya Community believes that with the Messiah/prophet Mirza Ghulam Ahmad, amongst

other matters he would bring the peace to the World. The Community is ruled by the Khilafat (the spiritual institution of successorship to prophethood) and the 5th Khalifa Mirza Masroor Ahmad resides in the UK. The Ahmadiyya Community has more than 15,000 mosques, nearly 1000 schools, its own hospitals and a 24-hour satellite TV channel (MTA). This is supported by a website; www.alislam.org, a publication (Islam International Publications) and an international charity Humanity First.

1.5.6 The Ahmadiyya also follow the Tahrik Jadid scheme, founded by the second Khalifa Hadhrat Khalifatul Masih on 23rd November 1934. According to the Tahrik Jadid, a follower 'must decide how and how much sacrifice they can do for defending the community'. According to the Tahrik Jadid, the community must follow the following principles:

- Lead simple lives;
- Spread the word of Islam to the world;
- Dedicate their lives to the sake of the Islam and to God and fulfil duties to God for example praying and fasting;
- Dedicate their holidays and all their free time for the benefit of their community and charitable work;
- Ensure that the children are raised in Waqf (devotion);
- The Ahmadiyya, who cannot work, also have to offer themselves to the community;
- The Ahmadiyya should dedicate a 5th of their income (as a minimum) to their communities;
- They are very close-knit communities, and they feel that non-believers are not Muslim;
- Women are seen as upholders of religion.

According to Tahrik Jadid, the Ahmadiyya are forbidden to attend cinemas, theatres, circuses and must live a simple lifestyle e.g. in the food they eat, their dress, their housing and so forth.

1.5.7 The headquarters of the Ahmadiyya moved to London in 1984 following an announcement by the Pakistani President Zia-ul-Haw to criminalise Ahmadis calling

themselves Muslims and using Muslim practices in worship. Ahmadis are considered a religious minority and persecuted for their beliefs in Pakistan and in other countries and regions around the world. The DHR Reviewers were of the view that Tamseela's faith could also be an isolating factor for her. This factor is equally applicable to Nadim who had fled Pakistan citing religious persecution, although the review has not seen direct evidence of this in the UK.

1.5.8 Tamseela's experience as an Asian female, previously widowed, devout follower of her faith and re-marrying provide a unique intersectional lens of her life. She married three times, and this may have been viewed as an 'unusual occurrence' within her culture and faith community. Although this perception is not readily overtly evidenced.

1.5.9 There is evidence that Tamseela experienced organisational and individual barriers to receiving services, which she could reasonably have expected to access. Such barriers related to her sex, age, faith and marital status, which were exacerbated by language. Whilst she had engaged with services and sought assistance e.g., occupational therapy, medical services for herself and her partners, these were affected by language barriers. English was not Tamseela's first language and there is no evidence of her being provided with an interpreter in relation to her own healthcare. Critically, as she grappled with the complexities of Nadim's mental health, the Home Treatment Team (HTT) professionals were providing her with complex information in English in the vital first meetings with them which she may not have understood fully. An interpreter, which included by a health care professional with Urdu language skills was provided in 5 of 14 meetings.

1.5.10 As a widowed woman in the Ahmadiyya faith Tamseela was disempowered and isolated. Her sense of isolation and loneliness was exacerbated when her home was burgled. Through her mosque a male suitor - the perpetrator, was identified as a match for Tamseela for marriage. Both Tamseela and Nadim were older in age and both had lost their respective spouses to ill-health. This match making process was male driven, although it seems that both parties were content with the arrangement and union.

1.5.11 In a similar vein, Nadim experienced organisational and individual barriers to services, which he could reasonably have expected to access. As a man, he was faced with individual barriers relating to his sex, age, mental ill-health, faith, and his English language ability. He was experiencing deteriorating mental ill health, whilst in the UK, and there is some evidence of him receiving medical treatment in his birth country, Pakistan. Nadim's deteriorating health was becoming evident in the home, where he was isolated, and work environments, yet he was unable, unwilling or unaware of how to ask for medical assistance in the UK. This was initiated by his wife Tamseela or his cousin Ali. On a visit to his GP surgery Nadim was pointing to his head, unable to articulate what he was experiencing. He did not have the benefit of an interpreter, which ought to have been provided via language line or similar.

1.5.12 It is more likely than not that Nadim's sense of shame due to losing his employment, his inability to financially support Tamseela and his deteriorating mental health driven by cultural expectations and perception further exacerbated his isolation at home.

1.5.13 In addition, Nadim did not receive the required support and assistance at his place of worship, which was also his place of employment as a low paid security officer. The mosque was an integral part of his life due to his faith. Notwithstanding his regular attendances, Nadim's workplace were aware or had suspicions that he had deteriorating ill health. His eventual removal from workplace suggests that his mental health did eventually result in the termination of his employment. There is little evidence that indicates that he was provided with the requisite occupational advice and support in the employment setting.

Domestic Abuse and Domestic Abuse Homicide

1.5.9 The Domestic Abuse Act 2021 creates a statutory definition of DA, emphasising that DA is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse.

1.5.10 DA is a form of Gender Based Violence/Abuse whereby women are disproportionately victimised by men who are disproportionately the perpetrators. Whilst there is data in this field, it is recognised that DA alongside other forms of

gender-based violence/abuse is both under-reported and under-recorded. There are two sources of data, which highlights part of the picture - that provided by the Police Forces in England & Wales and the Crime Survey for these countries.

1.5.11 The 42 Police Forces in England and Wales recorded a total of 1,316,800 DA related incidents and crimes in the 12 months to year ending March 2019.[1] This represents an increase of 118,706 from the previous year.

1.5.12 Of the DA related incidents and crimes recorded in the year ending March 2019, the majority – 746,219 (or 57% of the total) were recorded as DA crimes i.e., offences against the law.[2]

1.5.13 Such offences include murder, violence against the person (including grievous bodily harm, wounding), threats to kill, rape, other sexual offences, harassment, stalking, coercive control, criminal damage, theft, fraud and so forth. The remaining 43% represent non-crime DA incidents, which although recorded by the police, do not amount to a crime. For example, an incident could be an argument without threats in a private place e.g. a home address and when seen in isolation.

1.5.14 Just over one-third (35%) of the 1,671,039 violence against the person offences / crimes recorded by the police in the year ending March 2019 were DA-related.

1.5.15 In contrast the Crime Survey of England and Wales for the aforementioned period, reports that 2.4 million women and men aged 16 – 74 years old state that they have experienced DA in the previous 12 months; 1.6 million women and 786,000 men. This equates to a prevalence rate of approximately 6 in 100 adults.[3] In short, in the last year women were more likely than men to be the victims of DA, which accords with the wider victimisation gender-based violence landscape.

[1] This date range is relevant to the time that this homicide took place.
[2] This volume of crimes has increased by 24% compared to the previous 12 months' period.
[3] ONS, Domestic abuse victim characteristics, England and Wales: year ending March 2019 accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

1.5.16 During the period reported (as above), woman aged 20 – 24 were more likely to be offended against as were men aged 16 – 19 years. In addition, the data also highlights that a higher percentage of adults experienced abuse carried out by a partner or former partner than by a family member.[4]

1.5.17 Whilst the Domestic Abuse Act 2021 (and the cross-government definition at the time of the homicide) refers to a minimum age of victims, there is no upper age limit. In 2017 the Crime Survey for England and Wales increased the age range for the self-completion module from 16 – 59 to 16 – 74 years.

1.5.18 The inclusion of the 60 – 74 age range saw an increase in the number of people reporting having experienced in 2017 (year of introduction), 2018 and 2019. In 2019, the overall prevalence rate of DA involving victims aged 60 – 74 years was 3.2%, which increased to 4.9% for women.[5] Research highlights that older people are likely to live with DA for prolonged periods of time.[6] This is exacerbated by 'systemic invisibility' as SafeLives research indicates that as older people are not accessing services for DA, there is a tendency amongst professionals to believe that older people do not experience DA.[7] In addition, victims aged 61+ years are more likely to experience abuse from a current intimate partner.[8]

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[4] ONS, Domestic abuse prevalence and trends, England and Wales: year ending March 2019. Prevalence, long-term trends, and types of domestic abuse experienced by adults, based on findings from the Crime Survey for England and Wales, and police recorded crime accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2019

[5] ONS, Dataset, Domestic abuse prevalence and victim characteristics – Appendix tables accessed via https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables

[6] http://safelives.org.uk/practice_blog/its-our-right-be-safe-any-age-how- can-we-make-it-easier-older-victims-get-help

[7] SafeLives, Spotlights report, Safe later lives; Older people and domestic abuse accessed via https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

[8] SafeLives, Spotlights report, Safe later lives; Older people and domestic abuse accessed via https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

1.5.19 The same 2019 Crime Survey report highlights that the prevalence rate of DA involving Asian or Asian British Pakistani women and men is 3.5%, which increases to 5.3% for women.[9]

1.5.20 In addition, the survey also highlights that the prevalence rate of DA for people of the Muslim faith is 3.7%, which increases to 5.3% for women.[10]

1.6 Terms of Reference

1.6.1 The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both by themselves and together, and to examine what lessons can be learnt for the future to prevent similar tragedies. Agencies were asked to review all contact from the *point of their first contact* with Tamseela and Nadim but will focus in particular (but not exclusively) on the period from 1 January 2014, or the first contact with the relevant agency, to the period of time of Tamseela's homicide. This timeframe was set to gather and analyse contact between agencies and the subjects of this review that may have had an effect upon the family. Those agencies that had contact were required to complete Individual Management Reviews (IMRs) for submission to the Panel.

1.6.2 The Key Lines of Enquiry identified for this review include:

- What signs or signals that could indicate that Tamseela was experiencing DA or any other abusive behaviour including coercive control from Nadim or another person? What was the power and control dynamic? Was there a cultural and/or religious aspect(s) to this?

- What was your agency's response to effectively assessing, identifying, and planning to meet Tamseela's needs and identify if opportunities were missed to identify risks faced by Tamseela? What individual and/or structural barriers affected this if any? Consider if culture and/or religion affected this in anyway?

[9] Ibid
[10] Ibid

- How did your agency effectively identify what Nadim's on-going needs were? What plans were arranged to meet his short – long term needs. Was Nadim receiving a coordinated level of service and how was this influenced by any potential cultural, religious and/or language barriers in your agency's delivery of services if any?

- How did your agency identify whether those living with Nadim required support from public authorities and/or voluntary sector? What individual and / or structural barriers affected this if any?

- Identify whether there were any cultural or religious issues or practices, which may have led to Tamseela being exposed to the risk of violence or abuse.

- How well did your agency "see beyond" the immediate sphere of professional and legal requirements – including statutory duty, in the provision of your services? Was any action limited by policy and / or practice?

- For professionals working with Nadim what were the signs and signals that could indicate there was [1]domestic violence / abuse including coercive control in his intimate partner and / or intra-familial relationships

- How effective is your public authority, agency, or voluntary organisation in promoting support for Black, Asian and Minority Ethnicity (BAME) women by raising awareness, preventing and/or tackling DA and equipping them to access support services? How is this promoted within communities?

Further to the previous point, what works well (and why) and what could have been improved by your agency's approaches and responses?

1.6.3 Tamseela's family had sight of the review's Terms of Reference.

1.7 Methodology

1.7.1 The approach adopted was to seek IMRs from all organisations and agencies that had contact with Tamseela and Nadim after they had provided chronologies. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the main individuals involved. Details of those agencies providing IMRs are identified in this review report.

1.7.2 Once the chronologies and IMRs were provided, panel members were invited to review them all individually, and then confidentially discuss the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored.

1.7.3 A consolidated chronology is highlighted later in this report.

1.7.3 The AWRC were also invited to answer key questions at the request of the panel to inform this DHR. Their report is attached at Appendix 3.

1.8 Contributors to the Review

1.8.1 Local and regional agencies were contacted to establish if they had contact either with the victim and/or perpetrator:

- Refuge
- Victim Support (Wandsworth Safety Net)
- Probation Service
- Community Rehabilitation Company (CRC)
- Wandsworth Drug and Alcohol service
- Southwest London and St George's Mental Health NHS Trust
- Chelsea and Westminster Hospital NHS Foundation Trust including West Middlesex Hospital
- Merton and Wandsworth Clinical Care Group Continuing Healthcare Team

- Central London Community Healthcare NHS Trust
- London Ambulance Service NHS Trust

1.8.2 The following agencies, in addition to interviews with individuals, that contributed to this Review were:

Agency	Contribution
Metropolitan Police Service (MPS)	Chronology and IMR
London Ambulance Service NHS Trust	Chronology
Victim's GP	Chronology and IMR
Perpetrator's GP	Chronology and IMR
Wandsworth Council's Community Safety Team	Report provided
Asian Women's Resource Centre	Report provided
Wandsworth Council's Adult Care Services	Chronology and IMR
Southwest London and St George's Mental Health NHS Trust	Chronology and IMR
Wandle Housing	Chronology and IMR

1.8.3 The DHR Reviewers had telephone and conference calls with the victim's family throughout the review process and provided their informative and helpful accounts.
1.8.4 The DHR Reviewers made several attempts to engage the Perpetrator's sons via the Police Family Liaison Officer, SMS messages and e-mails but were unsuccessful. However, a meeting with the perpetrator's cousin Ali with whom Nadim lived for a short period of time took place.

1.8.5 The Mosque where Tamseela and Nadim worshipped and where Nadim was employed contributed to the review as did Tamseela's neighbours. Independent cultural advice and support was provided by the AWRC.

1.9 Panel Membership

1.9.1 The Members of the Panel to oversee 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

(Full details of the Panel Members, their role and agency are recorded in Appendix 2)

1.9.2 In forming the panel for the review, consideration was given to the involvement of a specific Ahmadiyya community support organisation for women that could support the review process with expertise. The AWRC was identified as such a resource, and they provided their expertise to the Panel. The progress of this review has been greatly assisted by the AWRC that provided a valuable insight into Tamseela's cultural and religious background.

1.9.3 The AWRC is a specialist women's organisation providing quality assured support services to Black, Minority, Ethnic (BME) women and children who have experienced or are at risk of DA. Established in 1980 the Centre provides the provision of free advice & information, advocacy, outreach, support groups and training/workshops to women. The AWRC's work with thousands of women and girls, addressing a wide range of forms of Violence Against Women & Girls (VAWG) and complex needs over three decades has greatly assisted them in developing their extensive expertise.

1.9.4 The key aims of the AWRC include work towards Ending VAWG; addressing VAWG including domestic and sexual abuse, forced marriages, honour related abuse, faith-based abuse, and female genital mutilation.

1.9.5 National Health Service England (NHSE) engaged Dr Afzal Javed from Niche Consulting to support the review with specialist mental health expertise.

1.10 Contact with family, friends, and wider community

1.10.1 The DHR Chair has been the point of contact with Tamseela's family, namely her sister's family. Her nephew, Hussain, has been the main contact for the family.

1.10.2 The DHR Chair and Independent Reviewer had conference calls and telephone contact with Tamseela's family. The family received advocacy support by the voluntary organisation 'Hundred Families'.[11] In addition, they were provided with the Home Office leaflet entitled Domestic Homicide Review Information - Leaflet for Families and were consulted regarding the review's Terms of Reference. Tamseela's extended family were provided with draft copies of the Overview Report prior to its submission to the Community Safety Partnership.

1.10.3 The DHR Reviewers have held 'remote' interviews with Tamseela's sister, brother-in-law, two nephews and neighbours due to Covid-19 travel and associated public health restrictions. They were able to provide information to the Review, which proved valuable to the process.

1.11 Involvement of Perpetrator and/or his Family, Friends and Colleagues

1.11.1 The DHR Chair sought to engage with the perpetrator's sons via the police family liaison officer, although these attempts proved to be unfruitful. The independent Reviewers were able to facilitate contact with the perpetrator's cousin Ali who engaged with the Review.

1.11.2 In addition, the Reviewers made direct contact with, and met with a

[11] For more information regarding Hundred Families please visit https://www.hundredfamilies.org

representative from the mosque, Sulman (where the victim and perpetrator both worshipped and where Nadim was employed). He was able to provide information to the review, which proved valuable to the review process and has been included in this report.

1.11.3 The perpetrator Nadim's psychiatrist Dr Mona Ahmed was interviewed as part of the review whose comments are highlighted later in this report.

1.11.4 Nadim was interviewed on 24 July 2020 by the independent Reviewers and Dr Afzal Javed (Mental Health Specialist, Niche Consultancy) via conference facility in the presence of a mental health nurse. The details relating to this interview re highlighted in paragraph 2.4.

1.12 Parallel Reviews and Related Processes

1.12.1 The criminal investigation, Criminal Justice proceedings against Nadim and Coronial proceedings touching on the death of Tamseela have now all concluded. The proceedings against Nadim concluded with his conviction for Manslaughter on the grounds of diminished responsibility. He was sentenced to a Section 37 Hospital Order with Section 41 Restrictions that are without time limit.

1.12.2 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 illness. A section 37 is called a "hospital order". The judge decided that due to concerns about public safety Nadim needs to be on a Section 41 order, 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 that their discharge may then be subject to certain conditions.

1.12.3 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 and one of her nephews took place remotely via Microsoft Teams. The DHR Chair attended the inquest too.

1.12.4 The inquest concluded with a verdict of Unlawful Killing.

1.12.5 South West London & St George's Mental Health NHS Trust commissioned a Root Cause Analysis Investigation Report led by Dr Gavin McKay, Consultant Liaison Psychiatrist (North East London Foundation Trust). The investigation concluded '…. Throughout the patient's contact with Trust services no indicators were present in behaviour or assessment which would indicate a risk to the patient's wife. Although there were care and service delivery problems identified no root cause arising from the care provided by the Trust can be identified for the incident.'

