



ELMBRIDGE COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW

**Overview Report into the death of Bishakha
May 2016**

Independent Chairs: Jessica Donnellan and James Rowlands

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Associate Standing Together Against Domestic Violence

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“[Bishakha was] a brilliant creative and caring person has been snatched cruelly away well before her time. I ask God repeatedly: “why didn’t you take me?” I had achieved all that I wanted, and it was Bishakha who was going to take all of our dreams into the next generation.

I was so confident in her abilities that I was going to retire. Bishakha was already the backbone of our businesses as well as being an outstanding mother and daughter, absolutely devoted to her family. But it was her dedication to others that made her especially remarkable. This was shown by the number of former colleagues and business associates who came to her funeral, for which we were truly grateful.

Bishakha worked her way through state education, graduating as a Chartered Accountant. On sheer merit she became a director of the family business, running all aspects of three nursing homes, showing genuine concern and compassion for individual residents and staff. She was project managing a new state of the art home providing acute care. It is sadly now down to me to realise her wonderful project, which I am determined to do in her name. Bishakha had a flair for design and spent more than three years creating her ideal home for her family, typically completing it on time and on budget.

Bishakha was a problem solver. If she was analysing her own senseless death she would be looking for solutions, and I feel obliged and determined to do this on her behalf and on behalf of others. We were a close family. We had financial resources. We could have helped prevent this happening if we had been warned: I would have given all of my time and resources to ensure the right care and support were achieved. We appreciate the need for patient confidentiality, but it’s true to say that data protection in this case didn’t protect anybody”.

Antariksh (Bishakha’s father)

“What Bishakha treasured above all was meaningfully connecting with others. Forever interested in every person she met, Bishakha got on with everyone and made a special effort for those she felt particularly for. And her love never stopped there, but loyally extended to the family of her friends, whether she knew them personally or not. Never one to gossip, Bishakha didn’t talk badly about people and if someone did not impress her, she largely kept that to herself. Instead, she was constantly curious about the human experience, and the more people she connected with, the more she understood and the more she cared”.

Orpita (Bishakha’s friend)

1. Preface

1.1 Introduction

- 1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.
- 1.1.2 This report of the DHR (hereafter ‘the review’) examines agency responses and support given to Bishakha, a resident of Elmbridge prior to the point of her homicide at her home in May 2016. Elmbridge is a local government district with borough status in Surrey.
- 1.1.3 Following a call for urgent medical assistance to South East Coast Ambulance Service (SECAMB), Bishakha was found lying on the kitchen floor. She had sustained significant injuries inflicted by an axe and a knife and was pronounced dead at the scene. Manav was sitting on the kitchen floor inflicting severe injuries to himself. A number of other family members were also present, having arrived at the scene shortly after the homicide.
- 1.1.4 Manav was arrested and charged. He was subsequently found not guilty of murder on the grounds of diminished responsibility but was found guilty of manslaughter. He was sentenced to life imprisonment with a minimum term of nine years and 172 days. As will be discussed later in this report the family (and a number of friends) of Bishakha have expressed their anger and dissatisfaction with the criminal justice outcome.
- 1.1.5 The review will consider agencies contact/involvement with Bishakha and Manav from 20 May 2011 to the end of May 2016 (the date of Bishakha’s death). In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.
- 1.1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.1.7 This review process does not take the place of the criminal or coroner’s courts nor does it take the form of a disciplinary process.

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

1.2 Timescales

- 1.2.1 The Elmbridge Community Safety Partnership (CSP), in accordance with the December 2013 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' (hereafter 'the statutory guidance') commissioned this DHR. The Home Office were notified of the decision in writing on 9th June 2016. As revised statutory guidance was issued at the end of 2016, the review was subsequently completed in line with the new guidance.
- 1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR on 23rd June 2016. The completed report was handed to the CSP in August 2018. It was submitted by the CSP to the Home Office Quality Assurance Panel in January 2019 and considered in April 2019.
- 1.2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was considerably extended for a number of reasons:
- The first panel meeting was not held until 2nd September 2016 to ensure agencies could attend
 - While the criminal trial was held in October 2016, sentencing was not until December 2016
 - To enable family contact (see 1.9 below)
 - To enable contact with friends and colleagues (see 1.9 below)
 - To enable contact with the perpetrator (see 1.10 below).
- 1.2.4 Additionally, during the course of the review there was a change of chair (see 1.12 below), with a new chair appointed in January 2018.

1.3 Confidentiality

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

- 1.3.2 This review has been suitably anonymised in accordance to the statutory guidance. The specific date of death has been removed, as has the sex of the child involved (to further protect their anonymity, they are referred to as Child A).
- 1.3.3 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:
- Bishakha – victim
 - Manav – perpetrator
 - Antariksh – father of victim
 - Anemone – mother of perpetrator
 - Ish – brother of victim
 - Rajni – sister of perpetrator
 - Ella – colleague and friend
 - Maria – colleague
 - Nandita – friend
 - Orpita – friend
 - Ulka – colleague and friend.
- 1.3.4 These pseudonyms were selected by the chair but were agreed with Bishakha’s father, Antariksh.
- 1.3.5 As per the statutory guidance, the chair(s) and the Review Panel are named, including their respective roles and the agencies which they represent.
- 1.3.6 Agencies who provided information to the review are also identified, with the exception of five agencies which have been anonymised. Of these, four were sited nearby, and so naming them could provide location information which could be used to identify the subjects of the review. These are:
- A General Practice (where Bishakha, Manav and Child A were registered). This is referred to as the ‘Medical Centre’.
 - A (Fee Paying) Pre-Prep and Nursery School (attended by Child A)
 - Two Private Mental Health Providers (who were approached in relation to treatment for Manav).
- 1.3.7 Additionally, Manav worked as a contractor at a large international bank. This bank has not been named as this information could be used to identify the subjects of the review.

1.4 Equality and Diversity

- 1.4.1 The Review Panel did bear in mind all the protected characteristics of Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex and Sexual orientation during the review process.
- 1.4.2 At the first meeting of the Review Panel, it identified that the protected characteristic of Sex required specific consideration. This is because Bishakha was female, and Manav is male. A recent analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators¹.
- 1.4.3 Further consideration was given to other protected characteristics, including Bishakha and Manav's Race (both were British Asian), Religion and Belief (Bishakha was Hindu, so was Manav although when interviewed in prison he told the chair he was exploring other faiths). Additionally, the Review Panel considered Socio-Economic status.
- 1.4.4 These issues are discussed further in 5.3 below.

1.5 Terms of Reference

- 1.5.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from the homicide, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.
- 1.5.2 The Review Panel comprised of agencies from Elmbridge, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.
- 1.5.3 As information was provided during the review, it was established that Bishakha and Manav may have had contact with agencies in other parts of Surrey, as well as in London (for the purposes of Manav's work). These

¹ "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "Key Findings From Analysis of Domestic Homicide Reviews" (December 2016), p.3.

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

agencies were contacted for information and involved remotely where appropriate.

- 1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the ‘generic issues’ as set out in the statutory guidance and identified and considered the following case specific issues:
- Set out the facts of their involvement with Bishakha, Manav and Child A
 - Critically analyse the service they provided in line with the specific terms of reference
 - Identify any recommendations for practice or policy in relation to their agency
 - Consider issues of agency activity in other areas and review the impact in this specific case.
- 1.5.5 At the first meeting, the Review Panel shared brief information obtained from a ‘summary of engagement’ exercise about agency contact with the individuals involved. At this early stage it was clear that there had been limited contact with statutory services and no previous disclosures of previous domestic violence and abuse. As a result, the Review Panel agreed that, although Bishakha and Manav had been married since 2005, the time period for the DHR would be from May 2011 to the end of May 2016 (the date of Bishakha’s death). This five-year time period was chosen as it covered the period of Bishakha’s pregnancy through to her homicide, allowing for an in-depth consideration of the relationship in recent years. Where appropriate, information about the relationship outside of this time period is included to provide context.
- 1.5.6 Additionally, as Bishakha and Manav had limited contact with public services, consideration was given to how to engage with private sector providers. At the outset this included a (Fee Paying) Pre-Prep and Nursery school, which was invited to be on the Review Panel. During the course of the review, two Private Mental Health Providers and a large international bank were also identified. Where possible, these organisations were contacted for information and involved remotely in the review.
- 1.5.7 To inform the panel’s understanding of equality and diversity issues, consideration was given to engaging with specialist Black, Asian and Minority Ethnic (BAME) groups. Unfortunately, it was not possible to identify representation from a local service that had expertise on BAME issues. To address this gap the Review Panel accessed advice from the Surrey Police Diversity Directorate, as well as STADV’s Safety Across Faith and Ethnic

(SAFE) Communities Project². Additionally, this local gap in terms of BAME specialist provision led to a recommendation which is discussed in 5.3 below.

- 1.5.8 As it was identified that there had been extensive contact with mental health services, STADV contacted the NHS England Mental Health Homicide Team. They agreed to commission a report to assist the deliberations of the Review Panel (see 1.6.11 below) and ensure that the NHS England representative on the panel had appropriate expertise (see 1.8.1 below).

1.6 Methodology

- 1.6.1 Throughout the report the term ‘domestic abuse’ is used interchangeably with ‘domestic violence’, and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:
- 1.6.2 “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
- 1.6.3 Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- 1.6.4 Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”
- 1.6.5 This definition, which is not a legal definition, includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.
- 1.6.6 This review has followed the statutory guidance. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and

² For more information, go to: <http://www.standingtogether.org.uk/local-partnership/safety-across-faith-and-ethnic-safe-communities-project>

agencies that had contact with Bishakha, Manav or Child A. A total of 14 agencies were contacted to check for involvement. Six agencies returned a nil-contact. Seven agencies submitted IMRs and chronologies, with the General Practice submitting three stand-alone chronologies for Bishakha, Manav and Child A respectively. The chronologies were combined, and a narrative chronology developed.

- 1.6.7 Additionally, information was sought from two Private Mental Health Providers and a large international bank. The outcome of this contact is summarised in 1.7.3 to 1.7.5 below.
- 1.6.8 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the panel to analyse the contact with Bishakha, Manav and Child A, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Four IMRs made recommendations of their own and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the Terms of Reference for this review.
- 1.6.9 *Documents Reviewed:* In addition to the eight IMRs, documents reviewed during the review process have included: a published account of the Judge's summing up; a previous DHR report in Elmbridge; an educational quality inspection of the Pre-Prep and Nursery School, completed by the Independent Schools Inspectorate (ISI)³; the local training strategy; a demographic profile of the borough; and the STADV and Home Office DHR Case Analysis.
- 1.6.10 The chair(s) also reviewed three witness statements taken from colleagues and friends of Bishakha by Surry Police during their murder enquiry.
- 1.6.11 Additionally, the chair(s) considered a report commissioned by NHS England Mental Health Homicide Team. The report addressed the mental health issues in this case.
- 1.6.12 *Interviews Undertaken:* The chair(s) of the review have undertaken a number of interviews in the course of this DHR, including:

³ The Independent Schools Inspectorate (ISI) is the body responsible for the inspection of schools in membership of the Associations that make up the Independent Schools Council. The ISI reports to the Department for Education on the extent to which schools meet statutory requirements. For more information, go to: <https://www.isi.net/about/>

- Two face-to-face interviews with Bishakha’s father (of which one was completed by chair, Jessica Donnellan, with a further interview later being conducted by chair, James Rowlands)
 - One face-to-face interview with Bishakha’s colleague / friend Ulka (completed by Jessica Donnellan), as well as phone calls / Skype interviews with a colleague / friend (Ella) and two friends (Orpita and Nandita) (completed by James Rowlands).
 - One face-to-face interview with Manav (see 1.9 below).
- 1.6.13 Unfortunately, it was not possible to conduct an interview with other members of Bishakha’s family (see 1.9 below). Nor was it possible to interview Manav’s mother (Anemone) (see 1.10 below).
- 1.6.14 The chair(s) are very grateful for the time and assistance given by the family and friends who have contributed to this review.

