Bristol Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of Jean on 20\textsuperscript{th} July 2013

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Independent Domestic Homicide Review Chair and Report Author

Report Completed: 28th July 2014
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1. Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term “domestic abuse” is used in preference to “domestic violence”, as this term has been adopted by Bristol Community Safety Partnership after widespread consultation within the City and County of Bristol.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Jean (pseudonym) in Bristol on 20th July 2013 and was initiated by the Chair of the Bristol Community Safety Partnership in compliance with legislation. The Review process follows the Home Office statutory Guidance.

1.5 The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Jean and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation. They also offer the victim's family their sincere condolences for the recent death of her mother.

1.6 The Chair of the Review thanks all of the members of the Review Panel for their professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in
reviewing the conduct of their individual agencies. The Chair is joined by the Review Panel, in thanking, Veronica Shorttle for the efficient administration of the DHR.
2. Domestic Homicide Review Panel

David Warren, QPM, Home Office Accredited Independent Chair
Caroline Howard, Avon and Somerset Constabulary
Mike Hook, Avon and Somerset Probation Trust
Angela Clarke, Bristol City Council Children and Young People’s Services
Rhiannon Griffiths, Bristol City Council
Richard Lyle, NHS Bristol Clinical Commissioning Group
Pommy Harmar, Next Link Domestic Abuse Service
Sean Collins, North Bristol Hospital NHS Trust
Sarah Windfeld, University Hospital Bristol NHS Trust

Administrator:

Veronica Shorttle, Bristol City Council
3. Introduction

3.1 This Overview Report of the Domestic Homicide Review examines agency responses and support given to the victim, Jean, an adult resident of Bristol, prior to the point of her death on 20th July 2013.

3.2 Bristol is the largest City in the South West of England with a multi-cultural population of approximately 450000. With the surrounding urban zone there is an estimated 1,100,000 residents. It is the largest centre of culture, employment and education in the region and is home to two Universities. Its prosperity has been linked with the sea since its earliest days but in more recent years the economy has depended on the creative media, financial, electronics and aerospace industries. The city centre docks have been regenerated as a centre of heritage and culture and the busy commercial docks have moved to the outskirts of the city, at the mouth of the River Avon.

3.3 Incident Summary:

Jean was killed at approximately 3am on the 20th July 2013. She had been hit several times with a blunt instrument (a dumbbell) in the bedroom of the property she was sharing with her husband and daughter. Although living in the same property as her husband, they were estranged. There are two children of the marriage, the son had left the family home and lived independently. Their 18 year old daughter came home in the early hours of the night of the homicide. She woke at midday and went into her mother’s bedroom, discovering her dead on the floor, with her father, Molinder (pseudonym) on the bed next to her. Mohinder left the house and was later arrested by police. He admitted striking Jean on the head at least 12 times with a dumbbell bar.

3.4 The key purpose for undertaking this Domestic Homicide Review (DHR) is to enable lessons to be learned from Jean’s death. In order for these lessons to be learned, as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.5 The Review considers all contact / involvement agencies had with Jean, her husband and their family from 1st January 2010 and relevant events prior to that date.

3.6 The DHR panel consisted of senior officers, from the statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel or any of the Independent Management Report (IMR) Authors have had any contact with Jean, Mohinder or their children prior to the homicide.

3.7 Expert advice regarding domestic abuse service delivery in Bristol has been provided to the Panel by Rhiannon Griffiths, the Bristol City Council, Crime
Reduction Project Officer and Pommy Harmar, of Next Link Domestic Abuse Service, which provides a range of domestic abuse services in Bristol.

3.8 The Chair of the Panel, who possesses the qualifications and experience required of an accredited independent DHR Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance, is not associated with any of the agencies involved in the Review, has had no dealings with either Jean, Mohinder or their children and is totally independent.

3.9 **The agencies participating in this Domestic Homicide Review¹ are:**

- Association of British Investigators
- Avon and Somerset Constabulary*
- Avon and Somerset Probation Trust
- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- Bristol City Council Safeguarding Adults
- Bristol City Council Children & Young Peoples Services
- Bristol Multi Agency Risk Assessment Conference (MARAC)
- Corporate Alliance Against Domestic Violence
- Fairfield High School
- Information Commissioners Office
- NHS Bristol CCG*
- Next Link Domestic Abuse Service*
- North Bristol Hospital NHS Trust
- Riding Ltd*
- St Mungos*
- The Co-op Food Regional Distribution Centre
- University Hospital NHS Trust
- Validium Group*

3.10 British Telecom, the victim’s employer, was invited to participate in the Review but declined to do so.

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¹ Those that have completed an Individual Management Review (IMR) or Report are marked above with a *.
3.11 During the preparation of this report the DHR Chair has consulted with Jean’s son, daughter, mother, two sisters and her ex-husband. He has also consulted with Mohinder’s sister and solicitor. Notes of the subsequent conversations are set out in Appendix D of this report. Jean’s immediate neighbours were contacted, and their comments are also recorded in Appendix D. Sadly the victim’s mother died before the conclusion of the Review. On completing this report the DHR Chair read and discussed the lessons learnt, conclusions and recommendations with Jean’s family, her ex-husband and Mohinder’s sister. As a member of the family has indicated they may be considering taking legal action against one of the agencies, written copies of the Review were not supplied prior to publication.

3.12 Mohinder has told his solicitor that he does not wish to be contacted by the Review and did not want to be informed of the outcome. The solicitor advised Mohinder’s mother and one sister not to have contact with the DHR however his other sister has kept them informed of the progress and findings of the Review.
4. Parallel Reviews

4.1 The Coroner’s Inquest has been opened but in view of there being a criminal trial relating to Jean’s murder, it will not be continued.

4.2 Due to the perpetrator changing his legal team, the criminal trial was adjourned until May 2014. At his trial, the perpetrator pleaded not guilty to murder but guilty to manslaughter; however he was found guilty of murder and sentenced to life imprisonment with a tariff to serve not less than 17 years.
5. Timescales

5.1 The decision to undertake a Domestic Homicide Review was taken by the Chair of the Bristol Community Safety Partnership on 20\textsuperscript{th} August 2013 and the Home Office informed on 21\textsuperscript{st} August 2013.

5.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. In this case, due to the delay in the commencement of the criminal trial, a decision was made following the initial meeting on the 9\textsuperscript{th} October 2013 to adjourn the Review until the trial had concluded. The trial was adjourned a second time, until May 2014, and for this reason the Chair of the DHR called a Panel meeting on 27\textsuperscript{th} January 2014 to review progress on Individual Management Reviews (IMRs) and to ensure that actions had been taken to promptly address lessons learnt.

5.3 The Review was completed on 28th July 2014.
6. Confidentiality

6.1 The findings of this Review are restricted. Information is available only to participating officers/professionals, their line managers and the families of the victim and perpetrator, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2 As recommended within the “Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews”, to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

6.3 The name Jean is used for the deceased, who was aged 48 years at the time of her death. It was chosen by her mother on behalf of the family. The name Mohinder is being used for the perpetrator.

6.4 The Executive Summary of this report has been carefully redacted. After this overview report has been through the Home Office quality assurance process, a decision on whether to publish it will be made by the Bristol Community Safety Partnership. If it is to be published, the report and attachments, including the chronologies, will first be fully redacted.

6.5 The Review Panel has obtained the deceased’s confidential information, (including police and medical records) initially by way of public interest but on 17th October 2013, Jean’s mother signed an authority for the DHR to access all such confidential documents. The perpetrator’s medical records have been disclosed though the public interest exception in S29 of the Data Protection Act.
7. Dissemination

7.1 Each of the Panel members (see list at beginning of report), the IMR authors, the Chair and members of the Bristol Community Safety Partnership have received copies of this report. The Report has also been discussed in full with Jean’s family and with the perpetrator’s sister. Having received advice from Mohinder’s solicitor, his mother and second sister declined to engage with the Review.
8. The Terms of Reference

8.1 The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- 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.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

8.2 Overview and Accountability:

8.2.1 The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Bristol Community Safety Partnership on the 20th August 2013 and the Home Office informed on 21st August 2013.

8.2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

8.2.3 Due to the pending trial it was agreed, following the initial meeting on 9th October 2013, to adjourn the review until the conclusion of the criminal proceedings. This will enable the Panel to access witnesses after the trial.

8.2.4 This Domestic Homicide Review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

8.3 The Domestic Homicide Review will consider:

8.3.1 Each agency’s involvement with the following family members from 1st January 2012 and the death of Jean on 20th July 2013, other than the Police and Clinical Commissioning Group who will cover incidents prior to that date which are relevant to this case.

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2 Paragraph 3.3 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
(a) Jean - 48 years of age at time of her death - of Bristol
(b) Mohinder – 47 years of age at date of incident - of Bristol
(c) Son – 21 years of age at date of incident – of Bristol
(d) Daughter – 18 years of age at date of incident – of Bristol

8.3.2 Whether there was any previous history of abusive behaviour towards the deceased or their children, and whether this was known to any agencies.

8.3.3 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or her children, prior to the homicide.

8.3.4 Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

8.3.5 Could improvement in any of the following have led to a different outcome for Jean considering: -

(a) Communication and information sharing between services

(b) Information sharing between services with regard to the safeguarding of adults and children.

(c) Communication within services

(d) Communication to the general public and non specialist services about available specialist services

8.3.6 Whether the work undertaken by services in this case are consistent with each organisations:

(a) Professional standards

(b) Domestic abuse policy, procedures and protocols

8.3.7 The response of the relevant agencies to any referrals relating to Jean concerning domestic abuse or other significant harm from 1st January 2012. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, perpetrator or their children.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
(e) The quality of any risk assessments undertaken by each agency in respect of Jean, her husband, son or daughter.