1.12.6 The Trust's Root Cause Analysis Investigation Report has been considered as part of this review process.

1.13 Chair of the Review and Authors of the Overview Report

1.13.1 The panel was chaired by the review Chair Gerrard (Gerry) Campbell MBE.

1.13.2 Gerry Campbell is a former Metropolitan Police Service Detective Chief Superintendent with 30 years' experience of dealing with Community Safety and Public Protection matters with a focus on VAWG including DA and the management of offenders. Since leaving the Police Service he has been employed as a Strategic Program Lead for VAWG with a London Council and as a Director of Strategy for a Charity supporting South Asian women disowned by their families. In addition, Gerry is an advisor to UN agencies, the Royal College of Midwives, and is a published author on VAWG/Gender Based Violence.

1.13.3 Gerry is independent and has no connections with any of the individuals or agencies who form part of this review. Gerry retired from policing in November 2016, and he has no personal or professional connections with the police officers involved in this case or with the MPS. That said, Gerry was previously a Detective Superintendent with the police in Wandsworth between 2010 – 2012, which was declared as part of the Chair's application process. It was agreed that there was no conflict of interest. Gerry's experience was discussed with the CSP commissioner in

Wandsworth before the review commenced and it was decided that his knowledge would be invaluable in this review process.

1.13.4 Gerry was supported by Neelam Sarkaria in this review. Neelam is the former Head of the Crown Prosecution Service's Criminal Justice Unit and now works as a rule of law and gender-based violence expert in the UK and internationally. Neelam is an advisor to UN Women, UN Office of Drugs and Crime, UN International Organisation of Migration and the Royal College of Midwives. She is a published author and recognised subject matter expert on such matters.

1.13.5 Gerry and Neelam are referred to as the DHR Reviewers in this report.

1.14 Dissemination

1.14.1 Once finalised by the DHR Panel, the Executive Summary and DHR Overview Report, which incorporates an action plan was presented to the CSP for approval. After being agreed, the Overview Report was sent to the Home Office for review by its multi-disciplined and experienced DHR Quality Assurance Panel.

1.14.2 The recommendations are owned by the CSP as the accountable body, which is responsible for implementing the recommendations and disseminating learning through professional networks and with local communities, as well as receiving reports on the progress of an action plan.

1.14.3 Progress reports in implementing the recommendations will be communicated to the CSP.

1.14.4 The Executive Summary and Overview Report (encapsulating the action plan) will be published in line with the statutory guidance and as determined by the CSP. The report will be shared with Tamseela's family, with the Mayor's Office for Policing and Crime (MOPAC), as Police and Crime Commissioner for London, the DA Commissioner and the relevant agencies represented on the DHR Panel.

1.14.5 There is an undertaking from Wandsworth Council that learning from the review will be disseminated to local professionals through local professionals' training sessions supported by a '7-minute briefing'.

1.14.6. The report will be published on the Wandsworth Council's website and will be accessible by visiting https://www.wandsworth.gov.uk/community-safety/domestic-abuse/domestic-homicide-reviews/

1.14.7 Dr Javed has also prepared a learning lessons document, which NHS England will publish alongside this review report on NHS England website to support professional's learning.

1.15 Context (including Previous Learning from DHRs)

1.15.1 Homicides are recorded to be "domestic" when the relationship between a victim aged 16 years and over and the perpetrator falls into one of the categories which is also recognised by the Domestic Abuse Act 2021 statutory definition.

1.15.2 The Home Office Homicide Index's data for the 3 years' period to the year ending March 2018 show that most victims of domestic homicide were female (74% or 270). This is lower than the non-domestic homicides where the majority of victims were male (87% or 849).

1.15.3 In the cases of the 270 female domestic homicide victims the suspect was male in the majority of cases (260). Of the 96 male victims of domestic homicide in the same timeframe, the suspect was male in 50 of the cases and female in the 46 other cases.

1.15.4 The average age of the majority of female domestic homicide victims was 46 years and for male victims was 51 years. In DA Homicide, victims aged 65 years and over formed 6.9% of the total, whilst in non-DA homicides this age group formed 18.6%

of the total.[12] Of further note, son/daughters were the suspects in 3 cases [1 male victim and 2 female victims] recorded over this 3 years' period.

1.15.5 In the year ending March 2019, there were 671 victims of homicide, 33 (or 5%) fewer than the previous 12 months. In 48% of the cases adult female homicide victims were killed in a domestic homicide (99). This was an increase of 12 homicides compared with the previous year. In contrast, 8% of male victims were victims of domestic homicide (30) in the same time period. There were 4 male victims and 9 female victims of homicide involving another family member other than an intimate partner or former intimate partner. [13]

1.15.6 Over the last 10 years there has been an average of 82 female victims a year killed by a partner or ex-partner.

London Borough of Wandsworth

1.15.7 The London Borough of Wandsworth (the borough) is a culturally diverse borough located in Southwest London and has an estimated population of 329,700 (Office for National Statistics mid-2019 estimate).[14] Its population is forecast to grow by 15% to 377,297 by 2030; an average of 4,400 people per year.

1.15.8 The majority of the borough's population is female (54%). It is estimated that just under 30% of the population are from BAME backgrounds. The diversity of the borough is less than London as a whole (43% of Londoners are from a BAME background).[15] Of the BAME population in the borough just under 35% are of Asian/Asian British background, 20% are from mixed/multiple ethnic groups whilst the remaining 9% are from other ethnic groups.[16]

[12] Ibid

[13] Ibid

[14] https://www.wandsworth.gov.uk/planning-and-building-control/planning-policy/local-plan/local-plan-monitoring/local-plan-population/population-estimates-and-projections/

[15] https://data.london.gov.uk/dataset/gla-demographic-projections

[16] https://www.datawand.info/population-slicer/

1.15.9 Of those borough residents for whom English is not their main language, 9.5% speak another European language as their main language (excluding Russian). The next most common other languages are South Asian, followed by an African language and East Asian.[17]

1.15.10 About 11% of the borough's population live with a disability or long-term health problem, which is lower than in London or England as a whole.

1.15.11 Over the past 3 years (2016 – 2019) the number of DA incidents (crime and non-crime incidents) recorded by the police in Wandsworth decreased by 3.9%, to 4,101. That said, it is worth noting that in the same period that crime element of these incidents increased by 16.2% to 2,539 offences. Violence (with or without injury) and Public Order Act offences make up notable proportions of the recorded crime. Suffice to say, DA is under-reported in Wandsworth Borough, as it is in all other London Boroughs and other jurisdictions.

1.15.12 BAME victims account for approximately 38% of DA victims in Wandsworth, with limited variation over the past 3 years (of the reporting period.

1.15.13 Older age groups (65+) are under-represented in DA crime data, with 271 victims from the 2016 – 2019 data.

1.15.14 In terms of relationship identifier, the majority 70-71% of the offending over the past 3 years, has been perpetrated by a partner or former partner and a further 22-24% by another family member.

1.15.15 At the time of this index offence, Wandsworth Council commissioned the following agencies to undertake service provision to DA victims, survivors, and children on its behalf:

- *Wandsworth SafetyNet (delivered by Victim Support)* – Provided independent and confidential advocacy to all victims of DA and independent domestic violence advocacy (IDVA) services in the borough.

[17] https://www.datawand.info/population/

- Whilst this review was being conducted Hestia Housing & Support was commissioned to deliver the IDVA service, whilst continuing to deliver refuge accommodation services.

- *Refuge* – The national organisation Refuge[18] was contracted to provide a complex needs service. The Service provides support to victims of DA who have additional needs such as mental health, substance misuse, homelessness, and immigration. This service provides improved access to support for victims from BAME communities, disabled victims, lesbian gay bisexual trans-gender (LGBT) people and older victims. There is one specialist complex needs outreach worker who supports service users intensively on a longer-term basis than IDVA services and advocate on their behalf and work with partners to help them access the right support to help meet their needs. The service is provided in the service user's first language and interpretation is provided via language line as appropriate. The main referral pathway for the Wandsworth Complex Needs service is via Victim Support's Wandsworth Safety Net, DA multi-agency risk assessment conference, and the Police. The service also accepts direct referrals from agencies and self-referrals.

- Hestia (Housing & Support) – A national organisation, which is commissioned to provide the crisis refuge accommodation for high and very high DA victims and their children.[19] This provider is still supplying this service in addition to being procured to provide the advocacy and support service as highlighted in the first bullet point above.

1.15.16 In addition to the above the Wandsworth One Stop Shop in Battersea provides a drop-in meeting place for those experiencing domestic violence and abuse. The service provides information about:

- legal options;

[18] Further details about Refuge can be found by accessing https://www.refuge.org.uk

[19] Further details about Hestia can be found by accessing https://www.hestia.org

- including advice regarding injunctions;
- support with relocation and housing issues;
- advice and support for victims, to ensure the best possible solution; and
- advising professionals on how to support children & families experiencing DA.

1.15.17 At the time of documenting this review Wandsworth Council is working with Hestia to provide a second One Stop Shop in the Roehampton area of the borough, an area of high prevalence of DA. In addition, this also provides for geographical coverage of this expansive borough too, increasing accessibility to a greater number of people experiencing DA.

1.15.18 During the review process the council was leading the development of a VAWG strategy, which at the time of writing this review was going through local governance processes. This strategy is built upon a comprehensive needs assessment that has included survivor consultation. The VAWG strategy follows a public health approach and has embedded its core principles as; the development of a coordinated community response, the need to maintain the voice of the survivor at its heart and the need for local professionals and service providers to be cognisant of intersectionality.

1.15.19 During the review process, the partnership like others has been impacted by the Covid-19 pandemic. It recognises that DA has affected communities differently and acknowledges the need to refresh its Equalities Impact Needs Assessment. The review has been advised that this is underway. In addition, during the review process, the council has achieved White Ribbon status. This status signifies the council's commitment to the elimination of VAWG, encouraging people, especially men and boys, to act individually and collectively, and change the behaviour and culture that leads to VAWG.

1.15.20 Furthermore, the council has now also achieved accreditation by the Domestic Abuse House Alliance (DAHA) positively influencing the effectiveness of the council's housing department's overall response to DA. [20]

[20] For more information about DAHA visit https://www.dahalliance.org.uk

1.16 Post-Implementation Review

1.16.1 The panel agreed that a post-implementation audit should be undertaken by the CSP 12 months after publication of this report to ensure that the recommendations confirmed as being necessary through the review have been implemented, and that they are achieving the positive impact intended.

1.17 Chronology

1.17.1 The consolidated chronology for this review is as follows:

Date(s)	Agency	Description of agency activity/event	Comments / Outcome
25/01/2001 – 27/10/2006	GP - Medical centre	Seen at GP Surgery for a range of different issues including surgery stress, anxiety, depression, osteoarthritis. During this period Tamseela's mother passed away, which impacted her.	Referral for counselling and prescribe antidepressant medication
11/03/2003	Wandsworth Adult Services	Tamseela – Occupational Therapy (OT) contact and assessment. Outcome of equipment ordered and OT to liaise with Housing Association regarding kitchen and damp issues.	Case closed on 16.3.04
23/01/2009	GP - Medical centre	Tamseela consulted surgery re self-medication for her husband. Advice given to check with the neurologist. Reports stress at home as husband was about to be discharged from hospital. He has bilateral vocal cord palsy with tracheostomy.	
10/06/2009	Wandsworth Adult Services	Telephone call from Tamseela to Access Team requesting a carers assessment due to the support she provided for her husband.	
26/06/2009	Wandsworth Adult Services	Carers assessment completed. Tamseela was having difficulty coping with her caring role for her husband. Tamseela had a diagnosis of myopathy which impacted on her ability to use her hands. Several contacts via telephone and home visits.	Tamseela admitted to hospital. Tamseela stated she no longer required support at home. Referred to Dial-a-ride and the case closed.
11/03/2010	GP-Medical centre	At the surgery, Tamseela was in tears and feeling alone, husband passed away 10 days previously	Second husband passed away
21/02/2011 – 14/05/2014	GP - Medical centre	Tamseela is seen for palpitations - Very tearful and talking about death of husband and mother. Self-referral number given for Wandsworth psychological therapies. Reports sleeping too much	
22/12/2014	GP -Medical centre	Nadim - Seen first time as new patient from Pakistan, cousin interpreted	Refer to ophthalmologist for cataract
12/03/2015	GP - Medical centre	Tamseela: Low mood, feeling lonely PHQ 9 score 10/27	Patient health questionnaire to look at

			mental health. Anti-depressant citalopram 10 mg prescribed.
01/10/2015	GP - Medical centre	Nadim attended GP surgery accompanied by cousin who translated, 1 week history of productive cough. Is a smoker but declined referral to smoking cessation.	Has smoked for 40 years. Nicotine replacement therapy / health and smoking cessation advice given
15/04/2017	MPS	Victim of Residential Burglary Tamseela returned from a wedding to find her flat ransacked and £400.00 cash stolen. Believed Yale lock was slipped.	No arrests. Tenant called Wandle Housing and requested additional locks. Additional locks fitted (15.8.17)
12/09/2017	LAS	Tamseela: A 999 call was received in the Emergency Operations Centre (EOC) at 00:14 for an ambulance to attend (address 1). It was reported that Tamseela had a headache, felt weak, had high blood pressure and numbness in both hands.	Following a telephone consultation ambulance not dispatched.
02/10/2017	Wandsworth Adult Services	Tamseela: Telephone call from Tamseela to Access Team enquiring about support for shopping and housework.	Signposted Tamseela to voluntary shopping agencies. Tamseela looking into a private cleaning company
17/04/2018	GP - Medical centre	Tamseela - has increased low mood and anxiety as she had to attend A&E last week. PHQ9 reviewed with GP.	
14/06/2018	GP - Medical centre	Nadim - Recorded as speaking poor English and was difficult consultation. Pointing to both temples and saying they are causing him pain and intermittent headache. Patient speaking in Urdu	
06/08/2018	GP-Medical centre	Nadim - Recent marriage. Attended with wife who is also a regular patient to the surgery. Wife very concerned re odd behaviours and complained of headaches. Twisting his hands and feet around (3 weeks after marriage) No history of mental health problems, not self-harming. Wife not aware of any old abnormal speech	Advice from GP to go to A&E if concerns re behaviour. Plan for referring IAPT (Improving Access to Psychological Therapy)
20/08/2018	GP - Medical centre	Nadim seen at the GP surgery with Tamseela. Ongoing stress with new marriage (5 months). Not talking to wife-sleeping all day. Not contacted IAPT as per advice	
21/08/2018	SWLSTG	Nadim attended a 90-minute assessment with the CBT therapist and a Punjabi interpreter was present. His wife attended the first five minutes of the assessment and then left - asked to wait in reception. -Nadim explained he got married 6 months ago but did not tell his children until after the wedding - afraid that they were upset as not been in contact with him. -he reported that his first wife died of a heart attack in 2010. He described anxiety around financial difficulties due to employment issues, impacted by his anxiety. He also reported feelings of guilt around not being able to adequately provide for wife in UK and children in Pakistan.	Diagnosis recorded as depressive episode. Cluster is recorded as 21. Goals recorded as “to not feel this fear and guilt”. The patient was put forward for 1:1 counselling with an interpreter.

22/08/2018	SWLSTG	Nadim - Talk Wandsworth IAPT Self-referral received by telephone. Note is added to personalised care: Recorded that Client does not speak English his wife can speak on his behalf.	22.8.18 - Letter sent confirming appointment to see a CBT therapist for an assessment (enhanced triage) with an interpreter on 31st August 2018.
03/09/2018	GP - Medical centre	Nadim - Panic attacks with abnormal posturing-tension, not talking to wife of 6 months. Feels impending doom and anxiety. Low mood on and off. Memory difficult to access.	Psychiatry referral with Urdu interpreter
05/09/2018	SWLSTG	Non-Urgent Referral from GP. Diagnosis: Anxiety and Panic attacks. The note states no risk issues identified at referral.	
05/09/2018	SWLSTG	Wandsworth Single Point of Access (WSPA). The referral relays that the individual had issues as non-communicative with his wife and there was unclear picture re cognitions. The referral describes “abnormal” body movements and severe panic attacks experienced 3-4 times a week.	Prescribed propanol by his GP to treat his anxiety.
11/09/2018 – 2/10/18	SWLSTG	11/9/18 Assessment letter sent to Nadim outlining plan. This letter was in English. 28/9/18 – Telephone call made. No reply 2/10/18 – Appointment of 8/10/18 offered	
08/10/2018	SWLSTG	Nadim did not attend the appointment with WSPA. The WSPA staff member tried contacting the patient - Nadim, by phone but not answered.	
12/10/2018	GP - Medical centre	Tamseela – Reports feeling low again. Lives alone, feels bored and lonely, no family nearby.	Gym referral, volunteering and day centres discussed
16/10/2018	GP - Medical centre	GP received letter from St George's mental health to say that Nadim was seen at A&E then seen in mental health clinic	
16/10/2018	MPS	Police were called by the LAS to Nadim’s cousin’s address. Nadim was suffering a psychotic episode and beating himself. His cousin said he’d been acting strangely for 3 – 4 weeks, but this was the worst he’d seen him. No visible injuries, understood never been sectioned or diagnosed with anything similar before.	Police Merlin PAC shared with Wandsworth Mental Health Access Team. Graded Amber (Level 3 Risk) Nadim voluntarily admitted to St George’s Hospital
16/10/2018	SWLSTG	Liaison Psychiatry Service St George’s Hospital. The patient self-presented to St George’s Hospital A&E Dept. He reported a history of increasingly agitated behaviour for the previous 2-3 months. However, the nurse was unable to conduct full assessment due to language barrier (Urdu).	Nurse queried patient’s ability to make capacious decisions – required further assessment.