1.7 Contributors to the Review

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

- Surrey County Council Adult Social Care Services
- Surrey County Council Children’s Social Care Services
- National Probation Service (NPS)
- Citizens Advice Elmbridge (West) and North Surrey Domestic Abuse Outreach Service⁴
- Substance misuse services
- Victim Support.

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

Agency	Contribution
NHS 111 Service (Care UK)	Chronology and IMR
Health Visiting Service (Central Surrey Health) (CSH)	Chronology and IMR

⁴ The North Surrey Domestic Abuse Service is managed by Citizens Advice Elmbridge (West). The service provides free, confidential, independent and impartial advice to anyone aged 16 or above affected by domestic abuse living in the boroughs of Epsom & Ewell, Elmbridge or Spelthorne. For more information, go to: <http://www.nsdas.org.uk/about-us/>.

General Practice	in relation to Child A	Chronology only
	in relation to Manav	Chronology only
	in relation to Bishakha	Chronology only
Improving Access to Psychological Therapies Service (IAPT) ⁵ (Provided by Healthy Minds Surrey, Virgin Care) ⁶		Chronology and IMR
Midwifery Service (Kingston Hospital NHS Foundation Trust)		Chronology and IMR
(Fee Paying) Pre-Prep and Nursery School		Chronology and IMR
SECAmb		Chronology and IMR
Surrey Police		Chronology and IMR

- 1.7.3 Additionally, a Lone Private Mental Health Provider submitted a Chronology and brief IMR. This was possible because, while the contact related to Manav, the approach to this practitioner was by Bishakha. This information was shared as a result of contact initiated by the then chair (Jessica Donnellan). When the chair (James Rowlands) attempted to establish contact, no response was received.
- 1.7.4 During the course of the review, a further Private Mental Health Provider (a Psychiatric Hospital) was identified from information provided by the Medical Centre (which had written a referral for Manav). However, as there was no evidence that Manav had attended an appointment, the Review Panel decided not to approach this provider (see 1.10 below).
- 1.7.5 Lastly, Manav worked as a contractor at a large international bank. Information about Manav’s employment was collected as part of the murder enquiry and this was made available to the Review Panel in the Surrey Police

⁵ IAPT provides help and support for people over 18 years (who are registered with a GP in Surrey) who are experiencing mild to moderate mental ill-health. This can include stress, low mood, anxiety, panic attacks, depression (including pre and post natal), obsessive compulsive disorder, phobias, post traumatic stress and eating difficulties (not severe).

⁶ Virgin Care ceased to provide IAPT services in Surrey as of April 2017. Since that date, IAPT provision in Surrey is provided by any one of six providers. Each provider works on an activity-based contract, responding to either self-referrals and referrals from other sources. For further information, go to: <http://www.nwsurreyccg.nhs.uk/your-health/looking-after-your-mental-health/iapt>. The findings of this DHR will be shared with Virgin Care, local mental health commissioners and the other IAPT providers in Surrey.

IMR. While attempts were made to contact Manav's manager at the bank, these were not successful. Additionally, because of the time taken to secure consent for an interview with Manav the Review Panel recognised the difficulty in approaching the bank for information relating to him. Consequently, it was decided to approach the bank and seek general information from them as an employer. This enabled consideration of the bank's approach to employee welfare, including mental health and domestic violence, as well as in relation to the management of contractors like Manav (see 1.10 below).

1.8 The Review Panel Members

1.8.1 The Review Panel included the following agency representatives:

Name	Agency
Adam Colwood, Detective Chief Inspector	Public Protection, Surrey Police
Annabel Crouch, Policy Manager, CSP	Elmbridge Borough Council
Christopher Raymer, T/Detective Superintendent	Public Protection – Surrey Police
Dr Caroline Warren, National Medical Director for 111	Care UK
Clare Stone, Chief Nurse	North West Surrey Clinical Commissioning Group (CCG)
Conor Walsh, Safeguarding Support Officer	SECAmb
Debra Cole, Safeguarding Adults and Domestic Abuse Lead	Surrey and Borders Partnership NHS Foundation Trust (Mental Health)
Gordon Falconer, Senior Manager	Surrey Community Safety Team, Surrey County Council
Helen Blunden, Safeguarding Lead	North West Surrey CCG
Helen Mott, Senior Probation Officer	National Probation Service
Kerry Randle, Serious Review Group Chair	Local Children's Safeguarding Board (LSCB)
The Head ⁷	(Fee Paying) Pre-Prep and Nursery School

⁷ Not named to enable anonymity, see 1.3.6.

Margaret Bourne, Chief Executive	Citizens Advice Elmbridge (West) and North Surrey Domestic Abuse Outreach Service
Marion Songhurst, Safeguarding Advisor Adults	Virgin Care
Ian Vinall, Head of Safeguarding	Children, Schools and Families Directorate, Surrey County Council
Melanie Bussicott, Head of Community Support Services (Equalities)	Elmbridge Borough Council
Rebecca Wilbond, The Safeguarding Midwife	Kingston Hospital NHS Foundation Trust
Sinéad Dervin, Senior Mental Health Commissioning Manager	NHS England
Steve Hams, Interim Director of Clinical Performance and Delivery	Surrey Downs CCG

1.8.2 *Independence and expertise:* Agency representatives were of appropriate level of expertise and were independent of the case.

1.8.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 2nd September 2016. There were subsequent meetings on 12th December 2016, 13th October 2017 and the 12th April 2018. Draft reports were reviewed at the latter two meetings with the Review Panel subsequently receiving updates from the chair and signing off the report electronically in August 2018.

1.8.4 The chair(s) of the review wishes to thank everyone who contributed their time, patience and cooperation to this review.

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

1.9.1 The CSP did not notify the family of Bishakha in writing of their decision to undertake a review. This was because the CSP agreed with STADV that the latter would provide this notification on their behalf. In the interim, the family of Bishakha were kept informed through the Surrey Police Family Liaison Officer (FLO) and the Victim Support Homicide Service. However, direct contact was not made with Bishakha's family by the then Chair (Jess Donnellan) on behalf of the CSP and STADV until November 2016. While the responsibility for managing this contact was STADV's, in any future DHRs, the CSP should undertake to inform the victim's family directly of its decision to conduct a review as soon as possible.

- 1.9.2 Despite this delay, the chair(s) and the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and wider community.

Bishakha's Family

- 1.9.3 Initially, contact with the family (with Bishakha's father, Antariksh) was via the Surrey Police FLO, with this subsequently transferring to the Victim Support Homicide Service in August 2016. Victim Support undertook to update Antariksh on the review's progress, and regular updates were provided by STADV to Victim Support to enable this.
- 1.9.4 Subsequently, the then chair (Jessica Donnellan) wrote to Antariksh in November 2016 and, at a first meeting that same month, provided a copy of the Home Office DHR leaflet, information on AAFDA⁸ and discussed the Terms of Reference. Since April 2017, Antariksh has been receiving support from AAFDA who have liaised directly with chairs, initially the then chair (Jessica Donnellan) and, from January 2018, the chair (James Rowlands).
- 1.9.5 There were no apparent communication or language barriers in relation to contact with Antariksh, with communication methods including face to face meetings and via Victim Support and then AAFDA.
- 1.9.6 Consideration was given to approaching Bishakha's mother and brother. In different conversations both chairs asked Antariksh whether he would facilitate contact. However, Antariksh did not feel this was appropriate saying that he did not want to cause his family further trauma. He did agree to ask Bishakha's mother and brother to contribute to her Pen Portrait. A Pen Portrait was provided by Antariksh at the end of July 2018 and is included in full at the start of the report.
- 1.9.7 Antariksh had opportunities to contribute to the development of the report. In addition to meetings with the chair(s) he received a copy of the draft report in early June 2018. Antariksh then met with the chair (James Rowlands) in the company of the AAFDA advocate in late July 2018. In this meeting Antariksh said he was happy for his AAFDA advocate to be the primary person to liaise with chair about the detail of the report. Antariksh's focus was the criminal justice outcome. There was a discussion about this, including why this was outside the scope of the review. However, the chair invited Antariksh to put on

⁸ AAFDA are a national charity providing help to families and professional, including emotional, practical and specialist peer support to those left behind after domestic homicide. For more information, go to: <https://aafda.org.uk/about-us/>

record his feelings about this. These are included in the summary of the criminal justice outcome in 2.1.4 to 2.1.7 below.

1.9.8 The Review Panel agreed that Child A was too young to be interviewed.

Bishakha's friends and work colleagues

1.9.9 During their enquiries, Surrey Police took statements from friends and colleagues of Bishakha. These witness statements were incorporated into the Surrey Police IMR, and witnesses gave consent to their statements being used by the review. The then chair (Jessica Donnellan) initially contacted Bishakha's work colleagues about an interview. She received a response from Ulka. The chair (James Rowlands) subsequently made a further approach to Ella and Maria.

Known in the review as	Relationship to Victim	Means of involvement in review
Ulka	Friend / work colleague	Consent to use witness statement and interview
Ella	Friend / work colleague	Consent to use witness statement and telephone discussion
Maria	Work colleague	Consent to use witness statement

1.9.10 The chair (James Rowlands) also secured an introduction by Antariksh to childhood and university friends of Bishakha, initially establishing contact by email:

Known in the review as	Relationship to Victim	Means of involvement in review
Orpita	Friend	Interview
Nandita	Friend	Interview

1.10 Involvement of Perpetrator and/or his Family and Friends / Work Colleagues

1.10.1 On 24th August 2017 the perpetrator was sent a letter from the chair via the prison governor with a Home Office leaflet explaining DHRs and enclosing an interview consent form to sign and send back.

1.10.2 This initial approach led to an extensive period of correspondence between Manav and STADV. Broadly, the correspondence from STADV sought to secure Manav's involvement in the review. The correspondence from Manav

set out what he felt he could bring to the review and his expectations in relation to his participation. Throughout this correspondence, Manav asserted that the review should be suspended as he was intending to appeal, and at one point he instructed his then Legal Team to write to STADV to formally request this. In these exchanges Manav was provided with information on the opportunities for him to participate and the limits of this participation. He and his Legal Team were also directed to the statutory guidance, in particular the section relating to appeals (section 50 of the statutory guidance states that: “... *Any appeals lodged following the conclusion of criminal proceedings should not delay the submission of a DHR to the Home Office for quality assurance*”).