8.3.8 Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

8.3.9 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

8.3.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

8.3.11 Whether the impact of organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies’ ability to respond effectively.

8.3.12 Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8.3.13 The review will consider any other information that is found to be relevant.
9. Schedule of the Domestic Homicide Review Panel meetings

- 9\textsuperscript{th} October 2013 0900-1300 at Princess House, Princess Street, Bristol.
- 27\textsuperscript{th} January 2014 0930-1300 at Princess House, Princess Street, Bristol.
- 3\textsuperscript{rd} March 2014 0930-1200 at Princess House, Princess Street, Bristol.
- 28th July 2014 0930 -1330 at Princess House, Princess Street, Bristol.
10. Methodology

10.1 This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) of participating agencies;
- The Senior Investigating Officer;
- The Criminal Trial and associated press articles;
- The victim’s work colleagues;
- Members of the victims and perpetrator’s families, friends and neighbour;
- Discussions during Review Panel meetings.
11. **Contributors to the Review**

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation trust and health bodies must participate in a DHR; in this case, eighteen organisations have contributed to the review (listed in Para. 3.9 on pages 8 and 9). Six have completed Individual Management Reviews (IMRs) or reports. Two have provided information and advice. The perpetrator’s sister, the victim’s family, work colleagues, friends and a neighbour have provided information to the DHR chair. (See Appendix D).

11.2 A request was made for Jean’s employer, British Telecom, to provide information to the Review, as it was known that Jean had discussed her marital problems at work, however a reply was received from the BT Legal Department that BT declined the opportunity to contribute to the Review. BT is not a member of the Corporate Alliance Against Domestic Violence.

11.3 **Individual Management Review Authors:**

Victoria Caple, Avon and Somerset Constabulary

Sam Boobier, Bristol CCG

Pommy Harmar, Next Link Domestic Abuse Service

Tracey Tudor, St Mungo’s

Anne Payne, The Validium Group

Carrie Austin, Riding Commercial and Corporate Detective Agency

11.4 **Senior Investigating Officer:**

Detective Inspector Sim Cryer, Avon and Somerset Constabulary who briefed the Review Panel about the circumstances of the case.
12. The Facts

12.1 Jean and Mohinder had been married for 24 years and had two children. Jean had previously been married, but the relationship broke up without anyone else being involved. Her first husband, a lorry driver and an active member of the Territorial Army, spent so much time away from home that they gradually drifted apart.

12.2 In 1987, whilst serving in the British Army in Germany, Mohinder received 18 months imprisonment for wounding, during a domestic incident with a previous partner. He was dismissed from HM Forces. He received a caution in 1995 after assaulting a neighbour.

12.3 In February 2000 Jean attended her GP practice, after being assaulted by Mohinder. She told the GP that he had “smacked her with an open hand on the left hand side of her face and had hit her in the chest.” She also stated he had previously pushed her down the stairs. She described a deteriorating relationship as he had accused her of having an affair and stated she wanted to leave with the children. The GP recorded that “there was tenderness on her left mandible, bruising and redness and tenderness on her left breast”. An earlier GP record in 1995, noted Jean was depressed, crying, had a loss of libido and a poor relationship with her husband.

12.4 In 2001 Jean gained employment with BT in Bristol.

12.5 In 2004 Jean went to her GP after being head butted by her husband. She told the doctor that he had also hit her about 12 months earlier. On examination she was found to have a laceration on the bridge of her nose and swelling and bruising to the front of her face. Her teeth and gums were painful but not loose. At that time she did not report these incidents to the police or seek help from a domestic abuse support group. The GP Practice did not refer her or her children on to any other agency.

12.6 In April 2009 Mohinder was given a conditional caution for soliciting a known sex worker.

12.7 St. Mungos, which provides domestic violence support services, holds a record that states that Jean stayed in their emergency night shelter for one night in August 2011. Unfortunately, due to organisational changes, no other details have been retained. Her children were not aware of this incident.

12.8 Jean was close to several of her work colleagues and over the years talked to them about her marriage problems. She told them about her husband’s controlling behaviour and how he had head butted her and on another occasion had hurt her leg by driving off as she was getting into the car. In 2010 she told one colleague, that she had told her husband she wanted a divorce but had taken it no further.

12.9 Early in 2013 Jean rekindled her friendship with her ex-husband and later her relationship with him. She told him she was going to divorce Mohinder. In June 2013 she again told Mohinder she wanted a divorce. Jean was regularly going out in the evening, behaviour which Mohinder became suspicious of and employed a private enquiry agency to have her followed. The private enquiry agency, after conducting a telephone risk assessment, put a tracker device under Jean’s car.
12.10 On 9th June 2013 Jean telephoned the Police to report that she intended to end her relationship with her husband, who had been violent towards her in the past. She told the police that the last time he was violent towards her was five years previously when he head butted her and that this had been documented by her doctor. Jean stated that she was scared of him and what he might do, as he had already parked his car across the front of the garage to prevent her getting her car out. She said no threats had been made but he had been very quiet towards her. Due to the force policy “Public First”, whereby the level of police response was based on specific crime type classification, Jean’s report was recorded as a harassment incident rather than domestic abuse, so did not trigger police attendance. She was advised to call 999 should the situation escalate, and given advice to stay with friends or family if this became the case. She was also advised to consult a solicitor.

12.11 Six days later, at 10:05pm on Saturday 15th June 2013, Jean again rang the police to report that she was in the process of divorcing her husband and he was being aggressive towards her. He had locked her inside the house and blocked her car in the garage so she was not able to go out. She was frightened of him and she and her daughter had escaped into the garden. She stated that he had been previously violent towards her. Jean said she wanted him to go to his mother’s home. She explained that she did not want him to hurt her or to lose his temper. The police call handler said officers would attend as soon as possible.

12.12 Forty minutes later Jean recalled the Police stating that she was scared and that the Police had not attended. She said that her husband was being intimidating and she was afraid he might hit her. She explained that she did not feel safe in the house as he had followed her to her mother’s address earlier that day and that he was having her followed. He had told her that there was nothing anybody could do to help her and that she would have to live like this.

12.13 When officers attended a few minutes later they found that Jean’s husband had left the property for the evening. It was recorded that no offences were disclosed at that time and words of advice were given. An incident report was completed and subsequently a risk assessment was conducted which assessed the risk as “medium”.

12.14 On the 19th June 2013 a member of the Police Victim Advocacy Unit spoke with Jean (The Victim Advocacy Unit is responsible for contacting, by telephone, all standard and medium risk victims of domestic abuse). During the conversation Jean stated that despite her instigating divorce proceedings, her husband had refused to accept this and was still at the family home. All the fish in her garden pond had died, and she suspected he was responsible (During his trial he admitted poisoning the fish). She was advised to telephone the police on the non - emergency telephone number, 101, for assessment and to ensure that an incident was raised. Domestic violence support was discussed and a referral was made to the domestic abuse support service “Next Link”.

12.15 On the 21st June 2013, Jean reported to the Police that her husband was missing. That morning he had filled out his will, saying to Jean that he was going to meet his maker, but that he would always love her. He then left in his vehicle.
“missing person” report was raised on the police “Guardian” system, in accordance with the force policy, with the risk assessed as medium. The circumstances were recorded that “the relationship between Jean and Mohinder had been breaking down and he was finding this difficult to deal with as they had been together for 24 years. Over the previous two weeks his behaviour had deteriorated; he had started ignoring Jean and killed all of the goldfish”.

12.16 Mohinder returned home late that evening and Jean made another call to the Police requesting assistance as soon as possible, as she wanted her husband to leave the address. She was concerned about her safety, she said she had made the mistake of letting him in and now he would not go. He was aggressive, agitated and stated that he did not want a divorce. Officers attended and noted that Jean was intoxicated whereas her husband appeared to be sober, calm and reasonable. He agreed to stay with his sister for the evening and return in the morning to discuss matters with Jean further.

12.17 When Next Link contacted Jean on the 4th July 2013 she said she needed no further support, but if this changed she would contact them.

12.18 Mohinder self-referred to a private counsellor under his employer’s (The Co-op) staff support service and, during a telephone risk assessment, told the counsellor that he felt stressed and depressed because of his domestic situation. He stated three days earlier he had taken an overdose of paracetamol. He was advised to make an appointment to see his GP, which he agreed to do. While waiting for the appointment the counsellor kept in daily telephone contact with him.

12.19 On 8th July 2013 Mohinder saw his GP and told her he was feeling low and had taken an overdose of paracetamol two weeks earlier due to his marital problems. He explained his wife was going out five times a week, staying out late and that she had made accusations to the police about him. He was not eating and was sleeping poorly. He told the doctor they had two children and the youngest, who was 18 years of age, lived at home. The GP told him that she wanted to see him again in two weeks time, in the meantime he should “check out” a marriage counsellor; and she gave him the contact details of the “LIFT” Service and the Samaritans.

12.20 On 17th July 2013 Mohinder received a text message from the private enquiry agency he had employed, informing him of Jean’s movements and location. He drove there and discovered Jean in a car with her ex-husband.

12.21 Two days later, on 19th July 2013, Mohinder agreed with Jean that the marriage was over; but later the same day he sent her a text message. In it he stated he had two stipulations to agreeing to leave. One was that they would sleep together one last time; the other was that they should make love. She refused.