16/10/2018	SWLSTG	was assessed with the aid of an Urdu speaking A&E doctor. No known family history of mental health problems, although he suggested of similar brief (self-resolving) episode in 2014. Described his current onset as beginning in April 2018 – prescribed Propranolol by GP but was non-compliant. Mental State Examination – restless and distress, no overt anger or aggression, self-reported V&A hallucinations. Nadim's capacity not formally tested but he appeared to have capacity. Intermittent thoughts of harm to self (notes mention self-harming behaviours in department – slapping) but no plans to end life. No thoughts, plans or impulses to others. IMP – affective disorder with psychotic symptoms.	Plan – refer to WHTT for on-going assessment and treatment. Crisis plan discussed and agreed. Prescribed 2 x 5mg diazepam.
16/10/2018	SWLSTG	Accepted referral to WHTT. Family in agreement with plan.	
16/10/2018 **17/10/2018**	SWLSTG	WHTT staff contacted Nadim's mobile, to arrange a visit and give support. There was no response. Associate Specialist Doctor visited the patient for an initial assessment - could not take place as there was no interpreter present. The patient provided little information. The patient's wife explained that: -2 months ago, stopped going to the mosque to pray. -1 month ago, started to hit himself. - they married about 7 months ago (she was a widow) - at first, he was normal and continuing his job working as Security in a mosque - then he stopped talking – The patient describes arguing with him "Why aren't you talking?" - he would spend all day sitting at home - Tamseela described how she made one meal with lots of salt in it to provoke a reaction, but he ate the food and did not respond - he has said he is not enjoying anything, too much fear, says "I am a useless person to you... and the children". -The doctor made an attempt to explore the voices. - Nadim described how the voices made him scared and increased his heart rate. - sometimes voices are scary and sometimes normal - cannot say where voices come from though his wife said "just he imagines..." - Nadim had no source of income	Voicemail message left Case was closed to WSPA on this day too. Request to Merton Interpreting/ Translation Service for Urdu Interpreter on 18.10.18 at 12.00 hours at the patient's home address

		-Suicide. The doctor tried to discuss suicide. Tamseela relayed that Nadim often felt like "a useless person... no job... no money... Why am I living?" - Nadim said suicide was against his religion but even though he did not completely rule out suicide, certainly no imminent plans. Medication. Tamseela reported that the GP prescribed Propanolol 40mg but that he didn't take it as a friend warned them of side effects. Tamseela's religious community recently managed to facilitate a homeopathic prescription for "Aurum Met"	
18/10/2018	SWLSTG	Nadim's case was discussed in the MDT meeting on a daily basis throughout his care and treatment	
18/10/2018	SWLSTG	A nurse practitioner from WHTT visited Nadim at home. She was unable to engage in a meaningful conversation with the patient due to his English. Tamseela reported that Nadim was a lot better. She requested more diazepam tablets, but it was explained that it had not been prescribed. The patient can speak Urdu and Punjabi.	Plan was to arrange for Urdu or Punjab interpreter 19.10.18
19/10/2018	SWLSTG	A letter was sent to Nadim offering the first of six counselling appointments to take place on 25th October 2018 with a TAC therapist.	
19/10/2018	SWLSTG	WHTT nurse practitioner visited the patient with an interpreter present. Nadim's wife reported that he was difficult to manage at home. He was not verbally communicating. Nadim's tended to get agitated at times and became a management problem. Not sleeping well and reported constantly feeling scared that someone is coming to catch him. He normally sees human beings and an animal coming after him and this frightened him a lot. -No alcohol. Stopped smoking in January 2018. No illicit substances Nadim reported that his first wife died of heart attack in 2010. He felt low and depressed. Reported that he wanted to get better, look for a job and support his wife - Tamseela. Past Psychiatric History: In 2010, he was seen by a doctor in a Pakistan Hospital and was prescribed medication with good effect. Nadim could not remember the medication.	Medication: propranolol 40mg OD
20/10/2018	SWLSTG	An Urdu speaking nurse practitioner visited Nadim at home. He reported that he continued to hear voices mainly when on his own. He described the voices as evil/screaming and crying and this frightened him. He described being anxious and having tight stomach. Worried about his children in Pakistan. Tamseela reported the events which led to hospital as documented. She expressed unhappiness staying with Nadim and reported that she was feeling depressed. She was tearful. Tamseela reported that Nadim had not had a shower for 10 days.	Declined hospital admission. Cited family as a protective factor. Impression: Psychotic depression

21/10/2018	SWLSTG	An Urdu speaking nurse practitioner visited Nadim at home. Nadim had a shower the previous night and went out but did not enjoy it. He continued to feel depressed, his mood was low, but he did not feel suicidal. Nadim reported still hearing voices. His wife reported that he was slightly okay but continued with anxiety and the voices were less inside his head. Tamseela asked why staff came every day asking questions. Staff educated her on the process and that Nadim's case will be discussed with doctors next day.	Impression: Psychotic depression
22/10/2018	SWLSTG	WHTT staff called Nadim's wife to arrange a visit, but Tamseela declined saying no medication was being prescribed so what would the point in attending to ask further questions.	
23/10/2018	SWLSTG	Nadim was assessed by the Associate Specialist Doctor with an interpreter present. Nadim reported that he felt he had been getting worse each day. He described feeling anxious, numb and suffocated when he has a blanket over his head "like being imprisoned". He spoke of pressure/heaviness in his brain. He stated that he got frightened by loud noises. And spoke of seeing snakes and scorpions on occasion "and they scare me." Nadim explained that sometimes he experienced panic attacks. He described these as being so afraid that his hands and feet become immobile, and his voice cannot speak. They lased between 10-30 minutes. Sleep – says he managed 4-6 hours of broken sleep, his appetite remained poor, he went out in the street, his energy levels- feels tired, motivation- finds it too lazy to do things, difficult to concentrate, memory becoming worse, Suicidal – sometimes felt like it but would not do it. Protective factor- his religion, his belief in God. Nadim's wife added that one day he was very frightened and would not believe her when she tried to reassure him that a noise he had heard may have come from a flat above "He insisted it was not from in the house". Visual hallucinations – has talked in past about seeing a snake or scorpion – he gave an example of thinking that a rod coming from ironing board was in fact a snake.	Psychosis symptoms - Auditory hallucinations – talks of being able to hear banging noise (as if someone is beating someone else up) -Started 2 weeks previously - has heard this coming "from this side or outside" (gestures at wall or outside) but he cannot say where from exactly says when he hears this, he recites the Koran Plan was to start Sertraline and Zopliclone. Offer Benefits advice
24/10/2018	SWLSTG	The team social worker spoke with Tamseela to offer support with access to benefits and provide advice.	
24/10/2018	SWLSTG	An Urdu speaking nurse practitioner visited Nadim. Information about the prescribed medication was given to Nadim and Tamseela Nadim agreed to start antidepressant medication. Tamseela stated that Nadim had no interest in their relationship, and she would leave if there was no change.	
25/10/2018	SWLSTG	First appointment with TAC therapist. Note states: "Client says that he wants to enjoy life but at the moment he can't. He took time off work in the summer because he was feeling bad and then he lost his job in August and that has made things worse. He'd like to work but he is 66. He felt this way when his first wife died suddenly of a heart attack in 2010. In 2014 he came to England because he was a minority in his country and persecuted.	

		Gives details of family make up in UK and Pakistan. He doesn't have much contact with his four children. States that they sometimes call him, but he doesn't take their calls as he's ashamed. He feels regret that this has happened and annoyed with himself for feeling this way." Thoughts of harming himself are present but he cites religious beliefs as protective factor.	
26/10/2018	SWLSTG	The team social worker visited the patient with an interpreter. The social worker explored the patient's experience of feeling of being held. Nadim described the feeling of being restricted and restrained. He said he usually recites the Koran, and the feeling reduces. Improvement in sleep noted. Not reported to have been banging head or hitting himself in the last 3-4 days. Gathered background information on marriage and family. Noted tensions between them. The general impression was that the patient was still low in mood and had started taking medication. Benefit of medication reiterated. Identified Talk Wandsworth were offering counselling and the patient's wife was accompanying him to the sessions (had a session the previous day).	Home Visit. Assessment: Not psychosis Plan- suggested Relate counselling.
28/10/2018	SWLSTG	WHTT handover discussion: Plan- alternate day visits. Interpreter request for 30th .10. AM visit – ask side effects of Sertraline and Zopiclone? – any questions from the medicine info sheets? – support wife. Take out information for relate. Discharge early week commencing 29th	
28/10/2018	SWLSTG	A community support worker visited Nadim. There was no interpreter present. Nadim's wife reported there were no side effects from the Sertraline medication. Informed that an interpreter has been booked for next appointment.	
30/10/2018	SWLSTG	Nadim visited by an Urdu speaking nurse practitioner. The interpreter did not turn up. The nurse practitioner explored whether Sertraline and Zopiclone is helping. Nadim fully understands this question in his language and did say that his sleeping is much better and as well as his mood. Nadim's wife contradicted this and informed the nurse that her husband does not go out to do his usual shopping and does get angry at short notice. This was discussed with Nadim who confirmed that he does get angry, but this is something that has been happening since his marriage. Tension between Nadim and Tamseela was noted.	
30/10/2018	SWLSTG	Relate information was offered. Nadim was receiving weekly counselling, and his wife has been accompanying him.	

			Interpreter booked for 5.11.18
01/11/2018	SWLSTG	Second appointment. Note reads: “Client is taking Sertraline 50mg and Zopliclone for sleeping. He speaks very quietly and says his throat feels dry when he talks, and he wrings his hands. At home, he just sits or lies down and doesn't talk much. Sometimes he reads but not very often, and he prays five times a day. He would like to speak to his children but somehow, he can't. They call him, but he doesn't answer. He doesn't know why but doesn't want them to worry about him. He doesn't want them to see how he has become but he worries about it and about them. He wishes he had the courage to speak to them. His wife (a recent arranged marriage) gets cross with him because he doesn't speak to them, so it causes conflict at home.” Thoughts of harming himself are present but he cites religious beliefs as protective factor against risk to himself. Tamseela reported that they were attending Nadim’s usual counselling session that day. Tamseela was encouraged to send his repeat prescription to the local chemist. Plan: next home visit planned for 5th November.	
02/11/2018	GP - Medical centre	Nadim; call at 1820 hrs. Was seen by Community Mental Health Team who was going to advise us to prescribe sleeping tablets and anti-depressants	
November 2018	SWLSTG	WHTT: Plan - Morning visit with Interpreter. Is the Sertraline and Zopliclone helping? – set some tasks (which involve getting out of bed) - ask side effects of Sertraline and Zopliclone? – any questions from the medicine info sheets? – support wife – suggest discharge on Friday 9th 11. Nadim was visited by a nurse practitioner. An interpreter was present. The patient reported that he has been unable to leave the house over the weekend. Explained that the previous night he heard 'voices' of someone screaming, which did scare him a lot. Tamseela stated that she would like her brother / brother-in-law to speak with the team doctor about Nadim, but he refused consent.	
November 2018	SWLSTG	WHTT Plan: drop medication this evening / visit 7/11/18 and planned discharge 9/11/18.	Plan- Visit on Friday 9th with interpreter for discharge.
November 2018	SWLSTG	Nadim was visited by a community support worker. There was no interpreter present. She handed over the Nadim’s Sertraline medication. Tamseela queried why he had not been given any Zopliclone. The community support worker advised Tamseela to speak to Nadim’s GP. Nadim’s mood – some improvement noted. He had slept without Zopliclone the previous night but noted that it was a light sleep.	
November 2018	SWLSTG	The team social worker spoke to the GP practice medical secretary who advised that Nadim attended GP yesterday asking for antidepressants and sleeping tablets. Nadim was given 7 days Sertraline the previous	

		day and advised to get sleeping tablets from GP. She was also informed of the plan to discharge Nadim from WHTT on 9/11/18.	
November 2018	SWLSTG	Third appointment with TAC. Note reads: “Client's wife asked to speak to me alone before we started. She is finding it very difficult because she says he doesn't speak to her at home. He just 'sits like a statue' and won't answer her when she talks to him. She is quite tearful and says she feels depressed too. I advised her to speak to her GP and to have some counselling herself.” “I asked client about not speaking at home and he just reiterates that he tries but doesn't feel like it, doesn't have the strength and doesn't have the courage. Sometimes he is frightened of his wife because she shouts at him. I asked his permission to speak to his GP about his medication, which he agreed to. He would like to be well and healthy again but doesn't know how. He feels tired all the time. I asked him whether he would try to make contact with her and arrange a visit and he said he would try.” It does not appear that his experience of being shouted at was explored further. Thoughts of harming himself are present but he continues to cite religious beliefs as protective factor against risk to himself.	
November 2018	SWLSTG	A nurse practitioner visited Nadim. There was an interpreter present. Events leading to attendance in A&E were explored. Nadim noted to be communicating with a low tone and volume. He reported being fearful at times, having fluctuating appetite. The patient reported he is feeling a “bit” better however his mood could fluctuate due to stress related i.e., not feeling motivated to do things like attending to his personal hygiene and going out for walks. Nadim said he sleeps with the help of “medication” which is Zopliclone and without that he can barely get an hour and a half sleep. He was advised about going out of the house. Rated his mood on a scale of 0-10 as 5 or 6 which is a significant improvement, however, subjectively affect appeared blunt and lethargic. Nadim reported attending counselling the previous day. He denied any active plans to end his life saying life and death are in the hands of “God” and taking his own life is forbidden in his own eyes.	Plan: Medication was given: -14 x 50mg Sertraline and advised to see his GP before two weeks’ time for a repeat prescription. Discharged from WHTT back to GP. In times of crisis to call 999 or Mental Health support line/ within working hours to call GP
November 2018	LAS	A 999 call was received in the EOC from the police at 23:42 for an ambulance to attend address 1. It was reported that a 50-year-old female (we believe to be Tamseela) was deceased. 2355hours – LAS pronounced life extinct.	

November 2018	MPS	**<u>Tamseela found Murdered.</u>** 2300hrs – Tamseela's sister and nephews drive from Morden to her flat and nephews spoke with Nadim. Tamseela's nephews found her lifeless body. Nadim was arrested, and a murder enquiry was launched. Upon admission to custody, it was decided he required an Urdu interpreter. He was examined by a nurse who advised an appropriate adult should be present due to unspecified Mental (MH) issues. It was decided he should undergo a MH assessment following which he was deemed fit to be detained and interviewed. Nadim made no comment when interviewed. He was charged with Tamseela' murder.	Court Result In April 2019 at Croydon Crown Court Nadim pleaded guilty to Manslaughter on the basis of Diminished Responsibility. He was made the subject of a S37 hospital order under the Mental Health Act with Section 41 restrictions
November 2018	SWLSTG	Nadim was assessed by the Trust Forensic service whilst in Wandsworth Prison.	
November 2018	GP - Medical centre	Call from counsellor- was due to discuss patient dosage but found that he was arrested for the murder of his wife.	
11/12/2018	GP - Medical Centre	Patient safety team at Springfield hospital requesting post psychiatric history in Pakistan	Patient is on remand in custody. No records of past psychiatric history at previous practice Southfields groups practice or St Peters hospital in Chertsey
16/01/2019	SWLSTG	Nadim was admitted to the Trust's Medium Secure Unit for further assessment.	
April 2019	Court Outcome	Court Outcome: In April 2019 at Croydon Crown Court Nadim pleaded guilty to Manslaughter on the basis of Diminished Responsibility. He was made the subject of a S37 hospital order under the Mental Health Act with Section 41 restrictions	

2. The Facts

2.1 The Death of Tamseela

2.1.1 In early November 2018 Nadim was discharged from the care of the Wandsworth Home Treatment Team (WHTT) following a mental health episode whereupon he continued to live with Tamseela. Tamseela's sister Aleena last spoke to Tamseela

whilst she was out of the house shopping. Tamseela's sister Aleena and her nephew Hussain made several attempts at different times to call her. Three days later at 8.14pm Nadim called Aleena 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.

2.1.2 Aleena remained in the car whilst Hussain and Tariq called Nadim on his mobile phone and went to the front door of the house. 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. The brothers detained Nadim at the door, whilst their mother remained outside. They then all walked out towards the front garden area of the address from where they called the Police. Nadim said nothing and made no attempt to leave the scene.

2.1.3 The day following the tragic discovery of Tamseela's body a post-mortem examination was conducted by Dr Robert Chapman at St Georges Hospital, Tooting, London. This revealed that Tamseela had suffered extensive assault injuries including 'defensive injuries'. Dr Chapman concluded that the cause of death was likely to be due to an assault with a blunt instrument, potentially causing her to fall unconscious.

2.2 Sentencing of Nadim

2.2.1 In April 2019 Nadim appeared at Croydon Crown Court and pleaded guilty to manslaughter on the grounds of diminished responsibility. He was sentenced to a

Section 37[21] Hospital Order with restrictions under Section 41[22]. 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'.

2.2.2 The HM Coroner's Court Inquest took place in September 2020 and was presided over by Dr Shirley Radcliffe. The Inquest, which took place via Microsoft Teams was attended by Aleena, Tamseela's nephew (Hussain) and the DHR Chair.

2.2.3 The Inquest concluded with a verdict of Unlawful Killing.

2.3 Family History

2.3.1 Tamseela was born in February 1956 in Rawalpindi, Pakistan. She was one of five siblings; three sisters and two brothers. In 1980 Tamseela married a man who for the purpose of this review we refer to as 'H1'. Following the marriage, they moved to live in Libya. A few months later Tamseela's father passed away and she returned to Pakistan to attend his funeral. She never returned to Libya as she and H1 were divorced.

2.3.2 Three of Tamseela's siblings, except one brother, migrated to the UK in the 1980s. Tamseela arrived in the UK in 1985 and she married her second husband, 7 years later in 1992. There were no children to the marriage and Tamseela's family and others described her and her husband as being generous, charitable, loving and very happy together. Her husband sadly passed away of natural causes in February 2010.

[21] **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.

[22] **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.

2.3.3 Tamseela was known throughout her neighbourhood and community as a kind-hearted woman who strived to help everyone around her. She was described as having so much love to give by her extended family.

2.4 The Perpetrator

2.4.1 Supported by the NHSE Mental Health Reviewer – Dr Afzal Javed, the DHR Reviewers met remotely with Nadim on 24 July 2020 and obtained information regarding his medical history, his family, social background and relationships and the events surrounding the tragic incident. The statutory review process was explained to him including the objective of learning and Nadim consented to take part in the DHR meeting. Dr Javed provide the Urdu translation. Prior to our meeting Nadim's consultant Dr Mona Ahmed confirmed that the DHR had been explained to Nadim, that he consented to participation and that he had mental capacity to do so.