- 1.10.3 When the chair (James Rowlands) was appointed, this issue had not been resolved. On the 20th April 2018, a letter was sent to Manav by the chair by way of an introduction and, given the extensive correspondence that had already taken place, this included a summary of the preceding contact. As Manav had still not provided a signed consent form, he was asked to return this. He was also asked to provide information on his appeal. On the 30th April 2018 Manav responded. He re-stated his belief that the review should be suspended pending the outcome of the appeal and provided some additional information on this process (specifically that the grounds for his appeal were that the sentence was ‘manifestly excessive’). Manav indicated that information on his appeal and a consent form would come via a newly appointed Legal Team.
- 1.10.4 Having sought legal advice from Elmbridge Borough Council’s Legal Team, on the 21st May 2018 the chair responded. Noting that the information previously requested had not been provided, Manav was asked to provide a submission from his (new) Legal Team addressing the case for delaying the review and also including the requested information. A deadline of the 18th June 2018 was set for this submission to be returned. Manav was informed that the chair would then consider the submission and thereafter either agree to the timing of an interview or conclude the review without his participation. Manav was also made aware that if a submission was not received the review would be concluded without his participation.
- 1.10.5 No information was received from his Legal Team, but Manav subsequently returned a consent form and an interview took place in early July 2018. At the start of the interview Manav was reminded of the information previously provided about his participation. Manav was unhappy that neither his Legal Team nor his Offender Manager could be present to support him. He was asked if he was willing to continue in their absence and agreed to this. The interview was then completed, and Manav was sent a transcript for his approval.

- 1.10.6 A summary of the interview is included below in 4.2.3 to 4.2.12 below.
- 1.10.7 During their enquiries, Surrey Police took witnesses statements from Manav's family (Anemone and Rajni), as well as colleagues who worked with him at the large international bank where he was a contractor. This information is used in summary and set out in 4.2.13 – 4.2.22 below.
- 1.10.8 While contact was established with Manav's mother (Anemone), and discussions commenced in relation to her participation, she later indicated she would not participate in the review while her son's appeal was ongoing. Given the time taken to secure an interview with Manav, and the fact that his appeal was ongoing, a decision was made not to contact Anemone again as the Review Panel felt this was unlikely to be successful.
- 1.10.9 The same issues meant it was not feasible to seek contact with other family members (his sister, Rajni) or identify any other friends to could be invited to participate in the review.

1.11 Parallel Reviews

- 1.11.1 *Criminal trial:* The criminal trial concluded in October 2016. Manav was found not guilty of murder on the grounds of diminished responsibility but was found guilty of manslaughter.
- 1.11.2 Sentencing was delayed until the 1st December 2016 for psychiatric reports for the defence and prosecution to be completed. Manav was sentenced to life imprisonment with a minimum term of nine years and 172 days.
- 1.11.3 *Coroner:* The Coroner decided no investigation was required and therefore, no inquest was held. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.
- 1.11.4 *Appeal:* During the course of the review, Manav informed the chair that he was appealing on the grounds that the sentence was 'manifestly excessive'. At the time this report was handed to the CSP the outcome of that appeal was unknown.
- 1.11.5 *Care of Child A:* Child A had lived with his parents since birth up until Bishakha's death and there no previous involvement with Surrey Children Social Care prior to the date of the homicide. In May 2017 an Interim Care Order was granted for Child A and In October 2018, the Family Court awarded Surrey County Council a Full Care Order. Child A will remain with their paternal Aunt and Uncle for the remainder of their childhood. They have regular contact with their maternal family. This is a flexible arrangement which was worked out by the two families.

- 1.11.6 Once this report is finalised, it should be attached to Child A's Children Social Care records so that, should they wish to read the review when they are older, it is available to them.

1.12 Chair of the Review and Author of Overview Report

- 1.12.1 The initial chair of the review was Jessica Donnellan, Senior Projects Manager at STADV. Jessica has received Domestic Homicide Review Chair's training from STADV and has chaired and authored three DHRs.
- 1.12.2 For reasons unrelated to this case itself, Jessica was unable to draft the report. Consequently, in September 2017 James Rowlands was engaged by STADV as a report writer. While Jessica chaired the third Review Panel meeting, which discussed the draft report in October 2017, shortly thereafter it was agreed she would stand down from the role of chair.
- 1.12.3 In January 2018, James was appointed by STADV as chair of the review. A fourth panel meeting was scheduled for April 2018 to enable sufficient time for James to pick up the review.
- 1.12.4 James has received Domestic Homicide Review Chair's training from STADV and has chaired and authored three previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.
- 1.12.5 STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.
- 1.12.6 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.
- 1.12.7 *Independence:* Neither Jessica Donnellan nor James Rowlands have any connection with the Borough of Elmbridge or any of the agencies involved in this case.

1.13 Dissemination

- 1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the CSP for approval. Once agreed, they will be sent to the Home Office for quality assurance.
- 1.13.2 The recommendations will be owned by CSP, which will be responsible for disseminating learning through professional networks locally, as well as receiving reports on the progress of an action plan.
- 1.13.3 Progress will be reported to the Surrey Community Safety Board, the Surrey Against Domestic Abuse (SADA) Partnership, as well as the Surrey LSCB and the Surrey Safeguarding Adults Board (SAB). As a number of recommendations relate to health, progress should also be reported to the Surrey Health and Wellbeing Board.
- 1.13.4 The Executive Summary and Overview Report will also be shared with the Police and Crime Commissioner for Surrey.
- 1.13.5 The report will be published once complete in line with the statutory guidance, with a range of dissemination events to share the learning from the review.

1.14 Previous learning from DHRs

- 1.14.1 In the borough of Elmbridge, one previous DHR has been undertaken. This was a combined DHR and Serious Case Review (SCR) into the death of Adult S and Child CC. It was commissioned jointly between the CSP and the Surrey LSCB. The combined DHR / SCR was completed in August 2016⁹.
- 1.14.2 The chair (James Rowlands) reviewed the combined DHR / SCR and identified some learning that is relevant to this DHR, including: the limited contact with statutory services, contrasted against contact with a fee paying school and private health providers. In addition, the perpetrator was reported to have faced financial difficulties.
- 1.14.3 The combined DHR / SCR made some recommendations that are also relevant to this DHR. These were for the following agencies:
 - The private education provider involved (a secondary school) (relating to safeguarding training for staff and including domestic violence in PSHE (personal, social, health and economic) education)

⁹ Published at <http://www.elmbridge.gov.uk/safety/domestic-homicide-review/>.

- General practice (relating to the commissioning of the Identification and Referral to Improve Safety (IRIS) programme locally¹⁰)
 - Private health providers (relating to participation in DHR processes)
 - NHS England (to respond to the gaps that emerge between private and national health care providers which may threaten the safety of adult and child survivors of domestic abuse).
- 1.14.4 These recommendations have been considered by the Review Panel and are discussed further in the analysis.
- 1.14.5 It is commendable that Surrey County Council maintains a register of DHRs for Surrey as a whole, including their status, key issues and recommendations. The chair (James Rowlands) reviewed this register following the fourth panel meeting, in order to identify any relevant recommendations. No additional recommendations were directly relevant.

¹⁰ 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. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. For more information, go to: <http://www.irisdomesticviolence.org.uk/iris/>.

2. Background Information (The Facts)

THE PRINCIPLE PEOPLE REFERRED TO IN THIS REPORT						
Referred to in report as	Relationship to Bishakha	Age ¹¹	Ethnic Origin	Faith	Immigration Status	Disability Y/N
Bishakha	Victim	38	British Asian	Hindu	British citizen	N
Manav	Perpetrator	46	British Asian	Other	British citizen	N
Child A	Child	4	British Asian	Hindu	British citizen	N
Antariksh	Father					
Anemone	Mother in Law					
Ish	Brother					
Rajni	Sister in Law					
Ella	Colleague and friend					
Maria	Colleague					
Nandita	Friend					
Orpita	Friend					
Ulka	Colleague and friend					

2.1 The Homicide

2.1.1 *Homicide:* Towards the end of May 2016, shortly after 10am, a call from Rajni (Bishakha's sister in law) for urgent medical assistance was received by SECamb. Ambulance staff were dispatched and SECamb also alerted Surrey Police, describing the incident as the murder of a female and suicide attempt by a male. Police Officers were also sent to the scene.

2.1.2 Ambulance staff arrived first, followed by Police Officers shortly after. Bishakha was found lying on the kitchen floor. She had sustained significant injuries inflicted by an axe and a knife and was pronounced dead at the scene. Manav was sitting on the kitchen floor inflicting severe injuries to himself. There were also a number of other family members, including

¹¹ Age at time of Bishakha's death.

Bishakha's child, Child A, as well as Rajni (Bishakha's Sister in Law), Antariksh (Bishakha's father) and Ish (Bishakha's brother) at the property when they arrived.

- 2.1.3 *Post Mortem*: A post mortem examination was carried out in May 2016 by a Home Office Pathologist. Bishakha was found to have sustained 124 significant injuries including; 40 blunt force injuries, 21 cut wounds to her skull caused by an axe type implement; and 25 stab wounds to left side of her neck caused by a knife. Bishakha also had 28 stab wounds to her left thigh and 31 to her right thigh that had been inflicted by a knife. Bishakha had numerous defensive cut injuries to the back of her hands and forearms and notable bruising, indicating that she was alive for a period of time after the wounds were inflicted. The pattern and distribution of the injuries indicated that Bishakha had been moved or was moving during the infliction of the injuries. The cause of death was haemorrhage due to head and neck injuries.
- 2.1.4 *Criminal trial outcome*: In September 2016, Manav was found not guilty of murder on the grounds of diminished responsibility but was found guilty of manslaughter. After a delay for psychiatric reports, in December 2016 Manav was sentenced to life imprisonment with a minimum term of nine years and 172 days.
- 2.1.5 In their summing up during sentencing at Guilford Crown Court, the Judge said: "*It [the attack] was in any view a brutal and sustained attack in which you used an axe to attack her and a knife to stab her.... This clearly was not a momentary attack; you and your wife had argued about divorce... My conclusion is that there is a significant risk and there is risk that you would cause serious harm to members of the public, especially intimate partners*". The Judge also noted evidence of planning during the early hours of the morning, including research into the soft part of the skull and that Manav had also taken Bishakha's phone, turned it off and hidden it. He added that "*friends and family have lost a remarkable and special lady.*"
- 2.1.6 After he received the draft report, Antariksh asked to put on record his feelings about the criminal justice outcome. His comments were as follows:
- 2.1.7 Antariksh told the chair that he was angered by the outcome of the criminal trial, being unsatisfied with the conviction for manslaughter. Friends have also expressed their dissatisfaction with the criminal justice outcome.

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

- 2.2.1 *Background Information relating to Victim*: Bishakha was 38 at the time of her death. She was a second generation British Asian; her family had originated

from the Punjab, a state in Northern India. She was a practising Hindu. She was employed as the Financial Director in a family business. There had been no previous police contact with Bishakha.