12.22 Jean returned home at about 10pm that night and found Mohinder asleep on the sofa in the living room. She went to bed but, during the night, Mohinder went to the bedroom and attempted to have sex with her. She called him pathetic and he left the room returning with a dumbbell bar with which he hit her on the head an estimated twelve times causing her fatal injuries (During his trial he admitted attempting to have sex with her 20 minutes after her death).
12.23 A neighbour told the police that at about 11pm on 19th July 2013 she heard, through the adjoining bedroom wall, what sounded like sexual intercourse taking place followed, at about 3am, by what sounded more like physical violence.

12.24 Their daughter arrived home in the early hours of the morning and everything was quiet. When she woke at about noon, on 20th July, she saw her mother’s bedroom door was closed which was unusual. She went in to the room and found her mother lying on the floor beside the bed, naked and with obvious head injuries. Her father was sitting naked on the bed. As she went to her mother, her father dressed and left. An ambulance was called and Jean was pronounced dead. Later that day Mohinder gave himself up to the police.

12.25 The Pathologist report states “Jean received at least a dozen heavy blows from a blunt instrument, mainly to the back of her head, which tore the scalp, fragmenting the skull and severely injured the brain with heavy blood loss. The injuries were overwhelming and non-survivable. There were a few superficial, possible, defensive injuries to the upper limbs but unconsciousness would have supervened rapidly with death not long delayed.”

12.26 A full chronology of agencies’ contacts with Jean and her family is set out in full in Appendix E of this report.
13. **Overview**

13.1 The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that their reviews have been conducted in line with the Terms of Reference.

13.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference the IMRs detail how these were considered. The fact that Jean’s husband was a Sikh (although not a practicing one) was not found to be a relevant factor either to the circumstances of the homicide or to the way he was treated by the agencies with whom he had any contact. It was noted that Mohinder had reacted so negatively to their son announcing that he was gay that the son left home when he reached the age of 17 and had no further contact with his father, this was not deemed to be relevant to the homicide.

13.3 Agencies completing IMRs were asked to give chronological accounts of their contact with Jean, Mohinder and their children prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the DHR has covered the period from 1st January 2010 to 20th July 2013 with relevant information prior to the 1st January 2010 being included. The recommendations of individual agencies to address lessons learnt are listed in section 17 of this report and their action plans to implement those recommendations are catalogued in Appendix C.

13.4 Nineteen agencies / multi-agency partnerships were contacted about this review.

13.4.1 Ten agencies responded as having had no relevant contact with either Jean, her husband or any other member of her family. They are:

- Association of British Investigators
- Avon and Somerset Probation Trust
- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- Bristol City Council Children and Young Peoples Services
- Bristol City Council Safeguarding Adults
- Bristol MARAC
- Fairfield High School
- North Bristol Hospital NHS Trust
• The Co-op Food Regional Distribution centre

• University Hospital NHS Trust

13.4.2 One agency, British Telecom, has declined to contribute to the Review.

13.4.3 Two agencies, the Corporate Alliance Against Domestic Violence and the Information Commissioners Officer have provided information and advice.

13.5 Six organisations completed an IMR or a report with information indicating some level of involvement with Jean and/or Mohinder or their children.

13.5.1 Avon and Somerset Constabulary’s first contact with Jean was on the 9th June 2013, the initial contact and subsequent contacts are detailed in section 12 of this report.

The events of 21st June 2013 are worthy of particular note. Jean telephoned the police to report that Mohinder was missing. She explained that before going out that morning he had written his will and told her he was going to meet his Maker. The police checked his mother’s and sisters’ addresses and later that day Mohinder contacted the police to say he was ok and did not want to see any officers. During the evening Jean telephoned the police to request assistance as she was concerned for her safety, she had let Mohinder into the house and he would not leave. Officers attended and noted that Jean was intoxicated. Mohinder appeared calm and reasonable. He agreed to leave the house voluntarily. Their daughter was at the house when the police arrived and told them she did not think there was a risk of any violence between her mother and father. On that occasion, no further action was taken and a domestic incident was not recorded on the police guardian system.

13.5.2 NHS Bristol Clinical Commissioning Group (CCG). Neither Jean nor Mohinder visited their GP regularly and the only significant visits are those detailed in paragraphs 12.3, 12.5 and 12.19 above. As the first two visits relating to domestic abuse in 1995 and 2000 were hand written notes, rather than computer records, they were, unintentionally, not provided by the GP Practice to the IMR author.

13.5.3 Next Link received a referral for Jean from Avon and Somerset Constabulary on 21st June 2013. The referral detailed the incidents of the 15th and 19th June and included a CAADA DASH risk assessment carried out by the police. The referral gave set limited times when Jean could be safely contacted. It was only on the seventh attempt to speak to her on the telephone that contact was made. Jean said she could not talk then and would phone back the following week, she stated she did not want to be called again. Jean never telephoned back and on the 15th July the file was closed.

13.5.4 St. Mungo’s has taken over services previously run by the “People Can” Night Shelter which went into liquidation in November 2012. Whilst the “People Can” company records have been destroyed by the Administrator, a “seen check list” had been retained which indicated that Jean stayed at the night shelter for one night on 25th August 2011. There are no other details known.
13.5.5 **Riding Ltd**, the private detective agency, employed by Mohinder to follow Jean, provided a report to the DHR. The report describes the assessment procedures used to ascertain “why we should not be assisting” a potential client and how information is later disseminated to the client by a case manager. There is no mention of the use of technical equipment in the report.

13.5.6 **Validium Group.** Under a scheme provided to Co-op personnel, Mohinder self-referred to the Validium Group, a private counselling service and had a telephone risk assessment with a counsellor. He explained he was feeling depressed because of his domestic situation and had considered suicide. The counsellor advised him to see his doctor before having another appointment and made daily telephone welfare checks with him until he saw his GP. On one occasion when Mohinder did not telephone in, the counsellor contacted Mohinder’s sister to check on his welfare.
14. Analysis

14.1 The Panel has considered the individual management reports carefully through the view point of Jean, to ascertain if each of the agencies’ interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if the lessons have been identified and properly actioned.

14.2 The authors of the IMRs have followed the Review’s Terms of Reference carefully and addressed all of the points within it. They have each been honest, thorough and transparent in completing their reviews and reports. The following is the Review Panel’s opinion on the appropriateness of each of the agencies interventions.

14.2.1 Avon and Somerset Constabulary contacts with Jean and Mohinder are detailed in section 12 of this Report. The “Public First” policy, which altered the approach to dealing with calls from the public, was too rigid to cater for the needs of victims of domestic abuse and was quickly abandoned by the Force. Current Avon and Somerset Constabulary policy states clearly that a police officer will attend all calls and reports relating to domestic abuse and check the welfare of the parties. All reports of domestic abuse must be recorded as an incident on the police crime recording system “Guardian”. This did not happen on the first occasion Jean contacted the police.

On the second occasion when she reported that Mohinder had kept her at home, against her will, this was not dealt with or recorded as a crime of false imprisonment. The incident was however recorded on “Guardian” and a risk assessment was completed. As the risk was assessed as medium it was not referred to the MARAC but was sent to the Police Victim Advocacy Unit which has responsibility within the Force for contacting standard and medium risk victims of domestic abuse by telephone. While this type of intervention is an example of good practice, on this occasion it is let down in its application. Jean was told she was required to telephone “101” to have the incident raised on the police “Guardian” system rather than the member of the Unit doing it on her behalf.

On the 21st June 2013 Jean reported Mohinder as a missing person, after he had made threats to ‘meet his maker’, and filled out his will. Mohinder returned home late that evening and Jean made another call to the Police requesting assistance. Police attended and felt that Mohinder was acting more appropriately than Jean in the circumstances and were satisfied that the risk was mitigated by Mohinder going to another address. Bearing in mind the history of reports to Police between these parties, the panel believes that this decision was misguided. There were no information markers placed on the address at any point, nor Guardian incident/intelligence reports raised.

The Review Panel is satisfied that the IMR Author has been thorough and open in identifying, through the perspective of the victim, procedural failures and poor practice. The Author has considered these carefully and has presented workable proposals to address them. The Panel commends the Avon and Somerset Constabulary policy of having a specialist unit to check on victims
of domestic abuse, who are assessed as being of standard or medium risk and who would not therefore be referred to a MARAC.

14.2.2 NHS Bristol CCG. Although the victim’s mother signed an authority for the Review to have access to her daughter’s medical and confidential records, the GP practice decided not to give the CCG IMR author the complete medical records of either the victim or perpetrator, but rather to provide what they considered to be the significant entries. During the criminal trial it became apparent that the IMR author had not been provided with information regarding two occasions, in 1995 and 2000, when the victim visited her GP after being abused by her husband. This was due to the records being old hand written ones rather than computer files. While those two incidents, (detailed in section 12), were dealt with in a thoroughly professional manner in accordance with the practice at the time; analysis of the GP Practice records provided to the IMR Author, led her to have concerns with regard to the following consultations:

- On 21st August 2004 Jean was seen at the GP Practice, following an assault by Mohinder, when she had been head butted on the nose and forehead. There was no documentation regarding advice of who she could contact following the assault or discussion regarding feelings or mental health. Further, there was a lack of information regarding the children in her care and no referral was made to Safeguarding Children following the assault. The IMR Author was assured that practice would be different and appropriate should the same situation present now, as awareness and training has improved since that consultation in 2004.