2.4.2 Nadim was aged 66 years of age (at the date of the offence); born in January 1952 in Pakistan. He has four children from a previous marriage, two daughters (D1 and D2) who remain in Pakistan and two sons, (S1 and S2) who moved to the UK around 12 years ago. Nadim also has a cousin Ali who has lived in the UK for over 40 years with his wife and daughter. Ali visited Nadim in Pakistan around 8 years ago whilst he was living with his adult daughters and described him as being depressed, quiet and not talking much.

2.4.3 Nadim follows the Ahmadiyya faith, which caused him problems in Pakistan as he was not allowed to pray openly. This prompted him to move to the UK in 2014. The Police had reported that Nadim initially lived with his adult sons in the Surrey area and appeared happy but when they moved home there was not enough room for Nadim so after about 2 years he moved in with Ali and his family in London. He settled in and got along well with the family and still appeared happy, working in security at the mosque in London and was also very active participating in voluntary work.

Life in Pakistan

2.4.4 Nadim detailed in interview his life in Pakistan – as follows, whilst confirming his birthplace as being in Punjab; in a village 30km away from the regional district centre.

Nadim spent his early childhood in the village and moved to city of Chiniot around the time he was Year 11 at school. He recalls undertaking metric examinations in Chiniot before joining the army in 1971 where he remained for 32 years until his retirement as a non-commissioned officer in 2003. After leaving the army Nadim left his mother and other relatives in Chiniot.

2.4.5 Nadim was married to his first wife in 1982 whilst in the army and remained so until her death from a heart attack in 2010. Nadim set up a shop and worked in a factory after leaving the army. They had four children together in Pakistan; 2 boys and 2 girls. Nadim advised the DHR Reviewers that God gave him strength to cope after his wife passed away. A son and a daughter were married in Pakistan and the other two were unmarried. He coped with life in the service of the army and did not disclose any health problems to the DHR Reviewers and stated that his physical and mental health were fine during that time.

Arrival in the UK

2.4.7 Nadim lived with his married son (S1) and daughter-in-law when he first came to the UK. His son had been in the UK since 2000. He subsequently sought asylum in the UK following his arrival on a visitor's visa, on the grounds that he was being persecuted due to his Ahmadiyya faith.

2.4.8 Nadim's second son S2 was also living in the UK. Nadim lived with his oldest son from 2014 until 2018. When in the UK Nadim frequently attended the mosque in London. He was happy living with his son and daughter-in-law and did not experience any problems. Nadim commenced paid work as a security guard at the mosque working a 6-hour shift pattern. This work involved fewer working hours than the army. Nadim made friends mainly at the mosque and went there for religious functions with his friends.

Life with Tamseela

2.4.9 Nadim initially stated that he met Tamseela in either May, June or July 2018. They were introduced through his friend who he thinks undertook clerical work for the mosque management. Nadim told us that he met Tamseela's family initially and not Tamseela. Nadim then went on to say that he first met Tamseela in August/September

2018, and they were then married in November/December 2018; although he was uncertain and was confused about the dates and whether he met Tamseela before or after the wedding (which is explained later in this report). The review has identified that Tamseela and Nadim were married in January 2018.

2.4.10 Nadim did not get to know Tamseela, and he indicated that she had less time also to get to know him. Nadim could not detail a particular reason for the union with Tamseela. The nikah ceremony took place in Pakistan and Nadim and Tamseela completed and sent the marriage forms from the UK[23]. Nadim was advised by his friends that he should have the nikah in Pakistan and could not explain the reasons why. Nadim informed the DHR Reviewers that he told his children that he was getting re-married, and they did not object, however, no wedding celebrations took place in or outside of the UK. The Panel noted that the information available to them suggested that Nadim's children did not approve of the union.

2.4.11 After their marriage Nadim and Tamseela moved in together. Nadim disclosed that they were speaking to Tamseela's sister daily and meeting the family on a Friday. Nadim found Tamseela's family supportive towards him, and his own sons used to come and see him. They last visited him two weeks before the tragic events.

2.4.12 Nadim revealed that his own family were displeased that he had not discussed his medical conditions with them. Nadim used to live with his cousin Ali (married to Nadim's niece) in 2016-2017 for a period of 1 1/2 years due to the proximity of his home to the mosque. Nadim and Tamseela were fine for the first few months but after that Nadim left his job due to ill health and found that he had nothing to do at home. He recalled feeling unwell like this before the wedding. Tamseela was apparently unhappy that he was not earning money. Nadim was unable to explain his experiences with his health and therefore did not want to get another job. He states that this

[23] Nikah - The literal meaning for the Arabic word *nikah* depends on how it is used in a sentence:
1. If it says *nikah* between a female and a male, it refers to a marriage contract.
2. If it says man did nikah with his wife, (*nakaha*), it means sexual intercourse.
The technical meaning of *nikah*:
An Islamic contract between a female and a male, for the purpose of being together, intimacy, and forming a family.

situation impacted his relationship with his wife, resulting in verbal arguments between them.

The date of the incident

2.4.13 On the day of the tragic event Nadim was lying down on the bed and Tamseela was watching the TV. Nadim stated that Tamseela declined to switch off the television when asked by him. According to Nadim, an argument followed at around 9 -10pm and everything that happened afterwards Nadim described as being "God's will". He initially described striking Tamseela with the TV remote control. The Police investigation, however, through the crime scene examination describes a more violent attack.

2.4.14 Nadim stated that they used to go to bed around 11pm -12am. On the day of Nadim's arrest, Tamseela's sister Aleena and nephew Hussein called to speak to Tamseela and Nadim made excuses stating that she was reading the Qu'ran. The incident had taken place by that time.

Post incident

2.4.15 Nadim was unable to say what could have helped him before the tragic incident. During his interview Nadim stated that he did not seek help from the mosque, nor did he share how he was feeling. Our interview with a mosque manager Sulman, however, confirmed that Nadim did share his unhappiness. At the mosque people would look at Nadim and ask if he was OK as he was becoming irritable at work and was taking extended breaks. This has in part been reinforced when Nadim revealed to a co-worker that he was sad because his children from his first marriage didn't take the news of his re-marriage well.

a. Relevant health

2.4.16 Nadim recalls that his mental health symptoms mainly commenced after one of his daughters got divorced, which was followed by the death of his first wife in 2011. His first wife supported him until her death from natural causes.

2.4.17 In 2011 whilst in Pakistan he was presenting with stress symptoms including lack of sleep, lack of interest and mood. He attended hospital and was given

medication. It is Dr Javed's (NHSE consulting independent expert) assessment that this medical intervention is most likely to have been by a general physician in Pakistan. Most of his symptoms were associated with physical weakness.

2.4.18 Nadim states that the disagreements with Tamseela were placing stress on him and it was Tamseela who got him go to the doctor. He informed us that he had not consulted a doctor since arriving in the UK or access any other medical services before his wedding to Tamseela. However, there is evidence that his cousin Ali had taken him to register with a GP. He felt that he would not be able to explain how he was feeling to a doctor in the UK in terms of language, his understanding of how he was feeling or how to put this into words.

2.4.19 Nadim cannot fully recall what happened. He said he accessed services for the first time when Tamseela took him to the GP and stated that he was not feeling his normal self, had memory problems, was weak and felt stressed and tense. Nadim was given some medication, but he was not fully compliant in taking it. He informed the DHR Reviewers that he didn't tell his son and daughter-in-law about how he was feeling and doesn't know why he was unable to talk to them.

2.4.20 Nadim went on to recount that both he and Tamseela were not happy when they got married. Nadim's appearance and condition was such that Tamseela was worried and not happy. Days before the incident Nadim was becoming irritable, depressed and experienced weakness in his body. A week before the incident Nadim felt he had more problems and could not explain how he felt to the medical professionals he met for the first time. They asked him questions regarding his home life, health and issues and he was unable to explain. His GP gave him medication and Nadim was then seen by hospital staff. Tamseela took responsibility for his medication including sourcing homeopathic alternatives and would ensure that he took it. Nadim disclosed that he was not complying with his medication, although he told health professionals that he was taking it. Nadim would take it two or three days a week, but his wife told him his prescription medication was not helping him. Nadim recalls taking whatever medication he was given. The DHR Reviewers noted that Nadim's non-compliance with his medication was not identified by mental health professionals and

this is considered later in this report, particularly how medical professionals check compliance with medication.

2.4.21 The NHSE root cause analysis reveals that in late August 2018, Nadim self-referred to the Wandsworth Improving Access to Psychological Therapies (IAPT) service and commenced sessions with a therapist in October 2018. The month before this, Nadim reported his unhappiness in the marriage. Meanwhile Tamseela was reporting her concerns to her GP as well as alerting a female friend in the mosque's Women's Auxiliary (otherwise known as Lajna) that she was having marital difficulties. This was not elaborated on at the time and Tamseela died before any follow up conversation was held.

2.4.22 Nadim is feeling better now in hospital where he is taking his medication.

2.4.23 The DHR Reviewers also had the benefit of speaking to Nadim's cousin Ali who detailed that he knew nothing about Nadim's mental health problems until he saw him bashing his head against the wall prior to his admission to hospital a short while before the tragic incident.

b. Family, social background and relationships

2.4.24 An early remote meeting was held with Tamseela's nephew Hussain who was the main point of contact with the family. He recalls Tamseela attending the Ahmadiyya Community Women's Auxiliary Group in southwest London. Meetings were then held with Tamseela's sister Aleena, brother-in-law Altaf (husband of Aleena) and another nephew Tariq (younger son of Altaf). The Victim Personal Impact Statement submitted by the family is at Appendix 6.

2.4.25 Hussain stated that Nadim worked as a security guard at a mosque in London and was apparently asked to leave his employment. Hussain was concerned and wanted to know if the mosque knew that Nadim was mentally ill, noticed any signs and symptoms and more importantly what they did about it. Nadim joined the security team

at the mosque on 24 October 2016. He was in a paid role as a security assistant employed for 30 hours per week.

2.4.26 At the time of his employment it is unlikely that Nadim was the subject of a disclosure and barring service (DBS) check, as is now the current practice. That said, because of the wider security threat to the Ahmadiyya faith, community security checks, background checks and vetting is conducted with family, friends and community members here in the UK and abroad – and in this case also in Pakistan. The mosque management has advised the review that there were no issues or concerns raised at the time regarding Nadim's health. That said, the mosque did identify changes in Nadim's behaviour at work.

2.4.27 All staff including Nadim were/are required to undertake an induction program including accredited IT, communication skills and bespoke security training. Training is then conducted yearly thereafter.

2.4.28 Hussain was clear that the mosque members had arranged the marriage between Nadim and Tamseela. The mosque provided a match making service to bring single men and women of similar backgrounds and lifestyles together. Hussain felt that whilst this arrangement was mutually consensual (an arranged marriage) there were lessons to be learned. Hussain's mum and dad did ask Nadim whether he had any health problems when they met with him. Hussain's father Altaf has worked for the faith community for 35 years and Hussain wanted to ensure that Nadim was similar to his deceased brother-in-law/uncle (not biological, in a cultural sense). Due to the community/cultural practice, Tamseela needed to be chaperoned. They were not legally married in English law but had a nikah ceremony or Islamic religious ceremony remotely in Pakistan, which recognised them as husband and wife.

2.4.29 The mosque manager revealed that 'Rishta Nata' is a matchmaking body that helps and assists those requiring support in finding a suitable spouse in the Ahmadiyya faith.[24] This system introduces families and is the first stage of support in making

[24] https://www.rishtanata.org.uk

potential marriages. However, it is not a scheme everyone must adhere to and it operates rather as a support network. Most marriages are done through word of mouth and inter community contacts. The mosque has a department that makes first contact; however, the decision is with the couple. In the case of younger people their parents are also involved.

2.4.30 Tamseela had lost her second husband in 2010 and the process of 'Rishta Nata' was subsequently instigated.

2.4.31 Hussain's family saw Tamseela on a monthly basis. Hussain helped her with banking and other chores like fixing the boiler.

Contact with Family

2.4.32 The family members we spoke to were unanimous in their adoration of Tamseela. Tamseela's brother-in-law referred to her as 'the jewel in our life' and 'an ambassador for peace and love'. Tamseela's sister Aleena stated that she was down to earth and did not have any children of her own. Tamseela loved Aleena and Aleena's immediate family. She was always there to help the family and provided financial help if it was needed. Tamseela's warmth of character was reinforced by her neighbours Jennie and Joe with whom she would share food she had prepared. They did not know that Tamseela had recently re-married.

2.4.33 Tariq described Tamseela as his favourite aunty partly because she could not bear children, and she naturally viewed Tariq and his siblings as her children. Tariq used to go to her house for sleepovers and it was a really strong relationship. She was another mother to them and when Tariq and his siblings were younger, they spent more time with Tamseela.

2.4.34 By all accounts given Tamseela's second marriage was a happy and fulfilling one. Altaf informed the review that Tamseela was very happy in that marriage. Tamseela's nephew Tariq told us that he had fond memories reflecting 'My uncle was a great man and was partially blind. He was really kind and warm hearted. He never lost his temper, and he was kind and generous. In terms of his marriage to my aunt they travelled the world and had a lovely life. My aunty was distraught when he passed

away. When he passed away, she was grieving for a long time. We stayed with her for 3-4 months as my brother and I attended college nearby. With time she got better, and she managed. We used to see her, and she came to eat with us when we moved'.

2.4.35 In 2007 Altaf and Aleena moved to a new home. After Tamseela lost her second husband in 2010, they did what they could to help her with shopping and whatever she needed. Hussain recalls that Tamseela began to hoard things after her husband passed away in a distressing manner. Tamseela became sick and frail and wanted to settle down. Hussain thought that Tamseela's first marriage may have been arranged in the same manner. Tamseela wanted someone with her for companionship and security, which was reinforced after Tamseela's flat was burgled on 15 April 2017.

2.4.36 Aleena and Altaf tried to find Tamseela a suitor who was like her second husband but were unsuccessful in doing so. Aleena and Altaf started to look for a suitable partner who did not have children. Tamseela trusted Aleena to provide her with advice. There were other suitors for Tamseela, but Aleena did not approve of them. Tamseela apparently respected Altaf's advice and treated like a father figure even though he was younger than her. The Panel noted the lead role played by male members of Tamseela's community and the manner in which marriage arrangements take place. This was further explored in the DHR Reviewers' meeting with the mosque management.

2.4.37 Altaf stated that Nadim volunteered at the mosque and that the Ahmadiyya system is very traditional. Nadim was introduced to Altaf by a friend at the mosque they frequented, and everyone said that he was a nice man. Aleena had no preliminary concerns and thought Nadim seemed 'normal'. Aleena recalled that Tamseela's name had been given to friends to find a suitor – as part of Rishta Nata, and her husband's friend identified Nadim. He told the family that Nadim's children were married, and he did not have any liabilities due to his age. As a result, the family thought he was suitable for Tamseela. Tariq met Nadim before the marriage and described him to be smaller in stature than his aunt, was older and frail. Tariq was concerned that his aunt's needs would not be met as she would spend her time caring for him.

2.4.38 Aleena and Altaf held an initial meeting with Nadim before arranging for him to meet Tamseela at her home. Aleena, Altaf, Tamseela and Nadim met for tea. Aleena described Nadim as ‘normal’ and respectful and noted his odd sense of dress. Aleena and Altaf next met Nadim a couple of times thereafter on his own. Aleena’s family had some reservations about the proposed union and Nadim’s suitability.

2.4.39 A formal engagement was subsequently agreed after Nadim arrived at a meeting between the families, with his cousin and son (although it has been noted that Nadim’s children did not apparently approve of the union) or son-in-law and the nikah paperwork was signed. Nadim was described as being quiet that day and contributed little to the conversation, but it was acknowledged that Tamseela and Nadim liked each other. Altaf was described as a father figure to Tamseela, and he signed the paperwork for the marriage to take place.

2.4.40 A marriage fixing ceremony took place at Tamseela’s home. Nadim brought an Indian suit and some sweets to the function and was accompanied by two men and a woman. Tamseela did not want ‘a show’ and Aleena and Altaf attended alone without any other of Tamseela’s siblings. The eldest siblings were happy that Tamseela was getting married and were pleased that she would now not be living alone. Altaf states that it was Nadim who asked for the nikah to be announced in Pakistan as it could be done quicker. Altaf explained to the review that in the Ahmadiyya faith in the UK there is a requirement to have a marriage legally registered. That notwithstanding, it was agreed that the nikah ceremony would take place in Pakistan without a UK legally recognised marriage. Tamseela’s family harbored concerns about Nadim’s access to Tamseela’s money if they had been legally married in accordance with English law.

2.4.41 After the wedding had been announced in Pakistan, the family wanted to celebrate but Nadim did not want to as his children disapproved.

2.4.42 After the nikah, Tamseela disclosed to her sister that Nadim was seeing specialists at a hospital in Southwest London providing In and Outpatient mental health services. This caused the family concerns and there sprung a realisation that Nadim had a serious ill health condition.

2.4.43 Nadim was renting a room near the mosque and his cousin had called Tamseela to say that he had been taken to hospital. Tamseela attended the hospital and had asked the mental health professionals if her brother-in-law Altaf could look into Nadim's mental health issues as she did not speak English well, but according to family members this request was not acceded to. The family view is that Nadim was discharged from hospital when he should not have been. Nadim returned to the address he shared with Tamseela, although she was apparently not happy about this, but felt sorry for him when he had gone into hospital.

2.4.44 The last time Aleena saw her sister Tamseela alive was on 29 September 2018 when she visited her home with her husband to deliver sweets to mark her own daughter's marriage arrangement. Nadim was sitting and his mood appeared to be off. Aleena informed the DHR Reviewers that on a previous occasion whilst she was speaking to her sister on the telephone, her sister indicated that she needed to go home quickly as Nadim was home alone. She was worried he may do something to himself and disclosed that Nadim was always asleep. Aleena informed the DHR reviewers that Nadim did not speak, shop, pay bills and that Tamseela was doing everything. Tamseela was unhappy in her marriage from the first or second week. Nadim apparently, according to Aleena, had no interest in their home and was described as behaving like a lodger.