- 2.2.2 *Background Information relating to Perpetrator:* Manav was 46 at the time of Bishakha's death. He was second generation British Asian. His family had originated from Delhi, India. At the time of the homicide he was practising Hindu, although since being in prison he has said he has explored other faiths, in particular Islam. Manav was a contractor and had been employed through an employment agency since 2000. He had started a new contract with a large international bank in April 2015 and had remained working with them as a contractor until May 2016, when he had resigned. He was not in employment at the time of Bishakha's death. There had been one previous police contact with Manav, who was a witness in an attempted burglary investigation unrelated to this incident.
- 2.2.3 *Synopsis of relationship with the Perpetrator:* Based on information provided by family members to Surrey Police during their murder enquiry, Bishakha and Manav met at a convention and they were married in 2005. Family members described their relationship as happy and loving. They were due to celebrate their eleventh wedding anniversary later in 2016.
- 2.2.4 Bishakha and Manav had been living in another part of Surrey, but three weeks before Bishakha's death they had moved to a new town in the borough of Elmbridge. The property was a large, detached home which had been under construction for a number of years. Although they had received financial support from both their respective families towards this new home, the property had a large mortgage.
- 2.2.5 *Members of the family and the household:* Their only child, Child A, was born in April 2012.

3. Chronology

- 3.1.1 The following facts summarise contact between Bishakha, Child A and Manav and agencies. There was relatively little contact with statutory services, with some contact with both private education and health providers. The Review Panel noted the challenge this presented in terms of representing the experience and perspective of the victim and/or perpetrator. Participation by family and friends has helped address this and this is described further in section four.

2011

- 3.1.2 In 2011 Bishakha attended a number of routine appointments at the Medical Centre. Later that year Bishakha became pregnant and in September 2011 a referral was made to Maternity Services (provided by the Kingston NHS Foundation Trust), as well as to the Health Visiting Services (provided by Central Surrey Health, a provider of community health services in mid Surrey).

2012

- 3.1.3 Bishakha had a number of routine appointments or contacts with the Medical Centre and the Maternity Service through to April 2012 when Child A was born. After Bishakha and Child A were discharged from hospital there were two home visits by a Community Midwife towards the end of April 2012. Thereafter their care was passed to the Health Visiting Service.
- 3.1.4 Bishakha had a number of contacts with Health Visiting Services during the rest of 2012. The first was on the 30th April 2012, when a New Birth Home Visit was conducted. The second was on the 4th May 2012 when Bishakha attended a breast-feeding clinic alone.
- 3.1.5 Bishakha later attended a routine appointment at the well-baby clinic with Health Visiting Services in October 2012.
- 3.1.6 Health Visiting Service records also show a contact with Child A in June 2012; it is not recorded whether Bishakha or Manav were present.
- 3.1.7 During this period, Child A was also seen for a range of routine appointments at the Medical Centre. The records indicate Child A was usually in the company of Bishakha.
- 3.1.8 Bishakha also attended the Medical Centre in her own right, with an appointment in September 2012. The General Practitioner (GP) notes record

a GAD-7¹² score of 16/21 and a PHQ-9¹³ score of 3/27. These would indicate severe anxiety and non-clinical levels of depression. Bishakha did not want to access counselling and is recorded as being “*not keen*” about anti-depressants. A follow up appointment was booked for the 1st December 2012, although it does not appear that this happened as there is no further contact recorded for Bishakha alone through to the end of the year.

2013

- 3.1.9 In 2013 there were numerous contacts with the Medical Centre, relating to the health needs of Child A and some minor surgery for Bishakha. There is nothing in the record to indicate any concerns.

2014

- 3.1.10 In 2014 there were further contacts with the Medical Centre, relating to the health needs of Child A and there is nothing in the record to indicate any concerns. In July that year, the Health Visiting Service conducted a 27-month development review of Child A. Their development was recorded as “*normal*” and the record also reports that there were “*appropriate and positive interactions between mother and child*”.

2015

- 3.1.11 In April 2015 Manav began a new role as a contractor with a large international bank.
- 3.1.12 In June 2015 Bishakha attended a Parent-Teacher Interview with the Pre-Preparatory and Nursery School, a fee-paying school in Surrey.
- 3.1.13 Later that year, Child A started in nursery at the Pre-Preparatory and Nursery School. In September and October there were contacts with staff at the nursery, relating to a period of sickness in September and around care for Child A in October.

2016

- 3.1.14 At the start of 2016, Manav told his manager at the large international bank that he was frustrated because there had been a lot of changes at work and he did not feel he was getting a lot done.
- 3.1.15 In January 2016, Manav also attended the Medical Centre and disclosed stress at work and financial worries. He was prescribed a drug to aid sleep (from a self-report by Manav in April 2014, this prescription was Zopiclone).

¹² This is a self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder.

¹³ This is a self-administered patient questionnaire is used as a screening tool and severity measure for depression.

- 3.1.16 During 2016 there were further routine contacts with the Medical Centre and the Pre-Preparatory and Nursery School, related principally to periods of illness of Child A. With reference to the school, in these contacts Bishakha was identified as being present, with Manav being noted only once in the school record. This was in relation to a conversation with both parents during a parent evening.
- 3.1.17 Early in April 2016 Manav took on a new project at work.
- 3.1.18 On the 22nd April 2016 Bishakha contacted the NHS 111¹⁴ service (provided by Care UK). Bishakha asked for and received advice around care for Child A, who had been vomiting and retching.
- 3.1.19 A few days later, on the 25th April 2016, Manav also contacted NHS 111 requesting some sleeping tablets. He called shortly before 9pm. He spoke with a Health Advisor¹⁵, stated that he was having good and bad days and was struggling with his concentration. He complained of having suicidal thoughts and being troubled by memories of severe stress and that normal life on certain days had started to become impossible. When asked by the Health Advisor whether he had means and plans to attempt suicide, Manav confirmed he had suicidal thoughts and stated that “*the main thing is just to get some medications basically*”. He said that his problems had lasted for more than two weeks. Manav denied any major life event in the last six months and there was no evidence of any psychotic symptoms. Manav believed that he needed to be put back on antidepressants¹⁶ and said that he could not wait for three weeks to see his GP (which is the length of time he said he would have to wait to get an appointment).
- 3.1.20 The outcome of the triage was a recommendation that Manav needed to attend the Accident & Emergency (A&E) Department in one hour to access the Psychiatric Crisis Liaison team (although this would have been advice only; NHS 111 staff would not have contacted or made a direct referral to Psychiatric Liaison at A&E). The assessor stated that this is something that Manav may not want to do. Manav responded by saying that he did not need to go to A&E but reiterated that he needed to see a doctor and could not wait for three more weeks to pass.

¹⁴ NHS 111 is free to call if someone has an urgent health care need. Callers are asked about their symptoms and, depending on the situation, are provided with self-care advice or directed to another NHS service.

¹⁵ A Health Advisor is a call handler at NHS 111. They are a non-medical member of staff who uses a clinical triage tool (NHS Pathways) to assess presenting clinical symptoms and provide advice to a caller about the appropriate NHS service.

¹⁶ It is not clear why Manav was talking about being “*put back on antidepressants*”, as his prescription in January 2016 was a drug to aid sleep. It may be that this was a reference to previous presentation to his GP, but again this is unclear. For example, Manav presented to his GP in 2008 describing ‘stress at work’ and was prescribed sleeping tablets.

- 3.1.21 A Clinical Advisor¹⁷ reviewed and validated the assessment which had been completed with Manav by the Health Advisor. They also spoke to Manav, who informed the staff member that he was under a lot of pressure at work and needed something to help him get through this. He stated that he had suicidal thoughts every day. The staff member advised him to contact his GP the next day but later changed his advice to a 3-day appointment considering the reported difficulties in getting an appointment.
- 3.1.22 The next day, 26th April, Manav attend the Medical Centre and discussed his anxiety. He was examined and received a GAD-7 score of 16/21 and a PHQ-7 score of 19/27. A referral to the local IAPT service (Healthy Minds) was discussed (Manav would have been advised about making a self-referral). He was also prescribed an anti-depressant (Sertraline).
- 3.1.23 On the 29th April Manav approached his manager at work and told them he was struggling and was thinking of leaving. On the 3rd May he said he was intending to resign, stating that he had been building a new home and there were lots of issues which could result in him losing everything. On the 4th May he handed in his resignation.
- 3.1.24 On the 9th May Manav made a telephone self-referral to a local IAPT service, Healthy Minds Surrey (provided by Virgin Care Surrey).
- 3.1.25 On the 9th May Manav had a telephone and walk in consultation with the Medical Centre. Manav talked about low moods, being anxious and not sleeping well. He stated he was not suicidal but was having morbid thoughts. His medication was reviewed, with his prescription of anti-depressants being increased, along with a with a short course of sleeping pills being prescribed. At this appointment Manav told the GP he had resigned from his job.
- 3.1.26 On the 11th May Bishakha contacted Healthy Minds to say that he had not received a letter from them. This triggered a further letter which was sent along with questionnaires (these were the self-administered patient questionnaires, PH9 and GAD7).
- 3.1.27 Manav was also assessed face to face on 11th May 2016 by Healthy Minds. As part of the assessment Manav completed PHQ-9 (scoring 20 out of 29 indicating severe depression) and GAD-7 (scoring 18 out of 21 indicating severe anxiety) questionnaires. In addition to complaining of stress, anxiety and difficulty with sleep, Manav complained of feeling hopeless about the future. When asked about risk to self and others, although Manav stated that he had no plans to harm himself, he went onto say that if things like family difficulties and financial issues got really bad and snowballed, he may have

¹⁷ Clinical Advisors are Nurses or Paramedics who provide clinical advice and support to NHS 111 Health Advisors.

thoughts of “*not wanting to be here*”. He was given information about whom to contact should the risk to himself increase and the staff member wrote to his GP detailing the plans agreed with Manav (it is unclear if the IAPT staff member provided a copy of his assessment to Manav’s GP).

- 3.1.28 On the 11th May the Medical Centre received a letter, relating to this IAPT appointment, and on the 12th May Manav’s record states: “*refer to counsellor to: Choose and Book Service at NHS*”.
- 3.1.29 On the 13th May 2016 Manav attended his first treatment session with a (IAPT) psychological wellbeing professional in training. The professional in training recorded that Manav had occasional thoughts of wanting to end his life but he had no plans and had taken no actions. Manav stated that these thoughts had lessened. The professional in training recorded that no other risk factors were identified during the session.
- 3.1.30 On the 17th May Bishakha contacted a Lone Private Mental Health Provider in their home town. The provider is a Psychotherapy and Hypnotherapy practitioner who is registered with the International Association for Evidence Based Psychotherapy (IAEBP)¹⁸. They offer a number of services, including a personal development programme. Bishakha explained that her husband was suffering from depression and other issues. She made an appointment for Friday 19th of May.
- 3.1.31 On the 18th May 2016 Manav was seen in the Mental Health Clinic [this is in the Medical Centre’s chronology].
- 3.1.32 On the 19th May 2016 Manav attended the Medical Centre for a medication review. He was also prescribed a different antidepressant.
- 3.1.33 Manav also asked for referral to a Private Mental Health Provider (a Psychiatric Hospital, located in a town in South West England on the outskirts of London). The clinic is registered with the Care Quality Commission (CQC)¹⁹. A letter was prepared and sent. Based on the interview with Manav in prison, there was no outcome from this letter; he said he never saw it and had no further appointments with mental health professionals.
- 3.1.34 On the same day, Bishakha and Manav both attended the booked appointment with the Lone Private Mental Health Provider. After an initial

¹⁸ Members of the IAEBP have to meet certain membership criteria and standards, including undertaking Continuing Professional Development (ANTARIKSH D). For more information, go to: <http://evidencebasedpsychotherapy.com>. However, ‘Psychotherapy’ and ‘Hypnotherapy’ are not Protected Titles and, unlike for example a Practitioner Psychologist, do not have to be registered with the Health Care Professionals Council (HANTARIKSH C). For more information, go to: <http://www.hAntariksh.co.uk/aboutregistration/protectedtitles/>.