- On the 8th July 2013 Mohinder had a consultation at the GP Practice where he came across as distressed and advised the GP he was feeling low. He stated he had taken an overdose of tablets two weeks earlier and that Jean had made allegations to the police about him. The GP gave him a leaflet for the ‘LIFT’ Service (a psychological therapy service), advised him to stop alcohol use and gave him the telephone number of the Samaritans. It was planned to review this in two weeks time. The IMR Author made contact with ‘LIFT’ and found that Mohinder had not utilised this service. Following his recent overdose and display of low mood and distress within the consultation, the IMR Author felt it would have been good practice to have referred him to the Primary Care Liaison Mental Health Team.

Three high risk factors, alcohol, suicide/overdose and threats, were listed in Mohinder’s records which should have indicated a high risk of domestic abuse, particularly as it is recorded that Mohinder had told the GP that his wife had made allegations about him to the police. The GP advised the IMR Author that she still did not think that the information, in terms of the content of the consultation, would have led her to consider domestic abuse.

In the Review Panel’s opinion, the GP practice did not take all of the appropriate actions when Jean went to the practice in 2004 after being assaulted by her husband. Whilst it is accepted that knowledge and training regarding domestic abuse has improved since then; it is nevertheless noted that the GP failed to recognise the significance of the information being provided by Mohinder at his consultation on the 8th July 2103. The panel
considers that these risk indicators and evidence of police involvement, should have triggered consideration of domestic abuse by the GP.

The Panel acknowledges the complexities faced by the IMR Author and the thoroughness and honesty of her report.

14.2.3 Next Link. Duty workers endeavoured to make contact with Jean on several occasions by both phone and text. When contact was eventually made by telephone the worker introduced herself, explained that she was from Next Link, and offered Jean advice and support. Jean stated that she did not want to talk about it or to take up the offer of support. She stated very clearly that she did not want Next Link to call her again. The worker put this statement in the file notes, in quotes, as Jean had been very firm about this. The worker was unable to complete any assessment paperwork as Jean did not provide any information. Jean stated that she would call back the following week, but failed to do so. Next Link notified the police and closed the case. Whilst Next Link was presented with the dilemma of being told by Jean ‘Don’t contact me again’ the duty worker had to determine whether to step over the line of confidentiality. In this case Jean was judged to have capacity, she was an adult and was very clear in her instructions. The referring agency (in this case the police) were notified of the outcome of the referral.

The Review Panel is satisfied that Next Link treated Jean with respect and having followed all their procedures and policies correctly could do no more at that time.

14.2.4 Riding Ltd conducted a telephone risk assessment on Mohinder and did not identify any warning signs of the threat he posed to his wife. The report, written by one of the Company’s Directors after conducting an internal review, points out that it is to be expected that individuals who find that their partners are being unfaithful will be upset but how they react is rarely the same. The report author states that as a result of this case they have reviewed their current policy and are making sure all staff continue to risk assess all cases and know who to report to when they have concerns.

The Review Panel acknowledges that the Company was under no legal duty to contribute to the Review but has nevertheless taken the opportunity to review their contacts with Mohinder. The report does consider the risk assessment element but does not address any data protection issues which may be the subject of investigation by the Information Commissioners Office.

14.2.5 St. Mungo’s have taken over a service previously provided by “People Can” which went into liquidation in November 2012. All files had been destroyed by the Administrators when “People Can” closed and the only record available to St Mungo’s was a list of clients seen, which showed that Jean had stayed one night in the shelter.

The Review Panel thanks St.Mungo’s for the thoroughness of their search.
14.2.6 **The Validium Group Ltd** provides its customer companies, of which the Co-op is one, with employee medical assistance programmes. As Mohinder worked for the Co-op he was able to refer to Validium for counselling. During the initial telephone call a risk assessment was conducted; Mohinder said he felt stressed and depressed and had made a suicide attempt three days earlier. He was categorised as being at high risk and advised he should consult his GP. He agreed a contract with Validium, that while waiting for his doctor’s appointment he would have a daily welfare telephone call with the counsellor. Once he had seen his GP, he told the counsellor that he had been referred to an NHS service and he would not require further help.

The Review Panel is of the opinion that **The Validium Group** acted appropriately and in a professional manner. In particular the daily welfare checks system to those who they consider to be high risk clients is highly commended.

14.3 The Review Panel is disappointed that BT declined the invitation to participate in this Review as the victim was a BT employee at the time of her murder. Four of her work colleagues have confirmed that over a number of years Jean spoke openly at work about the abuse she received from her husband. None had ever received any training relating to domestic abuse. Whilst BT has not joined the Corporate Alliance against Domestic Violence it has participated in advising the Public Health Responsibility Deal Pledge on Healthy Workplaces/Responding to Domestic Violence in the Workplace in 2012/13.
15. Lessons to be learnt

15.1 The following agencies that had contacts with Jean or Mohinder have identified lessons they have learnt from the Review.

15.2 Avon & Somerset Constabulary

15.2.1 The short lived police procedural policy “People First” did not properly cater for victims of domestic abuse. That policy has already been changed.

15.2.2 Effective practice, and Force Policy, is that officers physically attend every single domestic abuse call or report to check the welfare of all parties. The first contact between Jean and the police, on the 9th June 2013, did not result in any police attendance.

15.2.3 The response from the Police Victim Advocacy Unit that Jean would need to telephone the “101” number to have the incidents she had contacted the police about placed on the police “Guardian” system, rather than it being done on her behalf by the Unit staff, fell below the standards one would expect.

15.3 NHS Bristol CCG

15.3.1 The GP could not recall the policy and practice at the time of Jean’s consultation in 2004, however, she felt that this situation would have led to appropriate referrals should it happen now as there are set procedures in place at the surgery, which she listed to the IMR author. That information shows that clear improvements have been made since 21st August 2004 and that robust processes are in place.

15.3.2 The GP who saw Mohinder on 8th July 2013 did not recognise the three high risk factors in his presentation, nor did she understand the significance of what Mohinder had told her relating to his wife making allegations about him to the police. She did not refer him to the Primary Care Liaison Mental Health Team, but instead left him to contact the Samaritans and LIFT.

15.4 Riding Ltd

15.4.1 As a consequence of Jean’s murder the company has considered its current policy and makes sure that staff continue to risk assess all cases and know who to report to when they have concerns. Where they do have concerns they will continue to escalate to the necessary service/agency

15.5 The Validium Group

15.5.1 Identified that they need to review the confidentiality contract they agree with clients, to ensure that it is clear that they will share information with the appropriate bodies without consent if they have reasonable grounds to believe the client may cause harm to themselves or to another.
16. Conclusions

16.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Jean, Mohinder and their children in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims in Bristol in the future?
- Was Jean’s death predictable?
- Could it have been prevented?

16.2 The Review Panel is satisfied that the IMRs have been open, thorough and questioning from the viewpoint of the victim. The organisations have used their participation in the Review to identify and address lessons learnt from their contacts with Jean and Mohinder in line with the Terms of Reference (ToR).

16.3 The Panel is of the opinion that the agreed recommendations appropriately address the needs identified from the lessons learnt. The Panel also recognises that the Bristol Community Safety Partnership and the individual agencies represented on the Review now have comprehensive domestic abuse strategies and polices in place. Provided those recommendations, strategies and policies are fully and promptly implemented they will improve the safety of future domestic abuse victims in Bristol.

16.4 The Review Panel, after considering all of the information provided, believes that Jean’s murder could not have reasonably been predicted. While Jean had told friends and the police that she was afraid of Mohinder, she also demonstrated her concerns for him when she thought he might commit suicide. The Panel believes that the police had insufficient information to conclude that he would resort to violence at that time; Jean’s daughter did not think her father would hurt her mother or herself and said that to police officers on 21st June 2013. The GP on seeing Mohinder on the 8th July 2014 formed the opinion, from his demeanour, that Mohinder was a mild tempered man and she consequently did not recognise the evident risk indicators. Riding Ltd, which frequently conducts work on behalf of individuals who suspect their partners of infidelity, highlights that when people contact them for the first time with such cases they regularly sound upset or stressed. When they conducted their routine risk assessment they did not identify warning signs that Mohinder may pose a threat to his wife.

16.5 Could her death have been prevented? Several of the victim’s friends and work colleagues were aware of the abuse she suffered during the marriage but there is no evidence that any of them encouraged her to seek help, although they were aware she had contacted the police. The errors made by the police in failing to identify the
offences of false imprisonment and harassment when Mohinder blocked Jean’s car in the garage and stopped her leaving the house were not considered by the Panel to be critical to preventing Mohinder’s future actions. The question more difficult to answer is that regarding the contact Mohinder had with his GP on the 8th July 2013. While the notes of the consultation set out in detail Mohinder’s marital problems and how low he felt, the GP’s temporary or interim solution to his cry for help appears inadequate considering his emotional state. Immediate positive action should have been a priority to address his needs and the risks evident from the information he gave during the consultation.
17. Recommendations

17.1 National Recommendations

17.1.1 Changes should be made to the Domestic Violence, Crime and Victims Act 2004 and/or Revised Multi-Agency Guidance on the Conduct of Domestic Homicide Reviews. (Home Office 2013), to require non-statutory organizations to participate in Domestic Homicide Reviews. Currently such agencies can choose whether or not to participate and this can leave employees vulnerable, as lessons are neither acknowledged nor addressed.

17.1.2 Guidance is required from the Department of Health as to which organisation should conduct IMRs relating to GP practices. Currently CCGs regularly fill this role, however, on occasions, it has been challenged by GP Practices and in this case the CCG has asked for clarity on this point.