2.4.45 The DHR Chair interviewed a senior mosque representative, Sulman. Nadim was described as being smartly dressed with no signs of deteriorating health. Nadim's mental health problems were apparently not known or disclosed. However, following his marriage to Tamseela, he showed signs that he was under pressure. Nadim told a colleague that his children did not take the news well of his marriage, which made him sad. The DHR reviewers noted that this was not in accordance with Nadim's own account to us. It is said, that at one point a co-worker had found him in tears where he mentioned his unhappiness.

2.4.46 Sulman reinforced the family's views that Tamseela was a kind-hearted, generous woman and was well liked in the community. Tamseela attended the Women's Auxiliary Group at the mosque and had apparently disclosed to a friend that

she had not regretted her marriage but would one day share her problems. This did not happen.

2.4.47 The Women's Auxiliary Group (called 'Lagna') draws its automatic membership from all young women over the age of 15 years.

2.4.48 The mosque representative informed the DHR Reviewers that the community regularly holds discussions and forums on marital issues and behaviour towards spouses. This is done at a local and a national level. Upon the confirmation and agreement of a marriage, a 'counselling' session takes place with the perspective couple to set expectations and roles and responsibilities of both in the marriage. At this stage it is explained that domestic violence and any abuse within the marriage are against the teachings of Islam and the practice of marriage. This is done before the marriage takes place. The DHR Reviewers noted that there was no way of measuring the impact of this activity on the community or couples who are potentially undertaking the 'counselling'.

2.4.49 In light of the ages of Tamseela and Nadim, it is unlikely that such as counselling session will have been conducted at the mosque.

2.4.50 The DHR Reviewers were given an insight into the community faith practice and noted that every Friday the 'Head of the Community' delivers advice on various topics including DA and the treatment of spouses. Every year at the annual convention one of the keynote addresses by the 'Head of Community' is focused on domestic 'behaviour' and how to inculcate a happy family life.

2.4.51 The community support and counselling body is also used to resolve marriage disputes and other problems. The mediation process undertaken highlights the law of the country and Islamic teachings. The focus is equally on both e.g. the Islamic ikah cannot take place until a counselling session and a marriage registration in the country has taken place. This accords with the reasoning provided by Tamseela's family regarding the choice of a nikah announcement in Pakistan.

2.4.52 According Sulman it is thought that Nadim's late father-in-law (now deceased and from his first marriage in Pakistan) had a key role in match making. The panel noted the possibility that the exact mosque procedures were not followed in Tamseela and Nadim's case. For example, it is suspected that the vetting stage was missing and the lead time in the match making was also reduced due to the age of the parties.

2.4.53 The family were asked about the responses to mental health and DA in their community when they met with the DHR Reviewers. Tariq stated that he is not aware what services and help are available for DA. Tariq's understanding is that this is a matter between husband and wife. There are discussions around how to form successful marriage – talking and communicating. Tariq's mother Aleena is of Pakistani heritage and Tariq highlights that from his perspective DA and mental health are taboo subjects in the Pakistani community. Nadim's mental health issues were not disclosed at the time of the marriage and there was a perception that they were brushed under the carpet. Tariq highlighted his thoughts regarding his community and stated that for his generation things are different now particularly the removal of the stigma associated with disclosure of DA. The DHR Reviewers considered that a learning opportunity presented for the community members to break down the potential barriers identified by Tariq in relation to DA and mental health. The CSP should engage, in our view, and work in partnership with the Ahmadiyya and other minority communities within the borough.

2.4.54 Tariq provided further insight into his Pakistani heritage from his mother's side. His father is Tunisian. In the Pakistani culture, according to Tariq, there is great emphasis on pride and how a person is viewed by the community. Nadim was suffering from poor mental health, and he was distraught that his daughter had divorced in Pakistan, and this may have been viewed as a shameful act. In Tariq's view, Nadim's daughter could not remarry because of the blame, shame and dishonour associated with divorce. Tariq highlighted the pressure on young people in the community. They require parental approval to select a life partner, and that the parents have a final say in the decision to marry.

c. The tragic incident

2.4.55 According to Tamseela's family members, she disclosed that Nadim's behaviour changed immediately after the wedding. Nadim became extremely quiet, reserved and uncommunicative. He told Tamseela that he could hear noises and would complain about the TV being too loud. Six months after their marriage, which took place in January 2018, it became clear to Tamseela that Nadim had problems with his mental health, and she could not cope resulting in their separation. Nadim first moved to a rental address in Southfields, Wandsworth but after a short time and due to his erratic behaviour, his landlord asked him to leave, and he moved for a second time to stay with Ali and his family. Ali told the DHR Reviewers that Nadim's mental health deteriorated during this period, and he was showing signs of depression. He would not talk to anyone, spent a lot of time alone in his room and only ate if food was prepared for him.

2.4.56 The DHR Reviewers have outlined the involvement of the statutory agencies below. This provides the details to the entries contained in the consolidated chronology attached at Appendix 4.

2.5 Metropolitan Police Service

2.5.1 The Panel agreed that the MPS was not required to complete an IMR in light of their limited interactions with Tamseela and Nadim prior to the homicide taking place. That said, the MPS provided the Panel with a letter, which confirmed that on a specified date in November 2018 Police were called to and attended the home address of Tamseela where they found her lying on her bed with severe head injuries; Tamseela was declared dead at the scene. The 999 call at 11.39pm by Tamseela's nephew Hussain stated, 'my aunt is dead, it looks like she has been beaten to death'. Police arrived at the scene at 11.45pm and were met outside by Hussain.

2.5.2 A Police Officer stayed with Nadim whilst another entered the address to assess the crime scene. Nadim was then arrested on suspicion of murder at 11.49pm; however, it should be noted that Nadim spoke Urdu not English. London Ambulance

Service (LAS) arrived on scene and a paramedic pronounced Tamseela deceased at 11.55pm.

2.5.3 Nadim was taken to Wandsworth Police Station and a homicide investigation commenced. Whilst in Police custody Nadim was subject to a mental health assessment by Dr 'GE' to determine his fitness to be detained and interviewed. During this assessment Nadim said that he had a fight with his wife Tamseela after she declined to switch off the TV or turn the volume down. He apparently was hearing the distressing voices of his daughters in Pakistan and thought that he could see their faces on the TV. They started to argue, and Nadim had used anything he could lay his hands on to hit her. Nadim now regretted his actions that he did not mean to kill her as he just lost his temper and became angry. Nadim said that he sometimes heard voices talking to him and that he had felt depressed and suicidal in the past but never attempted to take his own life.

2.5.4 Nadim was deemed fit to remain at the police station and as a result he was interviewed by Police in the company of a legal advisor, interpreter and an appropriate adult. He declined to answer any questions or provide any sort of explanation to the officers. On 14 November 2018, Nadim was charged with the murder of Tamseela and remanded into custody to appear at Wimbledon Magistrates Court following which he remanded into custody awaiting trial.

2.5.5 The MPS reacted to two reports from Tamseela due to her being a victim of crime; once in response to a criminal damage in 2008 and then a burglary in 2017. Police were also involved in a call to assist the LAS on the 16 October 2018 when Nadim's cousin Ali called them when he became concerned about Nadim's mental health. This resulted in Nadim being taken to hospital for a voluntary assessment (see paragraph 2.5.10 below). There were no incidents of DA reported between Tamseela and Nadim, nor were there any between Tamseela and her second husband.

2.5.6 On 7 January 2008 criminal damage to a window at Tamseela's address was reported to the Police. No suspects were located.

2.5.7 On 15 April 2017 Tamseela reported to the Police that whilst attending a family wedding she returned to find her home ransacked and burgled in which £400 cash was stolen. Understandably she was very distressed and had to be taken to Aleena's home address by the Police.

2.5.8 Police enquiries revealed that Tamseela frequently stayed away from her home following the burglary. She became lonely following the death of her second husband and even more so after the burglary, which left her feeling very afraid and vulnerable. This incident added a renewed momentum for Tamseela to remarry. In December 2017 Tamseela and Nadim were introduced by the community for a prospective arranged marriage. These meetings led in January 2018 to an Islamic (non-UK legally binding) marriage, after which Nadim moved into Tamseela's home.

2.5.9 Tamseela was close to her sister Aleena who is married to Altaf. They have three adult children Hussain, Tariq and their sister who was not interviewed as part of the DHR. They all live in the UK and had regular contact with Tamseela.

2.5.10 In about September 2018 Nadim had gone to stay with his cousin Ali. On 16 October 2018 Nadim was crying in his room and began hitting himself around the head. Ali and his wife tried to help him and calm him down but to no avail. This was the first time Ali had ever seen Nadim display any sort of violence and he was so concerned for his wellbeing that he called the LAS. Police were also called to this incident by the LAS from the scene (Source: Computer Aided Dispatch 3024 for that date refers). Nadim was thought to be suffering from a psychotic episode. Ali said he'd been acting strangely, having stayed with him for 3 – 4 weeks, but this was the worst he had seen him. No offences were alleged, and Nadim was taken to St George's hospital via ambulance for voluntary treatment.

2.5.11 A Police MERLIN[25] report was completed in relation to this matter and under the Adults Coming to Notice category the risk was initially graded as Amber Level 3 and following Pre-Assessment Checks (PAC) by a Multi-Agency Safeguarding Hub

[25] MERLIN - system the MPS uses to record and share information about missing persons, children and vulnerable adults.

(MASH) supervisor the grading remained the same. On 17 October 2018 the information was shared with Wandsworth Social Services.

2.5.12 Whilst Nadim was in the hospital under assessment Tamseela was contacted by Ali's wife to ask her for details about Nadim's GP and out of a sense of duty she attended the hospital to see him. She had thought that Nadim had been living with his sons so was surprised when she discovered that he was with Ali and his family. Tamseela stayed at the hospital with Nadim and the following day when he was discharged to the community Mental Health Team, Tamseela took him back to her home address to look after him. Nadim received daily visits from the Home Treatment Team (HTT) and then he continued with once weekly visits to a clinic.

2.5.13 Tamseela described Nadim's behaviour as progressively getting worse, including that he was hearing more noises and voices. Aleena and Altaf saw Tamseela and Nadim on Monday 29 October and described Nadim as being very withdrawn, mumbling and slurring his words and appearing very sluggish. Aleena and Tamseela would speak regularly on the phone every couple of days. The last time they had a phone conversation was in early November 2018. Coincidentally, this was the date that Nadim was discharged from the care of the mental health HTT.

2.6 GP Practice

2.6.1 The DHR Reviewers met with the GP practice where Tamseela and Nadim were registered finally in January 2022. The delay in obtaining an IMR was attributed to the Covid 19 pandemic and a meeting with the Lead GP was therefore arranged as an alternative.

2.6.2 Tamseela was under the care of a GP who has since retired from the practice. Tamseela joined the practice in September 2000. Little information is noted in her medical notes suggesting that she did not attend her surgery frequently and was in the main a well woman. Following her marriage, Tamseela informed her GP that having got married to Nadim, after so many years on her own, that he would not communicate with her. The GP surgery had not identified that Tamseela and Nadim were living apart at the time of Nadim's admission to A and E on 16 October 2018.

2.6.3 Nadim joined the practice on 3 August 2018. The medical conditions noted by his previous practice include not only a problem with his eyes due to cataracts but headaches too. No reference is made to mental health problems. In August 2018 Nadim complained of tension headaches to his new GP whom he visited with Tamseela. Tamseela interpreted on his behalf and an interpretation service was not used. Tamseela was advised to take him to hospital if his headaches persisted. A further consultation in August 2018 addressed Nadim's ongoing stress and on 3 September 2018 he was referred to the mental health team. He was seen to mumble under his breath and make little eye contact.

2.6.4 Nadim had been referred back to his GP from the mental health HTT with a medication plan in early November 2018. This tragic incident took place within days of this referral and before he was seen by his GP.

2.7 **Adult Social Care**

2.7.1 Adult Social Care (ASC) had limited historical involvement with Tamseela. In 2003-2004 there was a period of brief occupational therapy involvement regarding the instalment of equipment in her home, which related to Tamseela's second husband.

2.7.2 Following this in June 2009 Tamseela contacted ASC Access Team enquiring about a carer's assessment due to the caring role she was providing for her late (second) husband. Tamseela was having difficulty coping with her caring responsibilities as her (second) husband who was receiving 24-hour nursing support at home. This also impacted on Tamseela's own health, she had a diagnosis of myopathy, which affected her ability to use her hands. There were several contacts with Tamseela via telephone and home visits. The option of home support was discussed, however her late husband was then admitted to hospital, and Tamseela stated she no longer required support at home and the case was closed in April 2010.

2.7.3 In October 2017 Tamseela telephoned the same Access Team enquiring about support for shopping and household tasks. Following discussion, the Access advisor signposted Tamseela to voluntary shopping agencies, and Tamseela explained she

would like to look into a private cleaning company as services via Adult Services are means-tested.

2.7.4 ASC have confirmed that there are no records on their system regarding the death of Tamseela (second) husband, or of Tamseela's subsequent relationship with Nadim. The only notes on Nadim's record are of a Police Merlin report received on 17 October 2018 when concerns were raised by Police about Nadim's mental health, and of the Mental Health Act (MHA) assessment completed in Police custody following Tamseela's death. At the time of the Merlin report, the concerns raised related to Nadim's mental health, and he was taken to hospital. Whilst ASC have noted that there were no concerns raised regarding social care needs, and no further action was taken by them at this time, the absence of professional curiosity is noteworthy. The key issue is whether ASC, on receipt of the Police Merlin Report on 17 October 2018, considered the impact of Nadim's mental health on members of his household, namely Tamseela.

2.8 South West London and St George's Mental Health Trust ('the Trust')

2.8.1 The Panel agreed in advance that the Trust's Root Cause Analysis Report would form the IMR based on staff Interviews, statements, policy review and patient record review, subject to additional questions being answered.

2.8.2 Tamseela was not known to the Trust, but Nadim was a patient. The Trust worked alongside Tamseela to support Nadim's care including social care. A social worker spoke to Tamseela regarding benefits and how Tamseela was struggling to manage Nadim at home.

2.8.3 In late August 2018, Nadim self-referred to the Wandsworth IAPT service and he commenced sessions with a therapist in October 2018. It was noted then that he spoke Punjabi and Urdu. In September 2018, Nadim reported to his GP that he was unhappy in his marriage, whilst Tamseela was reporting her concerns about him not speaking to her. On 16 October 2018, Nadim presented to the Accident and Emergency Department at St George's University Hospital in distress. (We note that he was accompanied by his cousin Ali). Nadim was assessed by the Liaison Psychiatry Team and referred to the Wandsworth HTT for further assessment and

monitoring. He was under their care for a 2-week period - from 17 October to 9 November - after which he was discharged back to the care of his GP. HTTs assess patients being considered for acute hospital admission to offer intensive home treatment rather than hospital admission.

2.8.4 The key interactions with medical professionals identified by Dr Javed for this review include:

- 22 August 2018 - Nadim self-referred to the Wandsworth IAPT service. It was noted that he did not speak English and that his wife Tamseela could speak on his behalf. The DHR Reviewers were informed by the family representative that Tamseela's first language was not English. Whilst Tamseela was capable of speaking English for rudimentary everyday activities she may not, according to the family, have understood and translated medical terms. Nadim was offered an initial assessment with a Punjabi interpreter in attendance. He was diagnosed as experiencing a depressive episode.

- 4th September 2018 – Nadim was referred to the Wandsworth Single Point of Access Team (WSPA)[26] after being "uncommunicative" with his wife Tamseela. This was confirmed by Tamseela at the initial visit to the HTT.

- 5th September – WSPA: The GP's referral was received by the Wandsworth SPA. The referral was non-urgent with no immediate clinical risk noted. The referral was received by the team on the day it was sent by the GP. They received a non-urgent referral (i.e. patient to be seen within 28 days) on 4 September 2018 describing Nadim as being non communicative with Tamseela

[26] The WSPA offer triage and assessment of mental health needs for all service users who live in Wandsworth and have been referred to community mental health services. They receive 20-30 referrals per day, and it is not physically possible for the duty worker to contact every patient on the same day. There is only one duty worker per shift, and they are responsible for assessing whether the GP referrals are urgent or non-urgent and prioritise their contact accordingly. The duty worker uses a referral screening tool during the telephone triage and this assists in deciding the urgency of the referral. The timeframes for responding to referrals set out in the team Operational Policy state for emergency referrals - patients require assessment within 24 hours or assessments under the Mental Health Act. Urgent referrals - patients will be seen within 7 days of the referral. Routine i.e. non urgent- patients will be offered an appointment within four weeks. This is in line with commissioning arrangements.

and experiencing abnormal body movements and panic attacks. The GP prescribed Propanol to treat Nadim's anxiety. The GP did note that an interpreter would be needed.

- The WSPA duty worker attempted to call Nadim on 26 September 2018, but no contact was made.

- 2 October 2018, a letter was sent (in English) offering an appointment for 8 October 2018. The DHR Reviewers noted that Nadim could not speak English and that Tamseela's knowledge of English was limited.

- 8 October 2018 - Nadim did not attend this appointment. When Nadim did not attend the WSPA staff attempted to contact Nadim by phone, but the call was not answered. The DHR Reviewers noted the absence of information detailing the telephone number called and whether this was Nadim's.

- 16th October – Liaison Psychiatry: On 16 October 2018, Nadim self-presented to the A and E Department of St George's University Hospital with his brother (the DHR Reviewers and Panel now know that this was his cousin) and his wife, Tamseela, arrived later having been alerted by the Nadim's cousin's wife. Initially the Liaison Psychiatry Team were unable to assess Nadim due to his inability to speak English. He was later assessed with the assistance of an Urdu speaking doctor. Nadim explained that his current symptoms had begun in April 2018. He was restless and showed signs of distress (he had been slapping himself). He reported having intermittent thoughts of self-harm. He denied plans to end his life or harm others. The clinical impression was that Nadim had an affective disorder with psychotic symptoms. He was referred to the Wandsworth HTT for on-going assessment. Nadim and his wife agreed to the plan.