¹⁹ The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. For more information, go to: <http://www.cqc.org.uk/what-we-do>.

assessment, it was suggested that Manav attend a psychological training programme. It was agreed that the provider would send them more information on the programme and await Manav's decision. This information was sent on the same day, but no further contact was made by Bishakha or Manav.

- 3.1.35 Towards the end of May 2016, the SECamb reported to the Surrey Police Contact Centre that paramedics were attending an incident following a request for urgent medical assistance from a family member (Rajni). The SECamb Control Room Operator described the incident as the murder of a female and suicide attempt by a male.
- 3.1.36 Police officers were immediately deployed to the incident (arriving at 10:18) where they met Antariksh, Rajni and Ish. Upon entering the property, they found paramedics were in attendance. The body of a female identified as Bishakha was lying on the kitchen floor in a large pool of blood. She was found to have catastrophic injuries to her head and neck. A blood-stained axe and a knife were visible in the kitchen. Bishakha was declared deceased at the scene.
- 3.1.37 A male identified as Manav was also found at the address. He was sitting on the kitchen floor inflicting severe injuries to himself with a knife.
- 3.1.38 There was a child at the address who was identified as Child A. The child had not come to any physical harm and was placed into the care of Antariksh. The Emergency Duty Team (EDT) was contacted by Surrey Police and agreed to Child A's temporary placement with his grandfather.
- 3.1.39 Manav was initially taken to St Georges Hospital for treatment. Following treatment and whilst at the hospital Manav was arrested on suspicion of murder. Upon his discharge from hospital on Tuesday 24th May 2016 he was transferred to Guildford Police Station. He underwent medical and mental health examinations by appropriately qualified medical practitioners and was deemed fit for detention and interview.
- 3.1.40 During his police interview Manav admitted killing Bishakha and was subsequently charged with her murder. On Wednesday 25th May 2016 Manav appeared at Guildford Crown Court where he was remanded in custody to HMP Highdown.
- 3.1.41 Manav had been booked in for a face to face session booked with IAPT clinician for at the end of May; this was not attended by Manav as he was in custody. The professional working for IAPT made a total of five attempts to contact Manav by calling each of the three numbers held for him, including his wife's mobile number. Manav was subsequently discharged from the service.

4. Overview

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

Antariksh (Bishakha's Father)

- 4.1.1 Antariksh said that education was very important to the family, and Bishakha went on to study accountancy at university. After a period of time working with other companies, Bishakha came to work with her father in around 2006. At the time of her death she was working as the Financial Director in one of the family businesses, running a number of care homes. Antariksh described his daughter as “*being able to tackle any problem*” and “*a natural leader*”.
- 4.1.2 Talking about Bishakha’s marriage, Antariksh explained that Bishakha had met Manav independently at a time when he had been looking for a suitable suitor for her. As a result, this was not an arranged marriage but a “*love marriage*”. When interviewed, Manav said the same. Antariksh described Bishakha and Manav as “*happily married*”.
- 4.1.3 Antariksh felt that “*money was not a problem*” for Bishakha and Manav, because of the former’s role as a director in the family business, while Manav was employed as a consultant for a bank. Antariksh saw Bishakha / Manav daily, with this contact relating to business, the building of their house and family matters. He was not aware of any issues in the relationship.
- 4.1.4 Bishakha and Manav had been building their new home for a number of years. Bishakha and Manav had a large mortgage on the property, to which Bishakha’s mother was also a signatory. Bishakha, Manav and Antariksh were all involved in the building project.
- 4.1.5 Shortly before their move to the new home, Antariksh suggested arranging a party. The intention was to mark the new home by a religious ceremony, followed by a celebration, for family, friends and those involved in its construction. Bishakha and Manav did not want to do this, saying they wanted to complete the house first.
- 4.1.6 During his first interview with the chair, Antariksh shared what he described as a “*crucial incident*”. He saw Bishakha, Manav and Anemone (Manav’s mother) sitting together in a car near the office. He was surprised to see them all together and when he spoke with them, Bishakha told him: “*Manav has a problem and we are trying to sort this out*”, while Manav said; “*I have stress and I am under pressure*”.
- 4.1.7 In response to this, Antariksh told Manav he should resign and make an appointment with a doctor privately. Antariksh also advised Bishakha to take

Manav to a psychiatrist because taking him to the GP would not be enough. Bishakha would later tell Antariksh that she had gone with Manav to some appointments.

- 4.1.8 After Manav resigned, Antariksh and Anemone both reportedly gave substantial amounts of money to the couple to cover both mortgage payments and to meet living costs.
- 4.1.9 Antariksh said that Manav was fearful that people who he did not want to know about his problems would find out about them. Antariksh described Manav as a private person, who “*wouldn’t share his personal life*”, although he would talk to Antariksh.
- 4.1.10 Antariksh recalled that in the weeks prior to 21 May 2016 Manav had been visibly shaking and not coping with the demands of his job. Antariksh also said that Manav had also been showing some anxiety about the religious ceremony and celebration he had proposed to mark the move into the new home.
- 4.1.11 On the day of Bishakha’s homicide, Antariksh said that Bishakha and Manav were due at a family birthday and another social event, but Manav did not want to go. Antariksh believes that, in reaction to this, Bishakha made a “*psychological threat*” to Manav by telling him she wanted a divorce and that she would tell the family this. Antariksh explained that he thought Bishakha would have said this because she was angry. Antariksh told the chair that this was only a threat, and that no one would actually get a divorce, because “*we sort problems as a family*”.
- 4.1.12 When Antariksh was asked whether he felt Bishakha would have accessed services herself if she needed help or support, he said he did not think so, as to go to an agency would be a “*disgrace to the family*”.

Other family members

- 4.1.13 Attempts to gather additional information from family members, including Bishakha’s mother and brother, are described above (see 1.9.6).
- 4.1.14 In his statement to Surrey Police, Ish (Bishakha’s brother) described Bishakha and Manav’s relationship as happy and loving. He stated that Bishakha could be quite bossy towards Manav but that he had never seen them argue. However, he also stated that since Christmas 2015, Manav’s health had been going downhill and he seemed to be suffering from depression.

Colleagues of Bishakha

- 4.1.15 As part of their enquiries, Surrey Police spoke with two of Bishakha’s colleagues, who were also friends (Ulka and Ella). Bishakha had confided in both, talking about Manav’s health. Neither were aware of any domestic

violence in the relationship. Both advised Bishakha to seek medical help for Manav.

- 4.1.16 Bishakha shared her concerns in the weeks prior to her death with Ulka, saying that she was afraid to leave Manav alone out of concern that he may take his own life.
- 4.1.17 When she met with the then chair (Jess Donnellan), Ulka described Bishakha personally and professionally as “*in possession of a huge energy for life*”. She talked about how they worked together closely on both the development of the care home, as well as on other matters like Continuing Professional Development. Ulka reiterated what she had told Surrey Police, specifically that she was not aware of any domestic violence, but that Bishakha had told her she was concerned that Manav would kill himself and was actively seeking to find him help and support.
- 4.1.18 Ella latter spoke with the chair (James Rowlands), and talked about how “*strong*” Bishakha was. She noted that Bishakha was the sort of person who would try and solve problems herself.
- 4.1.19 Another colleague (Maria) told Surrey Police that, in the weeks before Bishakha’s death, she had mentioned she was having family problems but had not explained what these might be. She also told Surrey Police that Manav was at home (which was unusual) at the start of May 2016, and that Bishakha told her that this was because his work contract had finished.

Friends of Bishakha

- 4.1.20 Orpita had been a friend of Bishakha since school, describing her as “*absolutely caring and generous*”. She also said that Bishakha “*took care of herself*”. Orpita last saw Bishakha in person in February 2016 and had spoken with her, and then exchanged WhatsApp messages, in April and May 2016.
- 4.1.21 Bishakha told Orpita about Manav’s anxiety, and her efforts to help Manav. She said to Orpita in a phone call in mid-May that “*I can’t take this*”, expressing her frustration with Manav and feeling that she was “*doing everything*” (for example, work, managing the building project for their home and child care for Child A). Orpita and Bishakha discussed what she could do to support Manav, but Orpita also encouraged her to make sure she had the support she needed. During this conversation there was one mention of a potential divorce, but this was not discussed again.
- 4.1.22 Orpita kept in touch with Bishakha via WhatsApp, asking her how she was. She replied on the 16 May 2016 saying ““*Hi, we had a really bad [day] yesterday, so traumatic, I wasn’t able to work today*”, and then explained that she had:

- Booked a hypnotherapy session [for her and Manav]²⁰ but that these were expensive and a cause of stress
 - Come up with ground rules
 - Communicated what makes her anxious
 - Explained to him [Manav] that it's for him to break the cycle.
- 4.1.23 Although Orpita tried to get in touch with Bishakha again on the 18th May 2016 she did not receive a response and shortly thereafter found out about the homicide.
- 4.1.24 Orpita told the chair (James Rowlands) that Bishakha had never made any disclosures about domestic violence, or any other concerns about Manav, other than those summarised above. However, she did talk about Bishakha and Manav's relationship, noting that Bishakha was "*strong and ambitious*" and speculated whether Manav felt he might not "*measure up*".
- 4.1.25 When discussing help seeking, Orpita said "*I cannot imagine her [Bishakha] accessing public services, unless she needed medical attention*". Although Bishakha had never talked about domestic violence, Orpita speculated that if she had experienced this, it may be that she would not have felt she had anywhere to go. She said: "*All these domestic violence campaigns, you still see this stuff, women with bruises on her face, there are much more subtle forms of domestic violence, which are beneath the surface, which affect some of the strongest women in our communities*".
- 4.1.26 Nandita and Bishakha had also known each other since school. Describing her as "*passionate, focused and determined and [someone who] ... would do her best to try and help you; she was really caring*". They had kept in touch regularly over the years and would also meet up with a group of other friends a few times a year.
- 4.1.27 Talking about Bishakha, Nandita said she could be very private. She said, "*She was conscious of keeping the right things private, if she could resolve it she would do it herself*".
- 4.1.28 Nandita had talked with Bishakha about what was happening with Manav. Bishakha had told her that things were really difficult and that Manav was suffering from depression. Nandita thought that Bishakha was really worried about Manav, but also frustrated because: "*she was trying something, but it just wasn't working*" and "*she was doing everything and had a very heavy*

²⁰ This is likely a reference to the initial appointment with the Lone Mental Health Provider.

burden in the relationship". Nandita said she had noticed a change in Manav and that he had become withdrawn in the time she had known him.