17.1.3 That the Home Office, when drawing up the regulation of the private security industry under the auspices of the Security Industry Authority (SIA), considers regulatory reforms relating to controls on how private information is obtained and utilised, and additionally the restrictions on the use of technical aids, which may impinge on the privacy of individuals. (Currently there appears to be more controls on the Police than there are on private companies).

17.2 Cross agency recommendations

17.2.2 The Safer Bristol “Information Sharing Protocol For Assessing and Protecting Victims Of Domestic and Sexual Violence and Abuse” (April 2011) should be updated to ensure agencies are clear that they can share information without consent on a case by case basis to prevent serious violence.

17.2.3 Organisations working with victims of domestic or sexual abuse should be signatories to the above mentioned information sharing protocol.

17.2.4 Organisations should support the work of the Bristol Domestic and Sexual Abuse Strategy Group, and identify an agency domestic abuse champion, similar to those already introduced by the Bristol Community Safety Partnership, the Bristol CCG and the North Bristol NHS Trust.

17.3 Individual Agency Recommendations

17.3.1 Avon & Somerset constabulary:-

- Refresher training needs to be delivered, to response officers, to recognise the signs of domestic abuse, as well as ensuring that “Guardian” reports are put onto the system appropriately. As domestic abuse is already a Police Crime Commissioner (PCC) and Force priority, training has already been rolled out throughout the summer of 2013, delivered by the Public Protection Unit. This is part of an ongoing programme of mandatory training. Specific
case studies should be used to demonstrate best practice as well as lessons to be learnt.

- Refresher training needs to be delivered to the Force Service Centre. It must be focused on recognising and listening to what the victims are telling them. For example, if the Force Service Centre had raised an incident relating to false imprisonment, the officers attending at the scene may have dealt with the situation differently and recorded the incident correctly. Again, case studies should be used. The Force Service Centre should also be well-versed in what support agencies are available across the Force. This way, should a victim be adamant that she wishes for no further involvement, referrals to support agencies are still made. This should be carried out within the next three months.

- Refresher training needs to be delivered to the Victim Advocacy Unit, in relation to what needs to occur should further offences be disclosed during their telephone conversation. Rather than advising the victim to ring 101, they should have been more pro-active and either raised the incident themselves, put Jean through to the Force Service Centre, or raised a log themselves in order for officers to attend. This should occur within the next month.

17.3.2 NHS Bristol CCG:-

- The GP Practice should become part of IRIS ((Identification and Referral to Improve Safety) programme.

- The GP Practice undergoes refresher training regarding domestic abuse.

- That a significant event audit is undertaken with regards to this event and that the practice explores more fully their use of risk assessments and their policy framework.

17.3.3 Riding Ltd.

The company's policy on risk assessments has been reviewed to ensure staff continue to risk assess all cases and know who to report to when they have concerns.

17.3.4 The Validium Group has reviewed the wording of the confidentiality agreement it makes with patients to ensure it contains a clause that any information that relates to a person’s safety will be shared with the appropriate authorities even if consent is not given.

17.3.5 Safer Bristol Partnership

- A public awareness campaign should be rolled out encouraging friends and family aware of domestic abuse to seek help.
18. Postscript

Action to be taken after presentation of the Overview Report to the Bristol Community Safety Partnership.

On receiving the Overview Report and supporting documents, the Partnership should:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that they are fully anonymised, apart from including the names of the Review Panel Chair and members.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.
- Sign off the Overview Report and supporting documents.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk.
- The document should not be published until clearance has been received from the Home Office Quality Assurance Group.

On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.
- Provide an electronic copy of the Overview Report (this must first by carefully redacted) and Executive Summary on the South Gloucestershire Safer & Stronger Communities Partnership web page.
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and include an audit process.
Appendix A

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>DAIT</td>
<td>Domestic Abuse Investigation Team</td>
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<td>DASH</td>
<td>Domestic Abuse Stalking and Harassment Risk Assessment model</td>
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<tr>
<td>DAU</td>
<td>Domestic Abuse Unit</td>
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<tr>
<td>DVLO</td>
<td>Domestic Violence Liaison Officer</td>
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<tr>
<td>DVU</td>
<td>Domestic Violence Unit</td>
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<td>DV1</td>
<td>Domestic Abuse Form</td>
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<td>IDVA</td>
<td>Independent Domestic Violence Advocate.</td>
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<td>MARAC</td>
<td>Multi Agency Risk Assessment Conference</td>
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<td>PNC</td>
<td>Police National Computer</td>
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<td>SOP</td>
<td>Standard Operating procedure</td>
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<tr>
<td>PND</td>
<td>Police National Database (previously named the INI - Impact Nominal Index). PND is a national Police computer system which allows officers to establish, in seconds, whether any police force anywhere else in the country holds relevant information on someone they are investigating. Previously, this information would not have been visible outside the force holding the record and was implemented following the Soham enquiry.</td>
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<tr>
<td>PPU</td>
<td>Public Protection Unit. In March 2012 public protection work within the Constabulary was completely reorganised. All safeguarding matters, primarily children, vulnerable adults, and domestic abuse survivors, are now dealt with by the PPU (Public Protection Unit). Broadly speaking, the risk assessment and investigation aspects of any such referral have now been separated. There are three PPU Safeguarding Co-ordination Units (SCU) across the force, and</td>
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three PPU Investigations Teams. The SCU manage referrals, intelligence and information sharing for all safeguarding matters, and is comprised of a mixture of police officers and police staff. The Investigation Teams deal with any subsequent criminal offences which are disclosed, are omni-competent for all areas of PPU work, and are solely comprised of police officers.
Appendix B Bibliography

Access to Health records Act 1990

Association of British Investigators Code of Ethics and Professional Standards.

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Data Protection Act Schedule 1 - 8 Data Protection Principles.


Department of Health Guidance on “Independent Investigation in Mental Health Services”.

Domestic Homicide Review Toolkit.


Employment Rights Act 1996

Equalities Act 2010

Faces of Britain

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

HM Government Information Sharing: Guidance for practitioners and managers.

Nice Guidance on “Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively”. (February 2014)

Safer Bristol:- Information Sharing Protocol For Assessing and Protecting Victims Of Domestic and Sexual Violence and Abuse (April 2011)

Safer Bristol: - Violence and Abuse: a strategy against violence and abuse against women and girls and domestic and sexual violence against men 2012 - 2015

Security Industry Authority; Introduction of business licensing, Regulatory Reforms and business Regulations.


# Appendix C Action Plan

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Scope of recommendation ie local/regional/national</th>
<th>Action to take</th>
<th>Lead agency</th>
<th>Key milestones achieved in enacting recommendation</th>
<th>Target date</th>
<th>Date of completion and outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Changes should be made to the Domestic Violence, Crime and Victims Act 2004 and/or Revised Multi-Agency Guidance on the Conduct of Domestic Homicide Reviews. (Home Office 2013), to require none-statutory organizations to participate in Domestic Homicide Reviews. Currently such agencies can choose whether or not to participate and this can leave employees vulnerable, as lessons are neither acknowledged nor addressed.</td>
<td>National</td>
<td>Government should amend the legislation to ensure private companies participate in DHRs to improve the safety of their employees</td>
<td>Home Office</td>
<td>To be set by Central Government</td>
<td>TBA</td>
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<tr>
<td>2. Guidance is required from the Department of Health as to which organisation should conduct IMRs relating to GP practices. Currently CCGs regularly fill this role, however, on occasions, it has been challenged by GP Practices and in this case the CCG has asked for clarity on this</td>
<td>National</td>
<td>As a matter of some urgency, the Department of Health should give guidance to GPs, NHS England, and Clinical Commissioning Groups (CCG) on which agency should conduct IMRs and sit as panel members on DHRs</td>
<td>Department of Health</td>
<td>To be set by Department of Health</td>
<td>Jan 2015</td>
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3. That the Home Office, when drawing up the regulation of the private security industry under the auspices of the Security Industry Authority (SIA), considers regulatory reforms relating to controls on how private information is obtained and utilised, and additionally the restrictions on the use of technical aids, which may impinge on the privacy of individuals. (Currently there appears to be more controls on the Police than there are on private companies).

| National | Home Office to consult with the Information Commissioner’s Office (ICO) | Home Office, ICO, SIA | To be set by Central Government |

4. The Safer Bristol “Information Sharing Protocol For Assessing and Protecting Victims Of Domestic and Sexual Violence and Abuse” (April 2011) should be updated to ensure agencies are clear that they can share information without consent on a case to case basis to prevent serious violence.

| Cross Bristol Agencies | Safer Bristol Partnership to update Information Sharing protocol and ensure partner agencies are signed up | Safer Bristol Partnership | March 2015 |

5. Organisations working with victims of domestic or sexual abuse should be signatories to the above mentioned information sharing protocol.

| Cross Bristol Agencies | Agencies to sign up to updated Information Sharing Protocol | All agencies | March 2015 |

6. Organisations should support the

| Cross | Agencies to identify a domestic | All | March |
work of the Bristol Domestic and Sexual Abuse Strategy Group, and identify an agency domestic abuse champion, similar to those already introduced by the Bristol Community Safety Partnership, the Bristol CCG and the North Bristol NHS Trust.