- 16 October - HTT: A referral was received successfully the same day. Information was passed to the SPA team who closed their open referral as they could see the case had been accepted by the HTT. HTT attempted to contact

Nadim the same day however did so without an interpreter. A combination of using Urdu speaking staff and interpreting services were used in follow-up appointments for a limited number of visits; on only 5 of the 14 visits was an interpreter provided either through an official interpreter or a staff member with Urdu language skills. Nadim's diagnosis whilst under the care of the HTT was changed to a non-psychotic condition and he was prescribed an anti-depressant and medication to aid sleep. Part of the role of HTT was to be aware of medication compliance and to indicate clearly in the notes how and when the medication was being supervised.

- 17 October 2018, the HTT Associate Specialist Doctor went on a first assessment of Nadim at his home, but there was no interpreter present. An interpreter had not been booked prior to the assessment taking place due to an oversight. It was the expectation of the Associate Specialist Doctor that once the referral had been accepted that an interpreter would have been arranged at the same time. He was unable to assess Nadim but spoke with Tamseela who explained that they had married 7 months previously and that Nadim was fine and in employment. He had, however, stopped working in August and started to slap himself in September. He had also stopped talking to her. Nadim had told Tamseela that he was not enjoying anything and felt useless. Nadim described hearing voices which made him scared. He denied any suicidal intent or plans.

- WSPA - Telephone triage assessment was attempted within the timescales however Nadim did not answer the phone. The appointment letter was not translated into Urdu despite the team being aware Nadim could not speak English. The GP was not contacted when he did not attend the appointment as per SPA policy.

- HTT continued with daily visits. In the main Nadim was seen either with an interpreter or by an Urdu speaking member of nursing staff.

- 23 October 2018 HTT Associate Specialist Doctor assessed Nadim with an interpreter he prescribed Sertraline and Zopiclone. The medication was supplied by nursing staff the following day.

- By 28 October 2018, the HTT staff, based on Nadim's presentation and following a clinical discussion, agreed Nadim had improved and could be visited on alternate days.

- Nadim was discharged from HTT on 9 November 2018 back to the care of his GP as the team assessed that he was no longer in crisis.

2.8.5 Between 26 October 2018 and 8 November 2018, Nadim had three counselling sessions with The Awareness Centre.[27] The therapist noted by his third session that Nadim's symptoms of depression had not significantly improved but would continue with his treatment.

2.8.6 Nadim was assessed under the MHA whilst in Police custody and was found not to be detainable under the Act. The Trust IMR indicates that during the assessment Nadim reported he had killed his wife Tamseela on a specified date in November 2018. On 15 January 2019, Nadim was transferred from prison to a medium secure forensic ward for further psychiatric assessment.

2.9 Wandle Housing

2.9.1 Wandle Housing was Tamseela's landlord. They were unaware that she had re-married, and that Nadim was in occupation. They had not had any involvement with Tamseela since 2017 and had no reason to be in contact save for sending letters such as rent statements, annual rent review/change letters etc. There were no reports from neighbours of any tenancy breaches or other problems, so Wandle Housing had no cause to contact Tamseela about her tenancy. The rent account was well maintained

[27] The Awareness Centre is a third party provider for counselling and psychotherapy services to the local and wider community in South London. The Centre work in partnership with Wandsworth IAPT.

and Tamseela had not reported any repairs since August 2017 when a lock change was carried out following a burglary. The DHR reviewers noted that that burglary actually took place on 17 April 2017.

2.9.2 Wandle Housing had no contact with Nadim at all.

2.10 London Ambulance Service

2.10.1 The panel agreed that an IMR was not required from LAS. The consolidated chronology details two contacts – the first in relation to a request for advice by Tamseela on 12 September 2017 and the second in relation to this tragic event.

3. Analysis

3.1 Cultural Context

3.1.1 The Panel was greatly assisted by the membership of the AWRC, in particular, the valuable insights that they provided into the Ahmadiyya sect, which complemented the DHR Reviewers engagement with the mosque. The distinguishing features to the approach to marriage and gender equality are invaluable to the central issues of this review. The views expressed by the AWRC are based on their knowledge and experience.

3.1.2 The Panel were particularly interested in the role that male family members undertake in relation to arranged marriages in this community. The AWRC advised the Panel that due to the close-knit nature of the Ahmadiyya community, there is inequality between men and women. Men are seen as the breadwinners and women are focussed on raising children. Male members, religion and the wider community play a prominent role in marriage arrangements.

3.1.3 The AWRC were of the view that older women are vulnerable within the community and if they are living alone or have been married before or are divorced

there is a stigma associated with this. There is an expectation for a woman to be married, and male members have a large say in this.

3.1.4 The inequality between men and women within the community was drawn to the attention of the Panel. The view of the AWRC is that women are not permitted to have a voice, their main role is to be a good wife and to raise children to train them, teach them, guide them on the moral and religious path. In the main the woman's primary role is a mother and that is the main Islamic concept.

3.1.5 The community is bound in brotherhood and sisterhood and extra importance is placed on manual labour to make sure that all members can understand the dignity of labour. For women, there are special programmes, so they practice on various branches of domestic science and household duties. Each country with an Ahmadiyya mosque has a national women's committee and a men's president. They have an annual timetable of events to bring the community together.

3.1.6 Members of the community spend long hours in the mosque attending functions and this results in marriage unions including international marriages. Mosques play a key role in arranging marriages for members of the communities. The Messiah allows men to marry non-Ahmadis and non-Muslims, because men can influence their wives into the Islamic belief and way of life the mosque wants. Yet, the Ahmadi women cannot marry a non-Ahmadi man, because it is difficult for a woman to practice her religion when married with a non-Ahmadi. In the marriage, the groom and the bride's guardian must be present, so the bride may or may not be present. The nikah must performed by a lawful authority within the community. Then the groom should give a reception (walimah), and this reception must not be extravagant.

3.1.7 According to the Ahmadiyya sect, 'man has been assigned to working outside the home as the breadwinner because of his greater physical strength and psychological abilities; likewise, the woman is physiologically and emotionally suited to bearing children and has been made responsible for their upbringing and maintaining the home. 'Within the community birth control and abortion is forbidden but women should have at least 2 years gap between pregnancies. Mosque leaders

practice mediation to keep couples together for the sake of the children and religion and it is very difficult for women to get divorces.

3.1.8 Marriages amongst Ahmadi Muslims are usually arranged, with the consent of both parties. Parents or guardians arrange the marriages of their children once they reach a suitable age and level of maturity. They believe that this method of mate selection produces more stable and happy marriages.

3.1.9 Ahmadi women are the upholders of religion. Women are expected to sacrifice everything for their faith and if you are successful in spreading the word of Islam then you are seen to be successful mothers, and successful Ahmadi Muslim women.

3.1.10 Although the AWRC have not provided support to women from the Ahmadiyya community, they do provide support to women from South Asia i.e., India, Pakistan, Nepal, Sri Lanka, Bangladesh and the Far East. They have also provided support to women and children from several African nations, the Middle East and Europe. They have an open-door policy towards all women in need.

3.1.11 As a result they are aware of the pressures South Asian women experience and many do not speak out against domestic violence due to cultural pressures of ‘izzat’ (honour) and ‘sharam’ (shame). South Asian women who speak out about DA are often stigmatised by their community and extended families and separated or divorced women face social isolation. Consequently, many women remain in abusive relationships, putting their physical safety at risk and damaging their self-esteem and confidence which often leads to self-harm and attempted suicide. South Asian women, particularly those who are more isolated, are not aware of their rights and entitlements consequently experience difficulties accessing services. This disadvantage is further exacerbated by cultural and religious pressures, immigration restrictions and language barriers. What we do know about the Ahmadiyya community is that if problems occur within the home, they try to deal with them internally through the religious institutions and try to keep families together through mediation.

3.1.12 The contribution from the AWRC has highlighted the need to consider how the borough works with marginalised communities.

3.2 Analysis

Adult Social Care

3.2.1 As previously highlighted, ASC were not involved with Tamseela at the time of her relationship with Nadim.

3.2.2 Tamseela had a carer's assessment in 2009, relating to her care for her late husband. Tamseela made the decision that no further support was required when he was admitted to hospital. There is no information to suggest an opportunity was missed at this stage, no concerns are indicated regarding Tamseela's relationships and due to the historic nature of this contact, it is not possible to analyse in the same level of detail as more recent contact.

3.2.3 Tamseela was not offered a carer's assessment regarding Nadim.

3.2.4 No cultural or religious issues or practices that may have led to Tamseela being exposed to the risk of violence or abuse were identified during the investigation.

3.2.5 Nadim reported to his GP that he was unhappy in his marriage to his second wife Tamseela.

3.2.6 ASC were not aware of Tamseela's marriage to Nadim. Tamseela could have been referred to Adult Services regarding her caring role towards Nadim, for a carer's assessment if she consented to this. This would have offered an opportunity to explore Tamseela's needs at the time from an Adult Services perspective. Adult Services however did receive the Police Merlin report on 16 October 2018 and omitted to look beyond Nadim's mental health problems to consider whether Tamseela required any additional support. The DHR Reviewers considered that this presented a learning opportunity for ASC, particularly in relation to professional curiosity to think of the impact of Nadim's mental health on Tamseela and any resulting support requirements

such as a carer's assessment. This requirement is now detailed in the current Wandsworth Council Carer's Assessment information pack.[28]

3.2.7 The brief contact with Tamseela in 2017 was over the telephone and the information presented, according to Adult Services 'appears appropriate in the outcome'. At the time Tamseela was living alone, and no concerns were raised regarding her relationships with others.

3.2.8 ASC is a partner in the Wandsworth DA Steering Group and their safeguarding team are reported to be involved in various multi-agency events each year. On an individual level social workers refer BAME clients to specialist services where appropriate.

South West London and St George's Trust ('the Trust')

3.2.7 The Trust acknowledge that there may have been a missed opportunity to gain collateral information about Nadim when Tamseela asked the team to speak to her brother (which was a reference to her brother-in-law). Nadim declined to consent to this suggestion. No carer's assessment was offered, despite indications that it should have been. Some staff in the team were not aware that Tamseela's brother-in-law could still be spoken to about the wider relationship issues and behaviours (collateral information), even though Nadim had not consented to this - and without breaching patient confidentiality. The Trust has identified the requirement for staff to be aware that they can speak to relatives (to gather collateral information and respond to some queries) even if the patient refuses to give consent. The DHR Reviewers considered this to be an area for future learning to ensure that background information should be obtained from relatives where possible.

3.2.8 The Panel reminded themselves of Principle 7 of the Caldicott Principles to assist their considerations: "The duty to share information can be as important as the

[28] https://www.wandsworth.gov.uk/health-and-social-care/adult-social-care/adult-social-care-information-and-advice/looking-after-someone/carers-assessments/

duty to protect patient confidentiality".[29] "Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies."

3.2.9 The DHR Reviewers noted that in only 5 of the 14 visits was an interpreter provided either through an official interpreter or a staff member with Urdu language skills suggesting that there was room for misunderstanding and an inability for Nadim to detail how he felt. It is accepted that Nadim could not speak English. It is unclear if any active consideration was given to Tamseela's needs as she acted as interpreter and communicated directly with HTT on Nadim's behalf. Tamseela's ability, in the DHR Reviewer's view, to access services for herself and Nadim was therefore diminished.

3.2.10 The justification for a change in diagnosis by the HTT was not documented in the medical notes, together with mistakes in recording compliance with medication. Staff were documenting Nadim was taking medication when actually he had run out of supply in breach of the medication code policy. HTT relied upon Tamseela to communicate to them when Nadim's medication was running out. The DHR Reviewers noted that Tamseela preferred her husband to take homeopathic medication, and it is unclear if this preference was ever shared with medical professionals and recorded. The Trust has acknowledged that no medicines reconciliation form was completed by the HTT.

3.2.11 There was a lack of coordinating care between the HTT and GP most notably in relation to Nadim's prescription of sleeping medication Zopiclone and his eventual discharge from the HTT on 9 November 2018. There was also a lack of coordination of care between primary care mental health and secondary care mental health services. Both services were working with Nadim at the same time however there was no communication between these agencies.

[29] Information to Share or Not to Share, The Information Governance Review, March 2013 accessed via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

3.2.12 The panel considered that Tamseela's needs were not identified or met at this stage. During a HTT visit Tamseela reported unhappiness staying with Nadim and that she herself was feeling depressed, the reasons for which were not recorded by her GP. In a further meeting Tamseela informed HTT staff that if Nadim's mental state did not improve, she would leave him. The mental health social worker who visited Nadim noted there were tensions between Nadim and Tamseela and suggested that they contact Relate. It is unclear to the DHR Reviewers if these tensions were further explored by the mental health social worker with Nadim and Tamseela, particularly any issues relating to Tamseela's personal safety. The lack of awareness of the signs and red flags regarding DA, in relation to Nadim in particular, is apparent and this has been identified as an area of development for professionals. The DHR Reviewers queried whether the current training provided to staff addresses this issue to enhance the awareness and understanding of mental health social workers. There were no specific conversations to explore these tensions further or the appropriateness of making a referral to Relate – a relationship support organisation. In addition, there was no documentation following up on the suggestion of the Relate counselling referral. The Panel considered that it would have been more appropriate to refer Tamseela to an Asian Women's support organisation that would have better understood her intersectional needs. Wandsworth Council's ASC have highlighted their commitment for training and development of staff in furthering awareness, knowledge, and skills in supporting women from BAME backgrounds experiencing or exposed to DA. The DHR Reviewers noted that ASC did not know that Tamseela had got remarried yet there was a disclosure to a mental health social worker relating to tension with Nadim. The lack of connectivity of information within ASC is apparent.

3.2.13 The DHR Reviewers noted that no information was recorded by Nadim's GP about why he was unhappy in his marriage. Tamseela indicated that her husband was not communicative. Such a comment was available at the time to HTT and should have triggered thinking about a Carer's assessment, which may have provided the opportunity for Tamseela to speak about any abuse.

3.2.14 The absence of language support for Nadim is notable. The initial assessment by the HTT could not take place as there was no interpreter present to assist Nadim aside for his wife. The Panel noted that all the information gained from this visit came

from Tamseela. There was no opportunity for the HTT to explain what they were doing directly with Nadim. Whilst Tamseela could speak rudimentary English, she may have had difficulty understanding medical terms.

3.2.15 The Trust recognises that an interpreter should have been booked for the HTT initial assessment of Nadim and all other visits. The Trust Executive Safeguarding Lead commissioned a task and finish group, which has since developed a Trust wide 'domestic violence' policy and overall strategy. In addition, guidance leaflets have been designed for staff and e-learning training packages have been developed for DA as well as in-house training, with the aim of rolling it out across the Trust.

3.2.16 The Trust has acknowledged that had the staff had access to IAPTUS (primary care mental health recording system) they would have been aware that Nadim's counsellor was reporting that his depression was not improving. The Trust has advised the review that its staff now have access to IAPTUS.

3.2.17 The Trust has identified that the HTT should review the quality of the handovers, and the accuracy of the details recorded therein. Diagnosis should be part of documented handover discussions. In addition, the HTT missed the opportunity to involve the GP in discharge planning.

3.2.18 The SPA's initial letter to Nadim following his non-attendance at an appointment should have been documented in Urdu – Nadim's first language. This omission was not in line with the SPA's 'Did not attend' policy. It is also of note that the SPA did not follow its own escalation guidance when the staff's caseload was too high influencing their effectiveness.

3.2.19 The Panel noted that the Trust's Root Cause Analysis has identified a number of key actions which includes lessons to be learned for the future. The Trust maintain that throughout Nadim's contact with Trust Services no indicators were present in behaviour or assessment which would indicate a risk to Tamseela. Although there were care and service delivery problems identified no root cause arising from the care provided by the Trust can be identified for the incident. The Panel was of the view that

the level of service delivery fell below acceptable standards when dealing with the circumstances of this case:

i. Re-training in the use of the electronic recording of medications given at home. Staff should not document compliance with medication unless they have checked;
ii. Staff should be able to have sight of the primary mental health care reports (IAPTUS);
iii. De-brief staff on the learning gained from the root cause analysis;
iv. Medication reconciliation forms completed for all new patients coming into HTT;
v. Providing interpreters for each appointment. Family members should not be engaged as the quality of the interpretation needs to be maintained to ensure clear communication directly with the patient; and
vi. Ensuring staff are aware of that they can speak to family members in limited circumstances to obtain wider information to inform risk assessments.

3.3 What might have helped?

South West London and St George's Trust ('the Trust')

3.3.1 A number of lessons have been learned by the Trust as a result 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 electronic prescribing system) instead of 'self-administered'.
- There was not a 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 Police

3.3.2 There were no concerns of DA between Tamseela and Nadim known or reported to police at any time, nor were there any concerns of such abuse in Tamseela previous marriage.

3.3.3 In relation to the mental health episode with Nadim he was identified by Police as being an Adult at Risk[30] and a Police Merlin report was created. This report was risk assessed in line with MASH guidance. The MPS has not identified any recommendations from their own analysis.

3.3.4 Given the UK national prevalence and impact of DA, preventing and tackling it is everyone's business. 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

[30] 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.

problem and are then motivated to do something about it.[31] Such positive action can be safely and effectively intervening, which can also involve calling the police.[32] An 'Active Bystander' programme is an effective prevention and intervention approach to tackling DA.

3.3.5 As part of an Active Bystander programme 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.[33]

3.3.6 The perpetrator's employer and the perpetrator and victim's faith community played a vital role in this DHR. 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.

3.3.7 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. The US academic Kimberley 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).

[31] 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
[32] Ibid
[33] More information about the Workplace Safe Spaces scheme can be found by visiting https://workplacesafespace.org/about

3.3.8 Research shows that the level of disclosure for BAME victims of DA is far lower than that of the general population, 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, which act as structural and cultural barrier(s) to accessing information or the assistance of support services.[34] BAME 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. [35]

3.3.9 Faith leaders are important role models in BAME and other communities as a source of pastoral care, 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.[36] The Panel recommends that Wandsworth Council further develops its inclusive engagement approach with local faith communities to improve awareness of preventing and tackling DA and mental health.

[34] 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

[35] 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

[36] 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 https://www.nacsw.org/Publications/SWC/SWC44_4.pdf

Adult Social Care

3.3.10 ASC 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 in light of her previous requests for support with her deceased husband eight years earlier. The Panel considered whether ASC would have had access to the previous information in relation to 2010 and whether this would have influenced decision making.