- 4.1.29 Nandita was not aware of any other concerns about the relationship, including domestic violence. Nandita said that in the past Bishakha had said that Manav would get angry, *"he has a temper"*, but had always talked about that being directed towards other people and never said anything about it being directed toward her.
- 4.1.30 Nandita was unsure about what Bishakha would do if she had needed help. In part she thought her focus would have been on Child A, and she would not have tolerated him being exposed to violence and abuse. However, she also speculated that *"... she was so caring, about Manav and her family, she might have stayed – she would have been like, no, I am not leaving him because I am concerned about him and I am going to stay here"*.

4.2 Summary of Information from Perpetrator:

- 4.2.1 During his police interview Manav stated that during the early hours of Saturday 21st May 2016 he and Bishakha had argued about getting divorced. Expanding on this for a psychiatric report Manav said that:
- During the evening prior to offence, there had been an ongoing protracted argument with Bishakha, who had stated during the argument that she wished to divorce him as his mental state had not improved. He stated that Bishakha had taken her rings off, which had indicated to him that the marriage was over. Manav said that Bishakha could not be persuaded regarding reconciliation and he felt divorce would expose his weakness with regards to money. He was concerned about how he would cope with the levels of debts. The argument stopped when his wife went to bed at approximately 2.00 to 3.00 in the morning. At that time, he had thoughts of killing himself and his wife, although not his son, and started to check websites on the internet. Manav said that he went to the garage and collected the axe
 - In the morning, Manav said that: the argument resumed; Bishakha confirmed that she wished to end the marriage; Manav stated that Bishakha started to hit him on the chest; and Manav said he had then pulled an axe out of his pocket and struck Bishakha.
- 4.2.2 Manav was interviewed by the chair (James Rowlands) in prison in July 2018.
- 4.2.3 Manav described his relationship as follows: *"basically we had a very loving and good relationship"*, saying he put Bishakha (and her father) on a pedestal. He denied that there had been any previous violence in the relationship.

- 4.2.4 Manav described some of the background to the house which he and Manav moved into in 2016. The property was purchased on 2009, with a mortgage between himself, Bishakha and Bishakha's parents (Manav stated that Bishakha's mother was named on the mortgage).
- 4.2.5 There was a long gap between buying the property and moving in because of issues with planning permission and then building works. Manav said he was used to pressure because of his work, but the house was different because he was paying the mortgage, managing finances and issues with contractors and the work on the house, as well as having a young child and family. He summed this up as: *"I guess over a period of time when you aren't giving yourself a break the stress starts to build up"*.
- 4.2.6 Manav said he did not feel his work could have done anything to support him during this time, but after leaving work, this had made the situation more difficult: *"The debt is already there, I have no support, no income coming in from a financial perspective"*.
- 4.2.7 Manav said that collectively this all had an impact on his wellbeing. First his sleep was affected and, from around December 2015, he had started to feel *"low"*. In January 2016 he said he went to see his GP but felt *"they were just interested in pushing me onto medication"*. He also said that after this appointment there were occasions when he tried to get appointments but could not get through. Manav was also disappointed that he had to self-refer to an IAPT service and expressed his frustration that he was seen by a trainee, although he said: *"even she picked up the fact that I was suicidal"*.
- 4.2.8 Manav could not recall his contact with NHS 111 in detail but again noted that *"...clearly they've got on their notes that I felt suicidal"*.
- 4.2.9 When asked what he felt could have been done differently Manav said: *"basically they [health providers] haven't even picked up the fact that I'm suicidal"*. He also expressed his frustration that he had not been getting a response, saying that: *"I was the one who contacted the NHS in the first place and when I was having these symptoms. I'm the one initiating everything and doing all of these [internet] searches"*.
- 4.2.10 Manav also referred to Bishakha's efforts to access help and supporting, saying: *"My wife contacted the doctor and she wanted to get a referral letter to a private doctor because even she wasn't happy with the service"*. Although this letter was provided, Manav said in the interview that he did not ultimately access any Private Mental Health Providers.
- 4.2.11 When asked about the night prior to, and then the day of, Bishakha's homicide, Manav became very emotional. He said that, after Bishakha had said she would leave him, *"All I was thinking at the time was the family finding"*

out". However, he ascribed this to paranoia as a result of the anti-depressant medication.

- 4.2.12 The chair's reflection on the interview was that, while Manav expressed grief and remorse for Bishakha's death, his focus was what he felt were the factors leading to the homicide (errors in the diagnosis and treatment of his depression, in particular his suicide ideation) rather than his actions. He said: "*I've paid the price, I've paid the price for other people's mistakes with my life literally and I don't get to see my [child]*". He made a number of similar comments during the interview.

Family members of Manav

- 4.2.13 As outlined in 1.10, Anemone (Manav's mother) was not interviewed as part of the review. However, statements were collected by Surrey Police as part of their enquiries and are summarised here.
- 4.2.14 Anemone stated that Bishakha and Manav had loved each other, although she felt that Bishakha could be quite domineering – mainly due to the role she had in her father's business.
- 4.2.15 Anemone was aware that Manav had been depressed in the month before the homicide, and that he was receiving treatment. Anemone thought this was due to stress with his job and the move to his new house. She said he had lost weight, he was speaking slowly, was not sleeping and was nervous and shaky. Anemone was unaware that Manav had left his job at the bank.
- 4.2.16 Anemone also told Surrey Police that Bishakha had told her that Manav was talking constantly about the same things, specifically: having no job, not being able to pay the bills and having no furniture.
- 4.2.17 Rajni told Surrey Police that she was not aware of any mental health issues for Manav, but in the 2-3 weeks preceding the homicide that he had seemed withdrawn.

Other people who knew Manav

- 4.2.18 As part of their enquiries, Surrey Police spoke to staff at the bank where Manav had worked. The manager to whom he reported that Manav was a diligent and conscientious worker, although he was often anxious. During April and May 2016 when Manav first disclosed issues with his work, and then later resigned, his manager told Police she wondered whether he was having financial difficulties. After his resignation on the 4th May 2016, his manager did not have any further contact with Manav.
- 4.2.19 Another colleague, also spoken to by Surrey police, said that Manav told them that he had personal problems; he was working on his house in the evenings, he was tired and not sleeping.

- 4.2.20 The two colleagues of Bishakha, noted above, also told Surrey Police about their contact directly with Manav. The first had last seen Manav in February 2016 in London. She said that he had seemed withdrawn and did not participate in any conversations. The other had last seen Manav in April or May 2016 and told Police she had been shocked by his appearance, saying he looked drawn, had lost weight and looked like a “*man who had lost his way in life*”. Nandita also said she had noticed a change in Manav.
- 4.2.21 As noted in 1.7.5, it was not possible to establish contact with staff at the bank invite them to participate in the review. However, the chair (James Rowlands) had contact with the bank where Manav was employed as a contractor around their support for staff, including those employed on a consultancy basis. This is discussed further in the analysis.

Other information

- 4.2.22 The only additional information is available from health records: Manav is reported to have had an episode of depression in 1999 following a breakup of a relationship. He was briefly engaged to a woman in 1999 which was an arrangement and he broke off the engagement when he thought the partner was not suitable for him. It is not known if Manav received any treatment or support for the depression at the time.

4.3 Summary of Information known to the Agencies and Professionals Involved

Bishakha

- 4.3.1 Bishakha had limited contact with statutory services, with some contact with a number of private providers. This contact related to education and health.
- 4.3.2 In relation to education, Bishakha had contact with the Pre-Preparatory and Nursery School in relation to Child A, although Child A had not been enrolled for long at the school. Bishakha’s contact related to Child A’s attendance at nursery. There was little additional information in the records and no concerns were identified at the time.
- 4.3.3 In relation to health, Bishakha had contact with a range of health services around pregnancy and maternity, as well as general practice. While the health care provided by Maternity Services was appropriate, there is no record of Bishakha being asked about domestic abuse at her 28 and 34-week appointments. Her contact with Health Visiting was also appropriate but, similarly, routine enquiry about domestic violence was not always undertaken.
- 4.3.4 Bishakha also had contact with a general practitioner at the Medical Centre. This related to a range of routine medical issues, either for herself or Child A.

Bishakha did speak with her GP once about mental health issues, following the both of Child A, and received appropriate advice.

- 4.3.5 Bishakha had brief contact with at least one private mental health practitioner (a Lone Practitioner), who she contacted when looking for help and support for Manav. This contact was limited, with a single introductory meeting being held.

Manav

- 4.3.6 Manav also had relatively limited contact with statutory services, although in period before the homicide he had a range of contact with mental health providers.
- 4.3.7 In relation to mental health, Manav had contact with General Practice, NHS 111 and an IAPT service.
- 4.3.8 In his contact with a GP at the Medical Centre, the health care he received was appropriate, including the prescription and review of medication in relation to his Depressive Disorder.
- 4.3.9 Manav's contact with both NHS 111 and the IAPT service has identified a number of issues. These included the extent and quality of enquiry around suicide ideation and hopelessness, and whether these informed the assessment of risk (the issue for NHS 111 was inadequate probing around suicidal ideation. In contrast, the IAPT service discussed suicide ideation and protective factors but it is not clear whether the staff member acknowledged and understood the significance of hopelessness as a suicide risk factor).
- 4.3.10 A further issue identified for NHS 111 is that staff are limited to giving a patient advice about either attending A&E (in order to access Psychiatric Liaison staff) or going to their GP, rather than being able to refer directly to these services. This was the case for Manav who received advice but did not always take this up. This means the pathways that join up mental health support for someone experiencing mental health crisis are not as robust as they could be.
- 4.3.11 Manav also had some contact with Private Mental Health Providers, but this appears to have been limited to an initial meeting with the Lone Practitioner and a referral to the Psychiatric Hospital (there is no evidence to indicate this was taken up).

4.4 Any other Relevant Facts or Information:

- 4.4.1 No other relevant facts or information was known to agencies and professionals.

5. Analysis

5.1 Domestic Abuse/Violence:

- 5.1.1 Bishakha died as a result of a single, fatal act of domestic violence during a sustained assault by Manav.
- 5.1.2 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was not able to determine where there was a broader history to this single act. This conclusion is based on the information gathered by Surrey Police as part of the murder investigation, as well as provided by agencies, friends and family. None of this information provides any evidence that would indicate that Bishakha was the victim of a wider pattern of domestic violence and abuse perpetrated by Manav. Additionally, when interviewed by the chair, Manav denied any previous violence and abuse. However, given Bishakha and Manav's limited contact with public services, it is important to note that the absence of evidence is not the same as being able to say such violence or abuse did not occur. It may simply be that it was not reported.
- 5.1.3 Regardless of whether there was a wider pattern of domestic violence and abuse or not, it is clear that there was an increasing amount of tension, as well as some relationship conflict, between Bishakha and Manav. Furthermore, shortly before the homicide, Bishakha stated she wanted to separate from Manav.
- 5.1.4 Tragically, it is not possible to build a picture of Bishakha's perspective of the relationship. Bishakha has been described as both professionally and personally active and outgoing. She was juggling family and work commitments and, from the accounts of her family and friends, she was successful, dynamic and well liked. Based on these same accounts, Bishakha appears to have been concerned about Manav and was finding his difficulties around employment and mental health increasingly challenging. As noted above, Bishakha also told Manav she wanted to separate. This issue of separation in relation to risk is discussed further below.
- 5.1.5 However, if Bishakha did have wider concerns about the relationship, or had experienced any domestic violence and abuse from Manav, she appears to have kept this to herself. While it is not possible to know either way, if Bishakha did have concerns which she did not share, this could have been for reasons of embarrassment or shame, or a feeling that she should be able to cope. Potential barriers in relation to these issues are considered further in relation to equality and diversity below (see 5.3).