7. Response officers will receive training, as part of their mandatory cycle of training, specifically in relation to recognising the signs of domestic abuse and speaking to witnesses at the scene

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsible Authority</th>
<th>Responsible Agency</th>
<th>Responsible Agency Details</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that response officers are able to record crime correctly on the Force IT systems.</td>
<td>Local</td>
<td>Avon and Somerset Constabulary (Police)</td>
<td>Public Protection Unit will monitor National Centre for Applied Learning Technologies (NCALT) training figures and evaluate the completion rate with a view to developing further training and awareness.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ensure that response officers are able to record crime correctly on the Force IT systems.</td>
<td>Local</td>
<td>Avon and Somerset Constabulary (Police)</td>
<td>All incidents are reviewed by their line management. The Safeguarding Coordination Unit will also dip-sample STORM logs, to ensure that Guardian incidents/intelligence are recorded correctly.</td>
<td>Ongoing</td>
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<tr>
<td>9. Force Service Centre to receive training specifically around support agencies available to victims, even if</td>
<td>Local</td>
<td>Avon and Somerset</td>
<td>Awareness will be increased as to the amount of safeguarding</td>
<td>May 2014</td>
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<td>they wish for no Police action to be taken.</td>
<td>Service Centre has a safeguarding champion, who will lead this training with assistance from the Public Protection Unit.</td>
<td>that is available to domestic abuse victims outside the scope of Police.</td>
<td>the Force Service Centre by the end of May 2014.</td>
<td></td>
</tr>
<tr>
<td>10. Force Service Centre to receive updated training relating to domestic abuse including case studies. The training will be generic but will centre on the needs of a domestic abuse victim.</td>
<td>Local</td>
<td>Joint training needs to be arranged, involving support agencies if necessary. The Force Service Centre has a safeguarding champion, who will lead this training with assistance from the Public Protection Unit.</td>
<td>Avon and Somerset Constabulary (Police)</td>
<td>May 2014</td>
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<tr>
<td></td>
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<td>This training will remind and encourage staff of the need to support victims as appropriate at every stage of the reporting process.</td>
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<td></td>
<td></td>
<td>Training will be delivered to each of the teams within the Force Service Centre by the end of May 2014.</td>
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<td>11. The Victim Advocacy Unit will receive training in order to ensure they are aware of the options available when further disclosures are made during telephone contact. If there is a requirement for further crimes to be recorded, the Victim Advocacy Unit should ensure that they record the crimes rather than relying on the victim to call 101.</td>
<td>Local</td>
<td>The Victim Advocacy Unit will be incorporated into the Integrated Victim Management pilot which will begin in March 2014. Training will be an integral part of the success of this pilot, and will focus on the safeguarding needs of the victim, how incidents are reported and the victim’s journey through the process.</td>
<td>Avon and Somerset Constabulary (Police)</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Integrated Victim Management will be extremely scrutinised as part of the pilot process. Measures will be put in place to ensure that any issues are managed as they arise along with feedback requested from staff and victims.</td>
<td></td>
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<tr>
<td>12. The GP Practice should become part of IRIS ((Identification and Referral to Improve Safety) training programme.</td>
<td>Local</td>
<td></td>
<td>Seymour Medical practice / Bristol Clinical Commissioning Group (BCCG)</td>
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Page 43
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<tbody>
<tr>
<td>13. The GP Practice involved in this DHR undergo refresher training in regards to domestic abuse.</td>
<td>Local</td>
<td>Seymour Medical practice / Bristol Clinical Commissioning Group (BCCG)</td>
<td>Training has been undertaken.</td>
<td></td>
</tr>
<tr>
<td>14. That a significant event audit is undertaken with regards to this event and that the practice explores more fully their use of risk assessments and their policy framework.</td>
<td>Local</td>
<td>There should be further exploration within the practice about the application of the policies and procedures they have in place with regards to domestic abuse.</td>
<td>Seymour Medical practice / Bristol Clinical Commissioning Group (BCCG)</td>
<td>There is evidence that a significant audit has taken place.</td>
</tr>
<tr>
<td>15. The Company’s policy on risk assessments to be reviewed</td>
<td>National – company-wide</td>
<td>Completed</td>
<td>Riding Ltd</td>
<td>The company's policy on risk assessments has been reviewed to ensure staff continue to risk assess all cases and know who to report to when they have concerns.</td>
</tr>
<tr>
<td>16. The Company should review the wording of the confidentiality agreement made with patients to ensure that it contains a clause that information that relates to a</td>
<td>National – company-wide</td>
<td>Completed</td>
<td>Validium Group</td>
<td>The company has reviewed the wording of the confidentiality agreement it makes with patients to ensure it</td>
</tr>
</tbody>
</table>
17. A public awareness campaign should be rolled out encouraging friends and family aware of domestic abuse to seek help.

<table>
<thead>
<tr>
<th>Local</th>
<th>Development and implementation of a public awareness campaign</th>
<th>Safer Bristol Partnership</th>
<th>March 2015</th>
</tr>
</thead>
</table>

person’s safety will be shared with the appropriate authorities even when consent is not given. contains a clause that any information that relates to a person’s safety will be shared with the appropriate authorities even if consent is not given.
APPENDIX D - Interviews with family, friends, neighbours and work colleagues

Family

On 16th October 2013 the DHR Chair met with the following members of Jean’s family.

- Her ex husband (seen on his own) he confirmed that he had been seeing Jean for a few months prior to her death and it was their intention to “get back together” once she divorced her husband (Mohinder). He said she told him she was scared of Mohinder and that she had spoken to the police about it. She had received a home visit from the police, but did not take the opportunity to go to the support group they recommended. He never heard her complain about any organisation. She knew there was help available.

- Jean’s son, daughter, and one of her two sisters with their partners. They wanted to be together at that stage but agreed to speak to the Chair individually after the trial. The daughter and son were aware that their mother had contacted the police and that they had come to the house on a couple of occasions. Her sister asked if the DHR could find out if she was ever given a safety plan. Jean’s daughter stated her mother had received a telephone call from a support group (she did not know the name) after the police visit, but she had said she did not want any support then. (The Chair later confirmed that as Jean had not wanted to engage with Next Link, she had not been given a safety plan, he informed Jean’s sisters and mother of this).

- Mohinder’s sister (one of two); she said Jean was her friend and she was still close to her niece and nephew, however her mother and other sister were still very upset and wanted to support Mohinder, as they knew Jean had been having an affair. She did not have any questions for the Review to consider. She knew the police had been called on a few occasions but had never heard Jean or Mohinder say anything detrimental about them. She did not wish to sign an authority for the DHR to access her brother’s medical records nor to choose a name for him for the purposes of the Review as she felt it may cause a family rift.

On the 17th October 2013 the DHR Chair visited Jean’s mother and sisters at the mother’s home address. The mother gave her authority as Jean’s next of kin for the DHR to access her medical records and any other confidential documents. She also chose the name Jean as a pseudonym for her daughter. She knew the police had been called to the house by Jean on a number of occasions but did not know the detail. Jean had never criticised any organisation that she knew about.

She said she would like to know the outcome of the Review in due course. (Sadly the victim’s mother who had been suffering with poor health died before the murder trial and the conclusion of the Review).
On 12th November 2013 the DHR Chair was informed that Mohinder’s mother and other sister did not want to speak to him at that time. On 7th January 2014 the Police Family Liaison Officer (FLO) contacted the Chair to arrange for him to speak to Mohinder’s mother and sister on 10th January. The following day the FLO contacted the Chair by email to inform him that Mohinder has employed a new solicitor, who has told the family not to speak to the police at all, so she was unable to confirm the meeting on Friday 10th January 2014. The Chair spoke to Mohinder’s solicitor who said she would speak to his Barrister and get back to him. Not receiving any reply the Chair telephoned the solicitor on 29th January 2014 and was told that Mohinder did not wish to engage with the Review and did not want his family to do so.

On 16th June 2014 and the 2nd July 2014 the Chair spoke on the telephone to the victim’s ex-husband and informed him of the lessons learnt, conclusions and recommendations. The ex-husband said he been shocked and upset when he learnt of the involvement of the private enquiry agent during the trial, but he was pleased the company had contributed to the Review. Nevertheless he expressed his doubt that the company would change. He has asked to have a copy of the Report and the Chair explained this could be given after the report has been considered by the HO QA panel.

On the 27th June 2014 the Chair informed the victim’s son and the perpetrators sister of the findings of the Review. He read to them the lessons learnt, conclusions and recommendations. The son said he was pleased with the findings and satisfied with the recommendations. He thanked the Chair for the Panel’s work and said he would inform his sister as he was not sure if she would want to speak directly to the Chair as she was still traumatized.

The perpetrator’s sister said she thought the Report was thorough and while she was disappointed with the decisions of her brother’s G, she was glad the Practice was taking action to ensure improvements in the future. She told the Chair her mother is in hospital and when she visits her next, she will inform her about the Review’s findings. She thanked the Chair for keeping her informed and for the recommendations of the Review.

On 2nd July 2014 The Chair spoke to the victim’s brother in law who represented her two sisters. He told him the lessons learnt, conclusions and recommendations. He accepted the findings and thanked the Chair.

As a member of the family indicated that they were considering civil action against one of the agencies, the Chair made the decision not to provide written copies of the report to the family at that time.

Friends / Work colleagues

- Friend A said he had met Jean through her work and had an affair with her between 2001 and 2009, keeping in contact, as friends, after the end of the relationship. Jean told him of Mohinder’s controlling behaviour, of the incident when he head butted her and also of when he drove off as she was getting
into the car, hurting her leg. She informed him of how, when he was in the Army in Germany, he had punched his girlfriend, knocking her teeth out.

- Friend B had worked with Jean until about 2010 and although he had not seen her since that time, he recalled her speaking about the domestic issues between Mohinder & herself; how Mohinder would say she was getting fat. When she told him she wanted a divorce, he had told her that if she tried to sell the house, he would burn it down rather than lose it.