GP

3.3.11 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 concerns regarding her new husband.

3.3.12 The GP surgery did not identify that Nadim and Tamseela were no longer living together in October 2018.

3.4 Best Practice

3.4.1 The panel has not identified any best practice in this review. During the DHR process, it is noteworthy that Wandsworth Council has achieved Domestic Abuse Housing (DAHA) accreditation and White Ribbon status.

4. Conclusions and Recommendations

4.1 Recommendations

4.1.1 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[37] 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:

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.**

[37] JAC is Electronic Prescribing and Medicine Administration

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

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

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.

Appendix 1

Terms of Reference for DHR 'Tamseela'

The terms of reference describes the role of the Domestic Homicide Review (DHR) and Wandsworth multi-agency panel in this statutory independent DHR.

We will:

- Identify what lessons may be learnt from the case focusing on the ways in which local professionals and agencies worked individually and collectively to safeguard the victim to prevent future domestic homicides;

- Determine how those lessons learnt may be taken forward;

- Examine and, where possible, make recommendations to improve risk assessment/ /identification/management mechanisms and system coordination arrangements within and between all the relevant agencies;

- Assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place to identify, prevent, tackle and respond to domestic violence / abuse, including the extent to which they are understood and adhered to by their staff to identify areas of improvement;

- Improve service responses by better understanding the overall "whole - system" needs of local people and where necessary, making changes to policies, practices, procedures and protocols[39];

- Enhance the overall effectiveness of efforts to better identify, prevent and tackle domestic violence / abuse and its impact on victims through improved inter and intra agency working;

[39] Whole systems need is based on whole systems thinking, that the parts of a system are all connected and, therefore, influence each other

- Maximise opportunities for fast time learning and overall partnership improvements as well as well as medium to longer term sustainable enhancements;

- Examine and make recommendations if appropriate to improve the accessibility of services to isolated communities including older people and those experiencing mental health problems;

- Identify what should change within agreed and reasonable timescales[40].

By:

- Recognising that the victim's family are a fundamental part of the DHR and ensuring that they are given the opportunity to contribute to and be involved in the DHR from its inception in accordance with their wishes;

- Undertaking Individual Management Reviews (IMRs) in all organisations that were involved with Tamseela or Nadim[41] since the start of their involvement with the relevant agency. Analyse those reports in terms of understanding what happened, why, where things went well, where things did not go well and what could have been done differently;

- Working collaboratively with the commissioned independently chaired Level II NHS Mental Health Review

- Taking into account any immediate learning and action arising from those IMRs then review the learning and, through a consolidated chronology, and joint discussions identify key lines of enquiry (KLOE) to explore further;

[40] The timescales will be highlighted in the agencies' Individual Management Reviews (IMRs)
[41] Individuals' initials are being used at present pending the relevant parties selecting their own pseudonym (as relevant)

- Interviewing family members, the perpetrator and any professionals as identified as particularly relevant to the KLOE and taking into account the interview records;

- Considering learning from the NHS Serious Incident processes (encapsulating the Level 2 Review) and working in partnership with the Independent Mental Health professional;

- Analysing the aggregated information and identify areas of strength in practice and areas where there is learning for the partnership system in Wandsworth Borough, in the London region and nationally, which will contribute to preventing similar incidents arising, and ways in which similar incidents could be managed differently as a partnership.

The key questions we will initially focus on are:

- What signs or signals that could indicate that Tamseela was experiencing [42]domestic abuse or any other abusive behaviour including coercive control from Nadim or another person? What was the power and control dynamic? Was there a cultural and/or religious aspect(s) to this?

- What was your agency's response to effectively assessing, identifying and planning to meet Tamseela's needs and identify if opportunities were missed to identify risks faced by Tamseela? What individual and / or structural barriers affected this if any? Consider if culture and/or religion affected this in anyway?

- How did your agency effectively identify what Nadim's on-going needs were? What plans were arranged to meet his short – long term needs. Was Nadim receiving a coordinated level of service and how was this influenced by any potential cultural, religious and/or language barriers in your agency's delivery of services if any?

[42] Including Honour Based Violence and forced marriage (as per the cross government definition of domestic abuse)

- How did your agency identify whether those living with Nadim required support from public authorities and/or voluntary sector? What individual and / or structural barriers affected this if any?

- Identify whether there were any cultural or religious issues or practices, which may have led to Tamseela being exposed to the risk of violence or abuse.

- How well did your agency "see beyond" the immediate sphere of professional and legal requirements – including statutory duty, in the provision of your services? Was any action limited by policy and / or practice?

- For professionals working with Nadim what were the signs and signals that could indicate there was [43]domestic violence / abuse including coercive control in his intimate partner and / or intra-familial relationships

- How effective is your public authority, agency or voluntary organisation in promoting support for BAME women by raising awareness, preventing and/or tackling domestic abuse and equipping them to access support services? How is this promoted within communities?

- Further to the previous point, what works well (and why) and what could have been improved by your agency's approaches and responses?

The following overarching principles and approach describe how we are going to work individually and together to do deliver against the terms of reference.

We will:

- Recognise that the victim's family is a fundamental part of the DHR and that they are given the opportunity to contribute to and be involved in the DHR from its inception;

[43] Ibid

- Ensure that the victim's family's voices are listened to and heard. Additionally, we will ensure that the victim's family are regularly updated with progress at agreed intervals by the DHR Chair;

- Take any cultural and language issues into consideration. For example, we are aware that the victim's sister's first language is not English;

- Ensure that the DHR is conducted professionally, effectively, efficiently and in a respectful way;

- Be open, honest, transparent and respect the opinions and contributions of the panel members;

- Work alongside the independent NHS England Reviewer to add valued support to this statutory review;

- Draw on the strengths, knowledge, skills and experiences of the multi-agency professionals in the DHR Panel with the support of the Independent Mental Health professional.

Timescales

The timescales for the submission of the agencies' IMRs will be determined by the content of the chronologies provided by the multi-agency partners.

Appendix 2

Members of the DHR Panel

Name	Role	Agency
Gerry Campbell	Independent Panel Chair	Independent Consultant
Neelam Sarkaria	Independent Reviewer and Report Writer	Independent Consultant
Dr Afzal Javed	Independent Mental Health Advisor	Niche Consultancy
Mark Wolski	Community Safety Team, Vulnerabilities Manager	Wandsworth and Richmond Council
Albina Hiorns	VAWG Manager	Wandsworth and Richmond Council
Jo Fraser-Ellis	Housing Review Manager	Wandsworth and Richmond Council
Martina Palmer	Senior Operations Manager	Refuge
Josephine Feeney	Senior Operations Manager	Victim Support
Marino Latour	Designated Safeguarding Adults Professional	Wandsworth and Richmond Clinical Commissioning Group (CCG) [now the Integrated Care Board]
Beverley William	Detective Sergeant Specialist Crime Review Group Officer	Specialist Crime Review Group Metropolitan Police Service (MPS)
Sharon Putt	Clinical Manager, Crisis Resolution Home Treatment Teams, Street Triage and Recovery Cafes	St George's Trust Home Treatment MH Service
Suna Parlak	Harmful Practices and Domestic Abuse Officer and Educator	Asian Woman Resource Centre
Virindar Basi	Head of Professional Standards & Safeguarding Adult Social Care and Public Health	Wandsworth and Richmond Council

Appendix 3

Report by Asian Women's Resource Centre (AWRC)

Background to the AWRC

AWRC is a specialist women's organisation providing quality assured support services to BAME women and children who have experienced or are at risk of domestic abuse.

Established in 1980 the Centre provides the provision of free advice & information, advocacy, outreach, support groups and training/workshops to women.

The AWRC's work with thousands of women and girls, addressing a wide range of forms of Violence Against Women & Girls (VAWG) and complex needs over the three decades has resulted in our developing extensive expertise, which feeds into our concurrent work in training, advising, influencing, developing policy and procedures with government, public bodies and professionals to ensure safety of women and girls.

Key aims

- Work towards Ending VAWG
- Address VAWG including domestic & sexual abuse, forced marriages, "so called" honour related abuse, faith-based abuse and female genital mutilation. The Centre also supports women with no recourse to public funds, through ensuring safety, security and dignity and by offering prompt targeted responses and reducing risks.
- Tackle the many challenges associated with VAWG such as homelessness, welfare benefits, debt, substance misuse, mental health, parental conflicts, employment and cultural and religious pressures such as "sharam" (shame) and "izzat" (honour) which hold women in abusive relationships.
- Ensures that the needs of BAME women are addressed in line with the ethos of "led by and for".
- Respond specifically to the needs of BAME women who have experienced gender abuse and reach out to communities and individuals who face multiple

barriers to accessing statutory & voluntary services and promote social and community cohesion.

1. **Please provide a brief overview of the Ahmadiyya sect's approach to marriage and gender roles within marriage. Are there any distinguishing features to the approach to marriage and gender equality?**

The Ahmadiyya Community describes themselves 'Muslims who believe in the Messiah, Mirza Ghulam Ahmad (1835-1908) of Qadian.' (www.alislamorg) According to Mirza Ghulam Ahmad he was the second coming of Jesus Christ and the last Mahdi which is written in Kur'an too. The Ahmadiyya Community believes that with the Messiah/prophet Mirza Ghulam Ahmad, all the religious wars will be end and he would bring the peace to the World. The Community rules by the khilafat (the spiritual institution of successorship to prophethood) and the 5th Khalifa Mirza Masroor Ahmad resides in the UK. The community has more than 15000 mosques, nearly 1000 schools, and they have their own hospitals (30). The community mainly watches their 24-hour satellite TV channel (MTA) and, follows www.alislam.org , have their original publication (Islam International Publications) and an international charity Humanity First.

The Ahmadiyyas also follows the Tahrik Jadid scheme, which was founded by the second Khalifa Hadhrat Khalifatul Masih on 23rd November 1934. According to the Tahrik Jadid, the member of the community must decide how and how much sacrifice they can do for defending the community. According to the Tahrik Jadid, the community must follow the below principles:

- Lead simple lives
- Spread the word of Islam to the World
- Dedicate their lives to the sake of the Islam and to god and fulfil duties to god for example praying and fasting.
- Dedicate their holidays and all their free time for the benefit of their community and charitable work.
- Ensure that the children are raised in Waqf (devotion)
- The Ahmadiyyas, who cannot work, also have to offer themselves to the community

- The Ahmadiyyas should dedicate a 5th of their income (as a minimum) to their communities.
- They are very close-knit communities, and they feel that non-believers and not Muslim
- Women are seen as upholders of religion.

According to Tahrik Jadid, the Ahmadis are forbidden to attend cinemas, theatres, circuses and must live a simple life (food, dress, housing, furnishing, etc.)

Ahmadiyya in the Islamic Countries

In 1958 and 1974, there were two serious attacks to the Ahmadiyya Community in Pakistan. In mid-1970s, the World Muslim League called on all Muslim Governments must take action against to the community.

In 1974, Prime Minister Zulfikar Ali Bhutto said that the Ahmadiyyas are a non-Muslim minority. Followingly, in 1984, the current President Zia-ul-Haw made a criminal offence for Ahmadis to call themselves Muslims, use Muslim practices in worship. Then headquarters of Ahmadiyya moved to London.

2. **What role do male family members undertake in relation to marriage arrangements?**

Due to the close-knit nature of the Ahmadiyya community, there is inequality between men and women. Men are seen as the breadwinners and women to raise children. Male members, religion and the wider community play a prominent role in marriage arrangements.

3. **What is the perception of an older, widowed woman in this society? Do women have a voice? Is there community pressure for single (is there an age limit to this) / widowed / lone women to be married?**

Older women are vulnerable within the community and if you are living alone or have been married before or are divorced there is a stigma attached to this. Women are accountability to the male members of the communities and are upholders of religion. There is an expectation for women to be married, she is not following religion if she is

not married, the marriage must be chosen by the community and male members have a large say in this.

Women are not permitted to have a voice, their main role is to raise children train them, teach them, guide them on the moral and religious path, this also involves being a good wife, obviously looking after your family, caring for your husband, looking after the home this is driven by religion and they will be asked questions about their children in terms of how well they have brought them up. In the main the women's primary role is a mother. And that is the main Islamic concept.

4. What is the norm or usual practice in terms of marriage ceremonies? Do community members play an active role at the mosque of match making?

The community is bound in brotherhood and sisterhood. They put extra importance on manual labour and to make sure that all members can understand the dignity of labour. For women, there are special programs, so they practice on various branches of domestic science and household duties.

Each country mosque has a national women's committee and a men's president, and they have an annual timetable of events to bring the community together. Members of the community spend long hours in the mosque at functions. These network results in marriage unions and networks, this also includes international marriages. Mosques play a key role in arranging marriages for members of the communities.

The Messiah allows men to marry non-Ahmadis and non-Muslims, because men can influence their wives into the Islamic belief and way of life the Mosque wanted. Yet, the Ahmadi women cannot marry a non-Ahmadi man, because it is difficult for a woman to practice her religion when married with a non-Ahmadi.

In the marriage, the groom and the bride's guardian must be present, so the bride may or may not be present. The Nikah must performed by a lawful authority within the community. Then the groom should give a reception (walimah) and this reception must not be extravagant.

According to the Ahmadiyya sect, 'man has been assigned to working outside the home as the breadwinner because of his greater physical strength and psychological abilities; likewise, woman is physiologically and emotionally suited to bearing children and has been made responsible for their upbringing and maintaining the home.'

Within the community birth control and abortion is forbidden but women should have at least 2 years gap between the pregnancy.

Mosques leaders practice mediation to keep couples together for the sake of the children and religion and it is very difficult for women to get divorces.

5. What is the practice of marriages of UK residents of Pakistani origin to be announced in Pakistan? How commonplace is this? In what circumstances would forms completed by male family members 'authorising' the marriage be completed in the UK and sent to Pakistan? Do you have any examples of the forms used?

Marriages amongst Ahmadis Muslims are usually arranged, with the consent of both boy and girl. Parents or guardians arrange the marriages of their children once they reach a suitable age and level of maturity. They believe that this method of mate selection produces more stable and happy marriages.

6. What is your understanding of the role of the two mosques that lead service for this faith community?
- What role is undertaken by the Women's Auxiliary Group / Service? Is this unique to the Ahmadiyya Faith?

Ahmadi women are the upholders of religion. Women are expected to sacrifice everything for their faith and if you are successful in spreading the word of Islam then you are seen to be successful mothers, and successful Ahmadi Muslim woman.

7. Have you dealt with cases involving women from this community who feel marginalised? Please can you provide an overview from your experience as opposed to specific examples.

Although the AWRC have not provided support to women from the Ahmadiyya, at least we are not aware if women who have approached us for support have been from the Ahmadiyya community, the Asian Women's Resource Centre does provide support to women from South Asia i.e. India, Pakistan, Nepal, Sri Lanka, Bangladesh and the Far East. In recognition of the changing ethnic diversity of Brent, we have also provided support to women and children from several African nations, the Middle East and Europe. We have an open-door policy towards all women in need.

As a result, we are aware of the pressures South Asian women experience many do not speak out against domestic violence due to cultural pressures of ‘izzat’ (honour) and ‘sharam’ (shame) South Asian women who speak out about DV are often stigmatised by their community and extended families, and as separated or divorced women face social isolation. Consequently, many women remain in abusive relationships, putting their physical safety at risk and damaging their self-esteem and confidence which often leads to self-harm and attempted suicide. South Asian women, particularly those who are more isolated, are not aware of their rights and entitlements consequently experience difficulties accessing services. This disadvantage is further exacerbated by cultural and religious pressures, immigration restrictions and language barriers. What we do know about the Ahmadiyya community us that if problems do occur within the home, they try to deal with them internally through the religious institutions and try to keep families together through mediations.