- 5.1.6 In contrast, Manav is reported to have been reserved and struggling with his mental health and his work, with his resignation early in 2016 likely exacerbating worries about money. This financial pressure is something Manav confirmed when interviewed by the chair.
- 5.1.7 It is possible to consider Manav's perspective, although in doing this, the Review Panel in no way sought to minimise Manav's responsibility for Bishakha's homicide.
- 5.1.8 Manav may have perceived his world as 'caving in', as well as feeling increasingly marginalised. Bishakha and Manav were part of a family network that was geographically and emotionally close. While Bishakha was actively trying to help him access help and support, this included the involvement of a number of family members and suggests Manav's personal circumstances had become a 'family matter'. Manav may also have felt indebted to those family members who had provided financial support.
- 5.1.9 Critically, on the night before Bishakha's death, it appears Bishakha had threatened to leave Manav if he did not "*snap out of it*", an eventuality that Manav would later claim (in speaking to Surrey Police) that he found too much to bear.
- 5.1.10 In the absence of evidence as to whether there was a wider pattern of domestic violence and abuse, the Review Panel considered whether there were other ways of understanding the circumstances of this case.
- 5.1.11 One explanation for Manav's act may be to focus on his mental health, specifically on whether this would account for the homicide. Manav had a Depression Disorder (although it was not of a severe degree with psychotic symptoms) and he is likely to have had previous depressive episodes. This was certainly relevant in the criminal trial, as demonstrated by the sentencing delay (for psychiatric reports to be completed) and the criminal justice outcome (Manav was found not guilty of murder on the grounds of diminished responsibility and convicted instead of manslaughter). This is also certainly the perspective that Manav would take, expressing this strongly during his interview. Issues related to mental health, and service responses, are discussed from 5.2.33 onwards.
- 5.1.12 However, it is also possible to explore the homicide through another lens, specifically the sex of those involved. Such an exploration is important because, even though there is an absence of any evidence to rule in or out a wider pattern of domestic violence and abuse in this case, sex is a risk factor in domestic homicide more generally; the majority of those killed being female, while most of those responsible are male (as noted above in 1.4 above).

- 5.1.13 While sex is biologically determined, people's every day lived experience is related to their sense of self in terms of gender. Ways of 'doing' gender are socially constructed, and include behaviours, activities and attributes that a given society considers appropriate for women and men. Using a gendered framework, it is possible to explore how Manav's ideas of masculinity might feature in the circumstances leading to the homicide.
- 5.1.14 Many writers have developed the idea of 'hegemonic masculinity'²¹. This is defined as a way of 'doing' gender that legitimizes men's dominant position in society and justifies the subordination of women. Critically, hegemonic masculinity is built on certain ways of 'being' a man. For example, men should be independent, strong and be a provider.
- 5.1.15 If someone subscribes to such ideas of how to 'be a man' - and builds their sense of masculine 'self' around these - there is likely to be a fear of being caught out, as well as a cost if they are found to be less than some or all of these things. This has been described as the 'fragility of masculinity'²². The fear of being exposed as 'less than a man' has been used to explain why some men act in certain ways in order to sustain or claim their sense of masculine self. While such actions can be directed towards themselves and other men, they are also frequently directed towards women. Often this takes the form of a sense of entitlement to authority or control over women.
- 5.1.16 While there are many ways to assert a sense of masculine self, violence is one of the most devastating way to do this. Such an assertion is at its most pronounced:
- '...if the person claiming hegemonic masculinity through violence murders those who could potentially challenge... [their] claim to authority. Murder is literally, rather than figuratively, a toxic form of silencing potential dissent to masculine claims of supremacy'²³.*
- 5.1.17 This has also been described as 'aggrieved entitlement', defined as:
- '...a fusion of that humiliating loss of manhood and the moral obligation and entitlement to get it back'²⁴.*
- 5.1.18 Using this concept to consider this case, Manav's personal issues (his depression, not coping at work, leaving his job and then no longer

²¹ Connell, R.A. (2005) *Masculinities*, 2nd edn., Oakland, CA: University of California Press.

²² Kalish, R. and Kimmel, M. (2010) 'Suicide by mass murder: Masculinity, aggrieved entitlement, and rampage school shootings', *Health Sociology Review*, 19(4), pp. 451 - 464.

²³ Myketiak, C. (2016) 'Fragile masculinity: social inequalities in the narrative frame and discursive construction of a mass shooter's autobiography/manifesto', *Contemporary Social Science*, 11(4), pp. 289-303.

²⁴ Kalish, R. and Kimmel, M. (2010) 'Suicide by mass murder: Masculinity, aggrieved entitlement, and rampage school shootings', *Health Sociology Review*, 19(4), pp. 451 - 464.

earning), and the fact that these had become a ‘family matter’, may have meant that he felt that his sense of masculine self was challenged.

- 5.1.19 This challenge may have been heightened if separation was a potential outcome. Indeed, if Bishakha and Manav had separated, this would likely have impacted yet more on him in relation to his home, family and finance. As a result, Manav’s fear of abandonment, characterised by his dependency on Bishakha and fears about the end of the relationship, may have been a trigger for the homicide²⁵.
- 5.1.20 Although this framing may help conceptualise Manav’s act, it in no way reduces his responsibility for it. Instead it demonstrates how ideas about gender and relationships, as well as the prospect of separation or the end of a relationship, can pose a significant risk to women in intimate relationships.
- 5.1.21 Recent research²⁶ into domestic homicide has explored the importance of ‘homicide triggers’. When found alongside an offender’s emotional or psychological state and the presence of acknowledged high risk factors, these triggers may indicate homicide is a real threat. Among these triggers are: separation/ rejection; failing mental health; financial ruin; and humiliation.
- 5.1.22 While the limited information in this case means it is difficult to be certain as to the presence of these markers, some appear to have been present. The prospect of ‘separation/ rejection’ has been discussed above, as has the issue of ‘financial ruin’. There is more explicit evidence about the presence of ‘failing mental health’ as Manav had depression, with this having a major impact from January 2016 onwards. The connection between depression, suicide ideation and risk has been noted as significant in recent research into domestic homicide²⁷.
- 5.1.23 It is also of note that the previous DHR in Elmbridge involved a homicide where the perpetrator’s behaviour was significantly influenced by fears around financial ruin.
- 5.1.24 Additionally, this is the second DHR locally where the victim and the perpetrator had relatively little contact with statutory services (the key issues in the previous DHR, as described in 1.14.2 above, were: limited

²⁵ Brennan, D. (2017) *The Femicide Census: 2016 findings - Annual Report of Cases of Femicide in 2016*. Available at: <https://www.womensaid.org.uk/femicide-census-published/> [Accessed: 31st January 2018].

²⁶ Monckton-Smith, J., Szymanska, K., and Haile, S. (2017) *Exploring the Relationship between Stalking and Homicide*. Available at <http://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf> [Accessed 15th April 2018]

²⁷ Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis – Report for Standing Together*. Available at http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf [Accessed 15th April 2018]

contact with statutory services in contrast to contact with a fee paying school and private health providers, as well as evidence of financial difficulties). There is tendency when faced with such homicides to conceive of these as 'inexplicable' and 'out of the blue'. In many ways that is understandable, given what family and friends have said about what is known in this case. However, the description of a homicide in this way can obscure the facts of a case (particularly when looking at the circumstances retrospectively) which may include common factors associated with the murder of female intimate partners²⁸. In this case, there were ongoing difficulties between Bishakha and Manav and, in the run up to the homicide, there was a confrontation relating to separation. This latter issue is a well-established risk indicator in domestic homicide. Nonetheless, the Review Panel noted with concern that there is relatively little practice guidance into cases with this profile.

It is important that professionals have a better understanding of how to identify those likely to be at risk and the actions that individual professionals or local partnerships can take to reduce the likelihood of future homicides. Additionally, a key purpose of DHRs is to reduce the likelihood of future homicides. As the Home Office has access to all DHRs as part of the quality assurance process, it is able to review learning across cases in a way that a single area cannot.

Recommendation 1: The SADA partnership to assure itself that the local training strategy, and professional development for Domestic Abuse Champions / Mentors, adequately:

- ***Reflects the gendered dynamics of domestic violence, including the concept of 'aggrieved entitlement'***
- ***Enables professionals to identify potential triggers associated with escalation, including financial issues, depression and suicide ideation.***

Recommendation 2: The Home Office to undertake further research into cases where there no known precursors of domestic violence abuse, and/or the victim/perpetrator have had little contact with statutory services, to develop a profile of these cases

5.2 Analysis of Agency Involvement:

Education

- 5.2.1 An IMR was provided by the (Fee Paying) Pre-Preparatory and Nursery School. Child A had not been enrolled for long and Bishakha had only routine contact with the school in relation to attendance at nursery, normally around illness or participation. There was little additional information in the records and no concerns were identified at the time.

²⁸ Dobash, R.E. and Dobash, R.P. (2009) "Out of the Blue" Men Who Murder an Intimate Partner', *Feminist Criminology*, 4(3), pp. 194-225.

From these contacts Bishakha comes across as an engaged parent. There was contact with Manav at a parent evening.

- 5.2.2 Child A's school fees would have represented a considerable financial commitment (in 2017/18 as an example, termly fees for pre-nursery and nursery child aged from two and a half years to six years old ranged between just over £700 to just under £3,500 depending on a child's age and the number of days a week they were in school). The school fees were paid from a joint account in the name of Bishakha and Manav.
- 5.2.3 While no recommendations were made in the Pre-Preparatory and Nursery School IMR, the Review Panel discussed whether there were opportunities to make information on domestic violence and abuse more available in this setting.
- 5.2.4 Consequently, a recommendation was made as follows. In making this recommendation, the Review Panel was mindful that the previous DHR in Elmbridge also involved a private education provider.

Schools, whether in the state or private sector, have a critical role to play in the response to domestic violence and abuse. This includes being a space where information on this issue, as well as the help and support available, can be promoted and shared.

Recommendation 3: The Surrey LSCB to work with all schools, including fee charging schools, to promote the inclusion of information on domestic violence abuse and the help and support available in school literature, including welcome packs for new parents

- 5.2.5 In relation to domestic violence and abuse, the Pre-Preparatory and Nursery School does not have a specific policy, although domestic abuse is addressed in their safeguarding policy as follows:
- Under emotional abuse – reference is made to seeing or hearing the ill treatment of another as a form of abuse
 - Under safeguarding issues – Domestic violence is listed as a specific safeguarding issue. The policy directs staff to the policy document 'Keeping Children Safe in Education' for further information²⁹.
- 5.2.6 Additionally, the chair was informed that the school's safeguarding training included information on the signs and indicators of domestic violence and abuse³⁰.