- Work colleague C, said Jean had told him not long before her death that Mohinder used to call her “a fat, lazy cow” and that she knew he was following her during May and June 2013. On the 17\textsuperscript{th} June 2013 she had telephoned him and said that she was going through divorce proceedings. When he advised her not to move out of the house, she had replied “you don’t know what he is like, he’ll kill me”.

- Work colleague D had worked closely with Jean for about nine years. Jean had confided in her about her marital problems and that she had recently rekindled her friendship with her previous husband.

- Three other work colleagues said they were aware that Jean was having problems and was getting a divorce but did not know any detail.

- Four of Jean’s work colleagues were contacted by the police on behalf of the Review, prior to its conclusion, and they all confirmed that they were not aware of any training relating to domestic abuse being provided by their employer. None knew if Jean’s line manager had been informed of her marital problems.

**Neighbours.**

One of Jean’s neighbours said she had heard banging noises from Jean’s bedroom at about 3am on the night Jean was killed, however she did not know any details about the family.
### Appendix E Chronology

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Source of Information</th>
<th>Agency Name &amp; Sector/Dept if relevant</th>
<th>Significant &amp; Relevant Events: details of contact, including whether the victim was seen/wishes and feelings sought and recorded</th>
<th>Action Taken</th>
<th>Author Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/09/2000</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Bristol Clinical Commissioning Group</td>
<td>Seen in GP Surgery: Problem Menorrhagia, menstrual period late by one month, tired, query pregnant. Normally 26 - 30 days. Partner had vasectomy, drunk one month ago and concerned she may have done something she can't remember. Doesn't want to be pregnant and wants meds to bring on period, explained must get pregnancy test first, not happy and walked out.</td>
<td></td>
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</tr>
<tr>
<td>16/04/2004</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Bristol Clinical Commissioning Group</td>
<td>Seen in GP Practice with Menorrhagia, combined oral contraceptive pill review, primary reason for use is to control her cycle. Happy with. Occasional cigarette. Discussed thrombosis risk and would refer to 'Stop Smoking and Stop' combined oral contraceptive pill. On examination blood pressure</td>
<td></td>
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</tbody>
</table>
150/84, trivial smoker of one cigarette a day.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Name</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/04/2004</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Seen in GP Practice for anxiety with depression. Labile weepy, low, poor appetite, can't sleep - work investigation, job threatened.</td>
<td>Fluoxetine capsules 20mg once daily and Temazepam 10mg one at night.</td>
</tr>
</tbody>
</table>
She was seen in the GP practice following an assault, head butted in nose and forehead. Previous assault one year ago. On examination laceration to bridge of nose, swelling and tenderness and swelling to the left frontal region. Teeth and gums painful but no loosening. Tearful, will stay with mother and decide on future. For analgesia Co-codamol Capsules 500mg +30mg to take four times a day.

No documentation regarding advice of who to contact following assault or engagement regarding feelings / mental health.

The author met with a GP of Seymour Medical Practice to discuss this consultation, practice and policy in 2004 and changes now. The purpose was to establish with GP what would happen now following a consultation like this. In 2004 what was the policy and what would have been expected practice at this time following a consultation like this? Would the notes of husband have been cross referenced in this scenario?

The children were children in 2004 (nine and thirteen years) and it is unclear if a referral was made to safeguarding children. The GP acknowledge that practices have changed considerably in the last ten years. On further analysis and scrutiny of the notes it is apparent that no referrals were made on 21/08 to support Jean.
No referrals were made to children services for the children at that time.
The GP advised the author when they met that she could not recall the policy and practice at that time. She felt that this situation would of led to referrals should it happen now. There are procedures in place. What would happen now is that they would speak to the individual about whether they would consider contacting the police and reporting the incident. They would discuss the children’s involvement in the incident and where required make a referral to social services with concerns for the children’s welfare. They would call the domestic violence helpline to ensure that the victim is provided with any appropriate information that they require for example advice support and a safe place to go.
The practice also reported that they are aware and involved in the IRIS scheme. (IRIS is a general practice-based domestic
violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial).

Supporting letters on both RG and NG were checked to ensure that no referrals that had been made had not been captured as part of the DHR process.

The author asked the GP if there were dates to the head butting incident. It is unclear from the records whether the second head butting took place on the 21/08/2004 and there is no reference in the GP records of RG seeking medical attention on the first head butting occasion which is anticipated to have taken place in 2003.
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Organization</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/09/2004</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Seen in GP Surgery with depression. Several difficult events over the past year. Sister and Mother both have secondary cancer. There is a complaint against her at work and finally recently her husband assaulted her. (This was the second time, the previous occasion was two years ago). Feeling low, feeling of self blame, poor sleep pattern, appetite okay, tiredness. No active thoughts of self harm, mother supportive. Provided with information re. Woman Kind. Referral made to Inner Care (Primary Care Mental Health Services).</td>
<td>Information provided re. Woman Kind and prescribed antidepressants.</td>
</tr>
<tr>
<td>06/10/2004</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Letter sent from Inner Care to Jean offering her appointment to come and discuss her current difficulties. Clearly states in this letter that if they do not hear from her within two weeks they will assume she does not require an appointment.</td>
<td>Inner Care offered her an appointment on the 6th October and they discharged her on the 8th December after she failed to make an appointment to be seen.</td>
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<tr>
<td>Date</td>
<td>Time</td>
<td>Source</td>
<td>Description</td>
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<tr>
<td>08/12/2004</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Letter from Inner Care sent to the GP to say that Jean had not taken up the offer of an appointment. Therefore, it was foreseen that she does not want to be seen by the team and was being discharged back to the GP’s care.</td>
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<tr>
<td>08/12/2004</td>
<td></td>
<td>Bristol Clinical Commissioning Group</td>
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<td>Between September 2004 and her death, Jean was seen in the practice but these consultation related to her hypertension and asthma. Nil else of note.</td>
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<tr>
<td>08/12/2004</td>
<td></td>
<td>General Practice (GP) Clinical Records - Jean</td>
<td>Documented evidence of physical abuse and reported domestic violence from husband. Evidence of depression in 2004. No notes were supplied beyond 16th September 2004 as there is no further mention of domestic abuse or depression after this time. The sleeping tablets and antidepressants were not continued beyond 2004. DHR author made contact with the GP involved to ask additional questions. She had past medical history of asthma, hypertension and some menopausal symptoms.</td>
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<tr>
<td></td>
<td></td>
<td>Bristol Clinical Commissioning Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>General Practice (GP) Clinical Records</td>
<td>Bristol Clinical Commissioning Group</td>
<td>Seen in GP Practice: Bereavement reaction. Sister who died had her birthday last week, becoming depressed. Has had counselling in the past unable to work.</td>
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<tr>
<td>08/12/2004</td>
<td></td>
<td>Jean</td>
<td></td>
<td>cont... Beyond 16th September 2004 she had no further consultation regarding depression or relating to any emotional or domestic abuse issues. She was not prescribed long term antidepressant after 2004. She was on long standing medication for her hypertension (high blood pressure) and inhalers for asthma. The Temazepam given on the 16th March 2004 was a ten day course only. There were no other professionals involved or referrals made to other agencies.</td>
</tr>
<tr>
<td>13/12/2005</td>
<td>Time Unavailable</td>
<td>Mohinder</td>
<td></td>
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</tbody>
</table>
Jean rang Police to report that she was intending to end her relationship with Mohinder who had been violent towards her in the past. Jean advised that the last time he was violent towards her was five years previously when he headbutted her and this was documented by her doctor. Jean stated that she was now scared of him and what he might do - he had parked his car across the front of the garage and she was unable to get her car out. No threats were made towards Jean and she stated that he had been very quiet towards her.

Jean was advised to call should the situation escalate further, i.e. if he returned and made threats or became violent. She was also advised to go and stay with friends/family if this became the case. She was also advised to seek legal advice. No physical Police attendance.