Appendix 4

Individual agencies' self-identified recommendations

Agency	Recommendation(s)
South West London and St. George's Mental Health Trust	1. Retraining in the use of the electronic recording of medications given at home. Staff should not document compliance with medication unless they have checked. 2. Staff should be able to have sight of the primary mental health care reports (IAPTUS). 3. De-brief staff in the learning gained from this root cause analysis. 4. Medication reconciliation forms completed for all new patients coming into HTT.
Wandsworth Adult Services	No separate recommendations made.
GP Medical Centre	No separate recommendations made.
Metropolitan Police Service	No separate recommendations made.
Wandle Housing Association	1. New and Procedure for approach with Clients as well as training for staff including Neighbourhood and Leasehold Officers 2. Raising awareness about domestic abuse amongst our residents

Appendix 5

Action Plan

TO BE COMPLETED BY THE CHAIR OF THE REVIEW					TO BE COMPLETED BY THE RELEVANT AGENCY'S DHR PANEL MEMBER			
Rec. No.	Category of recommendation* according to Home Office choices	Recommendation (verbatim from the Overview Report)	What is the desired OUTCOME of this recommendation? (What do we want the RESULT to be?)	How will we assess whether the desired OUTCOME has been achieved?	What are the ACTIONS or OUTPUTS necessary to achieve this result?	Who is responsible for completing this action and which agency do they work in?	Who will hold responsibility for reporting progress and ensuring the actions are completed. Which agency do they work in?	Proposed date of completion
1	Local	**That relevant agencies report progress on their internal action plans to the relevant panel of the Wandsworth Community Safety Partnership's governance structure.**	To ensure that the recommendations are taken effectively forward including influencing Strategy, Policy and Operational practices to improve service delivery. To act as a catalyst to ensure that the victim's family is updated with the progress of the DHR's recommendations	The Wandsworth CSP supported by the Borough's VAWG Strategic Group will determine if the actions taken meet the recommendations in a meaningful way. Victim family's feedback	The CSP governance has been reviewed and a VAWG strategic group will be re-established sitting below the CSP. This group will meet quarterly after all operational groups have met and will review the recommendations put to each agency seeking to relieve any barriers and track improvements.	Vulnerabilities Manager – Community Safety.	VAWG Team	Ongoing – the new governance structure will be in place by Q3 of 22/23

2	Local	**That the learning from this Review and other Domestic Homicide Reviews is embedded within and informs the action plan that underpins the new VAWG Strategy 2022-25**	To ensure that the recommendations are owned by the Borough VAWG Partnership and are taken effectively forward including influencing Strategy, Policy and Operational practices to improve service delivery.	The Wandsworth CSP supported by the Borough's VAWG Strategic Group will determine if the actions taken achieve the recommendations in a meaningful way and improve sustainable service delivery. Victim family's feedback.	The VAWG strategy will be refreshed in due course. Central to the strategy is the lived experience and the survivor's voice. Learning from all DHRs will be incorporated in this way.	Vulnerabilities Manager – Community Safety Community Safety Partnership	Vulnerabilities Manager – Community Safety	When annual refresh takes place
3	Local	**That the Wandsworth Community Safety Partnership 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**	That the CSP and other local stakeholders form the membership of the Borough's VAWG Strategic Group and are accountable for its performance in ensuring that its complementary delivery plan is achieved. To ensure that the recommendations are owned by the Borough's CSP and VAWG Strategic Group and are taken effectively forward including influencing	Meaningful delivery of the DHR recommendations, which include sustained activity to improve decision-making and service delivery in preventing and tackling domestic abuse	The VAWG strategic group will be reviewed in line with a new governance structure. The new structure will be signed off at the next DA operational group and implemented.	VAWG Team – Community Safety	VAWG Team – Community Safety	Q4 22/23

		domestic abuse.	Strategy, Policy and Operational practices to improve service delivery.					
4	Local	**That the Wandsworth Community Safety Partnership conducts an Equalities Needs Assessment to better understand domestic abuse victimisation and inform commissioning of services, service provision, partnership activity, communication, and engagement strategies.**	Improved and resilient engagement with marginalised communities to raise awareness to enable better recognition of domestic abuse and knowledge of how to access domestic abuse specialist services. Additionally, the engagement with communities will also provide information and evidence of the barriers to reporting and in accessing services.	Development of Communications and Engagement Strategies is a good starting point. A programme of engagement with diverse communities.	A task and finish group can be established to conduct the needs assessment while will be taken to the VAWG strategic group, then CSP and ultimately inform the updated VAWG strategy.	VAWG team – Community Safety	VAWG team – Community Safety	2023/24
5	Local	**That the Wandsworth Community Safety Partnership develops a strategy, which vividly**	To ensure that the recommendations are owned by the Borough VAWG Partnership and are taken effectively forward including	Meaningful delivery of the DHR recommendations, which include sustained activity to improve decision-making and service delivery in preventing	There is a VAWG strategy for Wandsworth Borough with accompanying action plan which will be progressed by the VAWG strategic group.	Vulnerabilities Manager – Community Safety	Vulnerabilities Manager – Community Safety	Completed but will be updated in due course

		encapsulates the prevention, early intervention, partnership priorities and its approaches to tackling domestic abuse.	influencing Strategy, Policy and Operational practices to improve service delivery. A borough or local area should have one main VAWG or Domestic Abuse 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 which stakeholders can be held accountable to.	and tackling domestic abuse				
6	Local	**That the South West London and St George's Mental Health Trust should ensure that retraining and /or the conduct of refresher**	To improve in a sustained way the monitoring and compliance with patient's medication regime and a richer understanding of the consequences	Audit, Inspection Reporting by the South West London and St George's Mental Health Trust	To send out a Learning Bulleting to all staff on Supporting Community Clients who are prescribed Oral Medication making reference to the Medicines Policy and the Adherence to Medication Policy.	Head Of Nursing, Acute & Urgent Care Head Of Nursing,	Trust Quality Governance Group	Completed Completed

		training takes place for the Wandsworth Home Treatment Team (WHTT) staff on the JAC[44] guidance to ensure compliance with their medicine monitoring regime.	of failure to do so at the individual and Trust organisational level.		Develop a flow chart around medication compliance and monitoring. All community teams to have this printed and placed in their files, Ensure staff are up to date on their EPMA training.	Acute & Urgent Care Matron, HTT Matron HTT		31/07/2022 31/07/2022
7	Local	**That the South West London and St George's Mental Health Trust staff do not document compliance with medication until: a. they have checked compliance or asked the patient if they have taken their medication on each visit; and**	To improve in a sustained way the monitoring and compliance with patient's medication regime and a richer understanding of the consequences of failure to do so at the individual and Trust organisational level.	Audit, Inspection and Review Reporting by the South West London and St George's Mental Health Trust	To ensure staff adhere to the guidance that outlines clearly how medications are checked in the community. (refer to Flowchart above). To review during supervision with staff, as part of audit of Quality Indicators, that this is being monitored, checked and recorded in the patient record.	Matron HTT Team Manager	Service Line Quality Governance Group	Completed Ongoing

[44] JAC is Electronic Prescribing and Medicine Administration

		b. clarified when further stock is due.						
8	Local	**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.**	To ensure that the South West London and St George's Mental Health Trust have additional information to support their decision-making	Audit, Inspection and Review reporting by the South West London and St George's Mental Health Trust	To amend relevant HTT and SPA operational policies to ensure all new patients checked on RiO and IAPTus	Matron HTT Head of Nursing, Community Service Line.	Service Line Quality Governance Group	30/09/2022
9	Local	**That the South London and St George's Mental Health Trust should ensure that clear guidance is provided to their staff detailing the**	To ensure that the Trust staff have access to language translation services to discharge their functions and responsibilities more effectively.	Audit, Inspection and Review reporting by the South West London and St George's Mental Health Trust	To ensure patients with language deficits or where English is not their first language, they should be offered an interpreter. This should not be a family member. (In 2019 the Trust partnered with the Language shop, to offer a	Head of Service Delivery	Trust Quality governance Group	Completed

		policy in relation to the use of and access to interpretation services for patients	To improve the quality-of-service delivery to patients and their family members and / or carers To prevent the use of family members who may not be qualified to translate medical information. To prevent traumatisation, repeat victimisation and /or contamination of witness account. Additionally prevents the victim's perpetrator being used in the role.		new improved service for all translation needs).		Trust Quality governance Group	30/09/2022
10	Local	**That the South London and St George's Mental Health Trust should ensure that the Commissioned Interpretation Services are readily available to meet staff**	To ensure that the Trust staff have access to language translation services to discharge their functions and responsibilities more effectively.	Audit, Inspection and Review reporting by the South West London and St George's Mental Health Trust	To re-issue note on the Trust intranet on where to access interpreters including the process for this and to send out an article in the Monthly Learning bulletin advising where to find the information	Communications Team / Quality Governance Team	Trust Quality Governance	31/09/2022

		requirements in delivering a high-quality service to patients and their families. This may require contract or inclusion in contract monitoring methodology.	To improve the quality-of-service delivery to patients and their family members and / or carers					
11	Local	**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**	To enhance engagement with the family and carers of patient to improve the flow of information, threat & risk assessment and inform decision-making. Contribute to the Whole Family / Think Family approach.	Audit, Inspection and Review reporting by the South West London and St George's Mental Health Trust How is this practice approach included within staff training?	To ensure the Trust is accredited with the Carers Foundation for the Triangle of care. Each team to have an identified Carers Lead.	Matron HTT	Service Line Quality Governance Group	Completed

		withheld consent.						
12	Local	**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.**	To encourage staff to think beyond their role to enhance the service to the service user and others such as family members and those performing a carer role. Contribute to the Whole Family / Think Family approach.	How is this practice approach included within staff training and embedded into practice?	• Learning event on professional curiosity. • Top Tip Guidance/	Head of Professional Standards & Safeguarding	Head of Professional Standards & Safeguarding	October 22
13	Local	**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**	Improved engagement with marginalised communities to raise awareness to enable better recognition of domestic abuse and knowledge of how to access domestic abuse specialist services. Such engagement with communities will also provide information and	Publicity and Engagement / community events held	The Community Safety Team will seek additional funding from the Council to enhance the communications package around VAWG to be proactive and far reaching.	VAWG Manager – Community Safety	Vulnerabilities Manager – Community Safety	Jan 23 for funding confirmation and 23/24 for spend if agreed

		abuse and accessibility to specialist support services	evidence of the barriers to reporting and in accessing services.					
14	Local	**That the Wandsworth Community Safety Partnership 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**	To improve awareness of domestic abuse across the faith communities, the threats/risk/harms involved and the referral pathways to specialist support services. To emphasise the role of faith leaders in preventing domestic abuse, raising awareness with the faith community and the zero tolerance to violence and abuse in all its forms notably domestic abuse	Engagement activities with faith communities United approach to preventing and tackling domestic abuse by Faith leaders in the borough	The new governance structure will allow for a 'voluntary sector' and outward facing forums to feed into the VAWG strategic group which will encourage engagement. Faith leaders will be engaged with and encouraged to attend the forums to ensure awareness raising and debunking of any taboo elements to open discussion.	VAWG Manager – Community Safety	Vulnerabilities Manager	Q4 22/23 onwards

15	Local	**That the Wandsworth Community Safety Partnership 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.**	That local employers recognise the importance of their role and that of their employees in preventing and tackling domestic abuse whilst supporting workers / co-workers who are victimised to access support services. To influence local employers to participate in an Employers' Initiative for sustainable action. To influence local employers to join the Employers Domestic Abuse Covenant (EDAC) given the importance of employers' role in preventing and tackling domestic abuse.	Establishment of a local Employers' Initiative Borough local employers signed up to EDAC	The Community Safety Team will request additional funding from the Council which will be used for bystander and intervention training including for employers and education institutions. Referral pathways will be reviewed and tested to ensure proficiency.	Vulnerabilities Manager – Community Safety.	Vulnerabilities Manager to the VAWG Strategic Group and CSP	Q1 23/34 onwards
16	Local	**That the GP practices and other**	To raise awareness of domestic abuse	The named GPs surgeries and the South West London	Will ensure that the GPs in Wandsworth follow up on their action plan with robust	Designated Safeguarding Adults	The GP Lead for Wandsworth	The Trinity Court Medical centre is going

		healthcare providers involved in the DHR should audit their compliance with the NICE guidance on *Domestic violence and abuse: multi-agency working (*Public health guideline [PH50]) and act on their findings.	(DA) with GPs, Surgery staff and other health providers to recognise the signs of DA earlier for quicker intervention to prevent the problem worsening. To prevent repeat victimisation and to ensure more timely support by specialist services. To aim to reduce the impacts of DA on victims and their children.	and St George's Mental Health Trust provide audit reports of their compliance	training in DV- including this DHR as part of their training. Will explore if funding for an IRIS programme could be sought in Wandsworth- but that's an aside action for me. I will also ensure that SWLSTG follow up on their 6 actions as assurance to the CCG. The NHS SWL ICB Primary Care team to ensure that the surgery provides the audit and will be reviewed	Professional- Wandsworth NHS South West London South West London Integrated Care System SWL ICB Primary Care Team		through a period of change at the moment- unable to give a date.

Appendix 6

Home Office

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Mike Jackson
Chair of the Community Safety Partnership Chief Executive of Wandsworth Borough Council
Wandsworth Council
Community Safety Safer and Stronger Communities Wandsworth
High St.
London
SW18 2PU

29th May 2024

Dear Mike,

Thank you for submitting the Domestic Homicide Review (DHR) report (Tamseela) for Wandsworth Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel felt there was good panel representation for this review, including voluntary organisations of direct relevance. The information provided by the Asian Women's Resource Centre is particularly helpful in getting a sense of the victim and perpetrator's community and how this may have impacted them.

Although there was not a specific tribute to Tamseela, there is a good sense of who she was, her kindness, deep faith, and that she was known across her community as a kind-hearted woman who strived help everyone around her. There was positive engagement by the author with Tamseela's family and it is good to see recognition of the issues around a lack of proper interpretation and the learning from this.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- On both reports, the front page is currently missing the month and year of death and the name of the commissioning CSP.

- Please clarify when the DHR process was completed as the report states August 2022 (paragraph 1.2.2) but the front-page states October 2022.

- The review has not been fully anonymised, with the date of death, the date of the trial and the inquest and the date Tamseela's body was discovered all included throughout. The victim's (presumably real) surname and her and the perpetrator's initials are also included in the chronology. Other initials (such as for Tamseela's deceased husband) are included, but it is unclear if these are the real initials. These should be amended.

- It is not stated if the family were invited to select their own pseudonyms, which would be helpful to clarify. 2.4.9 also uses the name 'Rana' and this is not stated to be a pseudonym. 2.4.10 and 2.4.20 uses the initial 'H' instead of Nadim.

- 1.10 does not include any information on how Tamseela's family were contacted, if this included the Home Office leaflets or information on specialist advocacy support, which should be clarified. There is no mention of whether the family had sight of the Terms of Reference, met the panel, or have read the report. 1.11, though titled 'Involvement of the Perpetrator' does not mention if he was contacted for the review. 2.4.3 however states he took part so this should be included under the appropriate heading.

- The age of perpetrator appears to be incorrect in the report.

- Please ensure that panel members' names, job titles and organisations are clearly listed (unless there are specific reasons not to name them).

- The section on parallel reviews should mention the Board Level Inquiry.

- Please review the section on dissemination to detail specifically who will receive a copy of the report, including a weblink to the site where it will be published and any additional plans to disseminate the learning.

- Please review the section on equality and diversity to more clearly answer whether protected characteristics acted as a barrier to accessing services.

- Please clarify the timeline to make sense of '*after about six months'* (paragraph 2.4.55): when other information in the report states the couple only met three months before the wedding.

- Please review paragraphs 1.5.9 to 1.5.18 and paragraphs 3.3.4 to 3.3.8 to ensure only relevant statistics/research are quoted. Please also ensure that research is current (generally considered to be no more than five years old or up to ten in exceptional circumstances).

- It would have been helpful to have the information from the different agencies combined and in a chronological order so as to see Tamseela's life in a joined-up way.

- There are some acronyms in the chronology which are not explained e.g. OT, MSE

- The report requires a thorough proofread.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix 7

Response to Home Office Quality Assurance Panel

DHR QA Panel comment	Comment	Action
On both reports, the front page is currently missing the month and year of death and the name of the commissioning CSP	Report updated	Report updated
Please clarify when the DHR process was completed as the report states August 2022 (paragraph 1.2.2) but the front-page states October 2022	Report updated to August 2022 (as highlighted in para 1.2.2)	Report updated as indicated
The review has not been fully anonymised, with the date of death, the date of the trial and the inquest and the date Tamseela's body was discovered all included throughout. The victim's (presumably real) surname and her and the perpetrator's initials are also included in the chronology. Other initials (such as for Tamseela's deceased husband) are included, but it is unclear if these are the real initials. These should be amended	Changes made to made to paragraph 1.1.1, 1.12.3, 2.1.1, 2.1.3, 2.2.1, 2.3.1 and to the chronology regarding dates. Names have been removed or replaced with pseudonyms The areas highlighted in the Home Office feedback have been removed, adapted or otherwise updated.	Reported updated as indicated
It is not stated if the family were invited to select their own pseudonyms, which would be helpful to clarify. 2.4.9 also uses the name 'Rana' and this is not stated to be a pseudonym. 2.4.10 and 2.4.20 uses the initial 'H' instead of Nadim	Paragraph 1.3.1 Paragraph 2.4.9 amended Paragraphs 2.4.10 and 2.4.20 have been updated with the pseudonym	Report updated as indicated
1.10 does not include any information on how	A new paragraph 1.10.2 has been inserted which highlights	Report updated as indicated

Tamseela's family were contacted, if this included the Home Office leaflets or information on specialist advocacy support, which should be clarified. There is no mention of whether the family had sight of the Terms of Reference, met the panel, or have read the report. 1.11, though titled 'Involvement of the Perpetrator' does not mention if he was contacted for the review. 2.4.3 however states he took part so this should be included under the appropriate heading	family engagement and the provision of Home Office leaflet, review of Terms of Reference and sight of the Overview report prior to submission to the CSP. Paragraphs 1.11.1, 1.11.2 have been updated. New paragraphs 1.11.3 and 1.11.4 have been added to the report.	
The age of perpetrator appears to be incorrect in the report	Paragraph 2.4.1 has been amended	Report updated as indicated
Please ensure that panel members' names, job titles and organisations are clearly listed (unless there are specific reasons not to name them) The section on parallel reviews should mention the Board Level Inquiry	The panel members details, roles and agencies have been made clearer in Appendix 2. The Board Level Inquiry has been included in the new paragraphs 1.12.5 and 1.12.6.	Report updated as indicated
Please review the section on dissemination to detail specifically who will receive a copy of the report, including a weblink to the site where it will be published and any additional plans to disseminate the learning	Paragraphs 1.14.4, 1.14.5 and 1.14.6 have amended and / or added A new paragraph 1.14.7 has been inserted. The web link has been included.	Report updated as indicated.
Please review the section on equality and diversity to more clearly answer whether	New paragraphs 1.5.9 – 1.5.13	Report updated as indicated.

protected characteristics acted as a barrier to accessing services		
Please clarify the timeline to make sense of '*after about six months'* (paragraph 2.4.55): when other information in the report states the couple only met three months before the wedding	Paragraphs 2.4.9 and 2.4.55 have been amended	Report updated as indicated.
Please review paragraphs 1.5.9 to 1.5.18 and paragraphs 3.3.4 to 3.3.8 to ensure only relevant statistics/research are quoted. Please also ensure that research is current (generally considered to be no more than five years old or up to ten in exceptional circumstances)	There has been some modification of paragraphs 1.5.9 to 1.5.18. This, which has been provided by Wandsworth Council and is relate to the homicide review. Paragraph 3.3.4 has been amended. The research used is within 5 years of the date of the report.	Report updated as indicated.
It would have been helpful to have the information from the different agencies combined and in a chronological order so as to see Tamseela's life in a joined-up way	This learning is noted with thanks for future reviews	Noted as learning
There are some acronyms in the chronology which are not explained e.g. OT, MSE	OT – added to the acronyms MSE – Written in full. No other reference, so not added to acronyms	Report updated as indicated
The report requires a thorough proof read	The consolidate chronology has been place in paragraph 1.17	Completed