DV Force Policy states that Police Officers will attend all calls and reports relating to domestic violence or abuse, and check the welfare of all parties. This did not occur and will be outlined in further detail within the IMR. No Guardian incident or intelligence reports were created.
<p>| 15/06/2013 | 22:04:57 | Storm Log AS-20130615-1225 | Police - Force Comms | Jean rang Police to state that she was in the garden, along with her daughter. She stated that she was in the process of divorcing her husband who was being aggressive towards her. He had locked her inside the house but she had managed to escape into the garden. She was concerned because the last time this had happened, he assaulted her. She wants him to leave and that he had been verbally aggressive towards her so far. She then recalled Police to state that she and their daughter were locked in the kitchen as they were scared of Mohinder. He was being very intimidating and she was worried that if she asks him to leave, he will assault her. | Officers attended the scene and noted that Mohinder had left the property for the evening. There were no offences disclosed and words of advice given. No crime was recorded. | I have the following concerns: Did the Police attempt to speak to Mohinder or daughter? What advice did Officers give and were any support agencies considered? Again, this will be detailed further within the IMR. |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Incident Description</th>
<th>Police</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/06/2013</td>
<td>23:39:00</td>
<td>Guardian Incident 57437/13 as a result of the above Storm Log and Officer attendance.</td>
<td>Verbal argument reported by Jean, who is in the early stages of divorce. Mohinder has refused to move his car and Jean believed he has taken the keys to her car, due to his demeanour and behaviour she has felt intimidated and called Police. Mohinder left the address to go to his mother's address around the corner. DASH R/A Medium stated that he follows her around and texts her excessively.</td>
<td>No crime was recorded. Storm log was closed with following comments &quot;AIO, Male has left property for the evening, no offences, words of advice given&quot;. Appropriate action was taken by Officers in respect of raising a Guardian incident however, there is no record of what advice was given by officers or any decision making rationale. This will be explored further within the IMR.</td>
</tr>
<tr>
<td>15/06/2013</td>
<td>14:05:00</td>
<td>Referral to Welsman Children &amp; Young People's Services</td>
<td>A secure email was sent to First Response, with a copy of the Guardian report. First Response are the first point of contact for the CYPS locality offices.</td>
<td>This referral was made in error, as daughter was already aged 18. There was no requirement for any further contact with First Response as daughter was aged over 18 at the time.</td>
</tr>
<tr>
<td>15/06/2013</td>
<td>14:05:00</td>
<td>Referral to Safeguarding Children's Team within the NHS.</td>
<td>A secure email was sent to SGCT, with a copy of the Guardian report. SGCT are responsible for disseminating information further within the NHS.</td>
<td>This referral was made in error, as daughter was already aged 18. There was no requirement for any further contact with SGCT as daughter was aged over 18 at the time.</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Event Description</td>
<td>Action</td>
<td>Note</td>
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<tr>
<td>19/06/2013</td>
<td>14:05:00</td>
<td>Referral to Police Victim Advocacy Unit following Guardian Incident 57437/13</td>
<td>VAU contacted Jean who stated that despite her instigating divorce proceedings, Mohinder had refused to accept this and leave the home. Jean has since noted that the fish she kept outside in her pond have all been killed and suspected Mohinder. She was advised to contact 101 for assessment and raise an incident. DV support was discussed and a referral made to Nextlink.</td>
<td>Appropriate action taken in a timely manner by VAU.</td>
</tr>
<tr>
<td>19/06/2013</td>
<td></td>
<td>Referral to Nextlink from the Police VAU following Guardian Incident 57437/13</td>
<td>DV support was discussed with the VAU and a referral made to Nextlink. On the 15.07.13 Nextlink called the SCU to advise that they were closing their file in relation to this incident. They spoke to Jean on 04.07.13 who advised them that she would call if she wanted any support. She had not subsequently called so Next Link closed their file.</td>
<td>Appropriate action taken in a timely manner by VAU.</td>
</tr>
<tr>
<td>21/06/2013</td>
<td>16:40:25</td>
<td>Storm Log AS-20130621-0839</td>
<td>Jean reported Mohinder as a missing person, after he had driven off 5 mins previously, having made threats to 'meet his maker', and filled out his will.</td>
<td>Addresses of mother and sister were visited, ANPR analysis of car registration and Mohinder's phone signal was located. Mohinder later made contact with officers (at 17:42) stating that he was safe and well but</td>
</tr>
</tbody>
</table>
refusing to meet. He later returned home (23:13). A debrief interview was conducted, Mohinder was calm and sober and agreed to go to his sister’s address in Clevedon. Jean was noted as having been drinking. She was with family and the welfare of the family was checked with no apparent concerns.

<p>| 21/06/2013 | 22:43:47 | Storm Log AS-20130621-1339 | Police - Force Comms | x-ref with log AS-20130621-1339 above. Jean called Police to stated that Mohinder had returned to the address after being reported missing. Jean was very concerned about the behaviour of her husband and stated that he is known to be aggressive, he doesn't want a divorce and she was very worried that something is going to happen. Police attended as per log above. | See above | See above | mind the history of reports to Police between these parties, I feel that this decision was misguided. There were no information markers placed on the address at any point, nor Guardian incident/intelligence reports raised. |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Referrer</th>
<th>Client</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/06/2013</td>
<td>Safeguarding Coordination Unit, A&amp;S Police</td>
<td>Next Link</td>
<td>Written referral received by Next Link duty team from Police Safeguarding Coordination Unit (SCU) The Police Guardian report detailing incidents on 15th June and 19th June were included. Also included was the CAADA DASH Risk Assessment carried out by the police on 15.6.13. Due to the time the referral was received and the information that she should only be contacted between 9am and 2pm, it was decided to call her the following Monday.</td>
</tr>
<tr>
<td>24/06/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>2 phone calls were made by the duty team to Jean. No contact made Jean</td>
</tr>
<tr>
<td>25/06/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>Phone call made by duty worker to Jean. No contact made with Jean</td>
</tr>
<tr>
<td>26/06/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>Phone call made to Jean. Jean did not answer phone. A text message was sent offering support.</td>
</tr>
<tr>
<td>02/07/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>Phone call made by duty worker to Jean. No contact made with Jean</td>
</tr>
<tr>
<td>03/07/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>Phone call made by duty worker to Jean. No contact made with Jean</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Practice</td>
<td>Telephone Consultation</td>
</tr>
<tr>
<td>------------</td>
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<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04/07/2013</td>
<td>Next Link</td>
<td>Next Link</td>
<td>Phone contact made with Jean by duty worker. Jean stated that she could not talk then and would phone back the following week (week beginning 8.7.13. She stated that she did not want to be called again.</td>
</tr>
<tr>
<td>08/07/2013</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Mohinder</td>
<td>Telephone consultation: Overdose of drug. History of marital problems. Low mood. Took an overdose of paracetamol three days ago. Approximately twenty. Appointment made for today to assess current suicidal risk and also call up poisons unit (but likely to be fine from this point of view).</td>
</tr>
<tr>
<td>Time</td>
<td>General Practice (GP) Clinical Records - Mohinder</td>
<td>Bristol Clinical Commissioning Group</td>
<td>Seen in the Practice. History of marital problems, wife going out five times a week staying out late, drinking, behaving like a teenager, making accusations to the police. Not much conversation going on. Distressed, not sleeping. Has two children, has youngest 18 living in the house with them. Older one lives away. Took overdose two weeks ago, feeling low, not eating, disturbed sleep pattern, discussed getting others to help, Samaritans number given. Number given for 'Lift' (name of psychological therapy service) to stop alcohol use, stopped weekend use months ago, blood pressure normal today 131/80. He was given a leaflet for 'Lift'. Plan to review in two weeks and check out marital guidance even if partner is not agreeing.</td>
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<td>08/07/2013</td>
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<td>08/07/2013</td>
<td>General Practice (GP) Clinical Records - Mohinder</td>
<td>Bristol Clinical Commissioning Group</td>
<td>cont... If the concerns had been more significant then they could have referred patient to the primary care liaison mental health team but that would have been if they had felt that he was at risk of committing suicide. This would have been their onward opportunity to refer but they didn't think it was appropriate and they also felt it was appropriate to supply him with the Samaritans number. It was confirmed the processes and policy would not be any different than what was followed on this occasion given the clinical presentation on that day. The author asked if it would be routine practice to look at the partners notes if they had access to them? The GP said that they potentially could if they felt it was appropriate but not in all situations both partners would be registered at the same practice. It wouldn't be something they usually do or feel it was necessary to do.</td>
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<tr>
<td>Date</td>
<td>Time</td>
<td>Source</td>
<td>Event Description</td>
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<tr>
<td>08/07/2013</td>
<td>Time Unavailable</td>
<td>General Practice (GP) Clinical Records - Mohinder</td>
<td>Seen at University Hospital Bristol in the A&amp;E department with overdose (Day after his wife died), his bloods were normal. Yellow on the Mental Health Matrix and discharged with the police.</td>
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<tr>
<td>08/07/2013</td>
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<td>General Practice (GP) Clinical Records - Mohinder</td>
<td>In the information supplied by GP Practice, it was unclear whether any further consultation took place between the 08/07 - 20/07. DHR Author followed up with Practice and confirmed this was the last consultation.</td>
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<tr>
<td>15/07/2013</td>
<td></td>
<td>Next Link</td>
<td>General Comment: No long term history of depression. Mohinder had a past medical history of asthma. Recorded episodes are the only episodes of an emotional or depressive nature. There were no other entries in the medical records related to domestic issues.</td>
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<tr>
<td>20/07/2013</td>
<td>12:27:16</td>
<td>Storm Log AS-20130720-0662</td>
<td>Case was reviewed. Jean had not called in previous week. SCU were notified. Case was closed.</td>
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<td>Police - Force Comms</td>
<td>Police despatched to the scene. When it transpired that Mohinder was no longer at the scene, officers were despatched to son's address, old work addresses, Mohinder's mother and sister's addresses. ANPR analysis was conducted, with no reads of his car registration that</td>
</tr>
</tbody>
</table>
thought that Mohinder was responsible, she stated that her parents are going through a divorce and he has done this. Caller stated that she had walked into her mother and father's bedroom and discovered her mother's body. Her father then left the room and she was not 100% sure if he was still there. Jean registered as deceased by Ambulance at 12:35. At 12:47 the premises were checked for Mohinder - including the garage and loft, with a negative result. Day. There was a possible match on public transport, so officers were despatched to Bristol Bus Station where Mohinder's photo and description were circulated. Both cars registered to the location were noted to be at the address.
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/07/2013</td>
<td>12:27</td>
<td>Storm Log AS-20130720-0662</td>
<td>Area tours were conducted and requests for observation were sent out forcewide for Mohinder along with his description and photograph. Mohinder was also circulated on PNC as wanted along with an All Ports Warning issued. At 20:58 on the 20.07.13, Mohinder was identified by a Police Officer whilst walking along a main road and detained.</td>
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<tr>
<td>23/07/2013</td>
<td>16:09</td>
<td>Guardian Incident 72109/13</td>
<td>Guardian incident raised due to the murder of Jean. The cause of death was described as multiple blunt force head injuries. In interview, Mohinder admitted to striking Jean with a metal dumbbell on a number of occasions causing her death. Murder investigation initiated.</td>
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