²⁹ Department for Education (2016) *Keeping children safe in education: Statutory guidance for schools and colleges*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/550511/Keeping_children_safe_in_education.pdf [Accessed 16th May 2018].

³⁰ Training content not reviewed as part of this DHR.

- 5.2.7 Although no incidents were reported to Surrey Police in this case, it is of note that Operation Encompass was launched in Surrey in June 2017. The project aims to safeguard and support children and young people who are involved in or affected by domestic abuse, or who are reported missing, by swiftly sharing information between partner agencies.
- 5.2.8 Every school day morning Surrey Police search their systems for incidents that occurred within the previous 24 hours where a child under 18 was linked, involved in or a witness to domestic violence or abuse or where a child was reported missing. Surrey Police will share this information and a short summary of the incident with the Education Safeguarding Team who, in turn, will share it with the child's school or college. The aim is to inform the school by 9:30am so that timely support can be offered.
- 5.2.9 It is important to note that Operation Encompass should be available to all children in Surrey, regardless of whether they are in state or private schools. The Review Panel therefore made the following recommendation. In making this recommendation, the Review Panel was mindful that the previous DHR in Elmbridge also involved a private education provider, illustrating the potential importance of these links given the large number of children in private schools locally.

Operation Encompass is an opportunity to develop effective pathways with local schools to improve the response to domestic violence and abuse. For it to be effective, this will mean working with schools to ensure that they have the right procedures, training and 'in school offer' to support staff and children appropriately if there is a notification. This should include all schools, whether in the state or private sector.

Recommendation 4: The Surrey LSCB to work with all schools, including fee charging schools, to deliver Operation Encompass and ensure that procedures and training to support staff and children are in place

- 5.2.10 Although it is outside the timeframe for the review, the Review Panel noted that Child A left the nursery soon after the homicide. During the Review Panel discussions, it was reported that there had been some challenges in managing the aftermath of the homicide in the school setting. This included a reluctance of other parents for Child A to be with other children. However, from the information available to the Review Panel, it appears that the school managed Child A's return to the school appropriately, based on advice from the school's own in-house counsellor, Child A's social worker and a national charity that provides support around childhood bereavement.
- 5.2.11 Nationally, there is a range of good practice for schools to help them deliver joined up, effective interventions which bring about lasting change for families. This can be used to enhance educational opportunities (such as the delivery of personal, social, health and educational (PSHE)), or in a

tragic case such as this, provide an age appropriate way of responding to the impact of a homicide on a school community.

- 5.2.12 According to educational quality inspection of the school, completed by the Independent Schools Inspectorate (ISI)³¹ in January 2017, the school has a strong personal, social, health and educational (PSHE) programme. However, while there are opportunities for children to explore healthy relationships in general, as well as specific opportunities in relation to domestic violence (for example in Year 6), the school's PSHE curriculum does not explicitly address healthy relationships in the context of domestic violence and abuse. The Review Panel therefore made the following recommendation. In making this recommendation, the Review Panel was mindful that the previous DHR (as described in 1.14.2 above) also involved a private education provider and made a specific recommendation in relation to PSHE. In implementing the below recommendation, the Review Panel felt that the LSCB should ensure it has robust links with the ISI to enable ongoing monitoring.

Schools have a key role in teaching children about healthy relationships, as well as a PSHE programme. An effective PSHE programme also considers the involvement of the whole school family, including parents.

Recommendation 5: The Surrey LSCB to work with all schools, including fee paying schools, to develop a programme with local specialist domestic abuse services to promote access to effective and high-quality resources for age appropriate teaching about healthy relationships in classroom settings

- 5.2.13 The school is a member of the Independent Association of Prep Schools (IAPS)³², which is part of the Independent Schools Council (ISC)³³. The school confirmed that neither organisation offers any additional guidance beyond making schools aware of their statutory duties, including under 'Keeping Children Safe in Education'.
- 5.2.14 As part of the DHR, a representative from the ISC was contacted and interviewed. They provided background information on fee paying schools, including a summary of the 'Independent School Standards Regulations' which includes a requirement to provide PSHE. While this is positive, that

³¹ The Independent Schools Inspectorate (ISI) is the body responsible for the inspection of schools in membership of the Associations that make up the Independent Schools Council. The ISI reports to the Department for Education on the extent to which schools meet statutory requirements. For more information, go to: <https://www.isi.net/about/>

³² The Independent Association of Prep Schools (IAPS) is an association for prep schools. <https://iaps.uk>

³³ The Independent Schools Council (ISC) brings together seven associations of independent schools, their heads, bursars and governors. <https://www.isc.co.uk/about-isc/>

requirement does not explicitly set out a requirement to ensure that PSHE addresses how to recognise, understand and build healthy relationships, consent, or how to recognise unhealthy relationships, including bullying, coercion and exploitation.

- 5.2.15 The Department for Education recently undertook a call for evidence in respect of the teaching of Sex and Relationship Education and PSHE, with this ending in February 2018. Shortly before this report was handed over to the CSP, the department published draft regulations and statutory guidance for relationships and sex education and health education³⁴. The UK Government has confirmed that all schools, including maintained schools, academies and independent schools, will be required to teach Relationships Education (primary schools) and Sex and Relationship Education (secondary schools). Any decision to also make PSHE mandatory would apply to all schools, extending the existing requirement in line with fee charging schools in having to teach this subject.

It is positive that there is already a requirement for private schools to include PSHE, and that more broadly, the Department for Education is consulting on the teaching of Sex and Relationship Education and PSHE in all schools.

Recommendation 6: The Department for Education to ensure that the good practice, resources and training developed following the consultation around Sex and Relationship Education and PSHE includes fee charging schools and to work with the sector around its development and implementation

Emergency Services

SECAMB

- 5.2.16 SECAMB's involvement with Bishakha and Manav was brief, relating to the day of the incident that led to Bishakha's death, however there appears to be evidence of good partnership working between the clinicians on scene, particularly given the circumstances and potential threat of violence. Despite no contact with Child A, in line with SECAMB policy and procedures, a Vulnerable Person (VP) referral was submitted.
- 5.2.17 A search for additional contacts has taken place, looking back prior to the timeframe and no other incidents have been found.
- 5.2.18 Although SECAMB had limited contact in this case, the SECAMB IMR made the following recommendations. While these do not relate specifically to this case, they demonstrate an application of learning from

³⁴ For more information go to: <https://www.gov.uk/government/consultations/relationships-and-sex-education-and-health-education>

this case to wider system issues, and so were accepted by the Review Panel:

- *“In line with a concurrent DHR in Kent and Medway, following the success of the SECamb Domestic Abuse pilot, consideration would be given into scoping with other agencies [about] how SECamb can feedback into the Multi-Agency Risk Assessment Conference (MARAC) in the absence of a Domestic Abuse coordinator / specialist”*
- *“The SECamb Safeguarding Team and Safeguarding Lead will also look into additional training for those working for the Helicopter Emergency Medical Service (HEMS) to support their VP referral writing to ensure sufficient information is recorded for the local authority to record and address their concerns³⁵”.*

Surrey Police

5.2.19 Surrey Police also had no prior contact with Bishakha and Manav (with the exception of an unrelated burglary, to which Manav was a witness). The Surrey Police IMR identified that there were no opportunities for Surrey Police to have prevented the tragic death of Bishakha.

5.2.20 However, the Surrey Police IMR also notes that the statutory guidance asks reviewers in situations where a victim had no contact with any agencies to consider whether more could be done to raise awareness of services available to victims of domestic abuse. The IMR notes that domestic abuse is a force priority and that Surrey Police runs regular domestic abuse campaigns as a single agency and jointly with partner agencies to promote the services and support available to victims of domestic abuse and to encourage reporting.

Health Services - Maternity and Health Visiting

5.2.21 The Medical Centre appropriately made a referral to Maternity Services (provided by the Kingston NHS Foundation Trust), as well as to the Health Visiting Services (provided by Central Surrey Health) in relation to Bishakha's pregnancy.

Maternity Services

5.2.22 In relation to Maternity Services, it appears Bishakha received appropriate care throughout her pregnancy and postnatal period.

³⁵ The SECamb IMR explained this recommendation as follows: *“Given the chaotic nature of incidents attended by HEMS, acquiring information for social care can be distracting when addressing an immediate clinical need, however SECamb will strive to work with HEMS in order to improve quality referrals in future and how to work with SECamb colleagues for information sharing following an incident such as the one centred around this IMR”.*

- 5.2.23 When Bishakha's patient health records were reviewed it was noted that she had been asked about domestic abuse at her 'booking in' appointment. However, there is no record of her being asked about domestic abuse at her 28 and 34-week appointments. It was not possible to establish whether the question was asked but not recorded or was not asked on these occasions.
- 5.2.24 In the Maternity Services IMR, it was reported that practice has now changed, and midwives are more aware of the risks posed by domestic abuse to the mother and unborn baby and its prevalence. The IMR notes that regular training is in place to update existing staff members and induct new staff to the working practices and the professional expectations for staff around domestic abuse.
- 5.2.25 No recommendations are made in relation to these issues in light of the changes to policy since 2012, and because the following recommendations were made in the Maternity Services IMR. These recommendations were welcomed by the Review Panel:
- *“The importance of the routine enquiry into the presence or potential for pregnant women to be the victim of domestic abuse should continue to be asked at the booking in appointment and at 28 weeks and 34/36 weeks to identify if the domestic abuse has started in pregnancy or escalated”*
 - *“The importance of contemporaneous record keeping needs to remain a high priority in order for the potential risks to mother and her unborn to be clearly identified within the patient health records, so an appropriate multi-agency plan can be formulated to safeguard and support the victim”*
 - *“The value of asking the routine enquiry questions prior to discharge home from the postnatal ward to be explored”.*

Health Visiting Services

- 5.2.26 In relation to Health Visiting Services, at the time of their contact with Bishakha, the service offer would have included consideration for antenatal contact on receipt of notification of pregnancy. As the maternity booking form did not disclose any social, safeguarding or health concerns, targeted antenatal contact was not offered by the Health Visitor. Since that time a routine contact for antenatal assessment with a Health Visitor is now offered to all first-time mothers in accordance with the Healthy Child Programme developed in 2012.
- 5.2.27 The first contact by the Health Visiting Service was the first face to face contact with the family at a Home Visit when Child A was 12 days old. This was completed and recorded in line with practice guidance and service offer in place at the time. During this visit, a Family Health Needs

Assessment was completed. Routine enquiry about domestic abuse was considered, but not undertaken as both parents were present.

- 5.2.28 Bishakha's attendance alone (i.e. without Child A) at a breast-feeding clinic on the 4th May 2012 would have been unexpected. The Health Visiting IMR notes that it is difficult to establish why Bishakha would have attended alone. She may have just settled her baby and wanted the opportunity to talk about feeding. She had also been proactive in seeking the advice of an NCT Breast Feeding Counsellor to support feeding. Bishakha may also have misunderstood the offer of the breast-feeding clinic or she or her husband may have been concerned about breast feeding in a public area.
- 5.2.29 Subsequent contacts, at the well-baby clinic, were recorded as attendances only. If there had been any concerns about parental or child health and well-being this would have been recorded in the Progress Record in accordance with practice at the time.
- 5.2.30 A 27-month developmental review was also completed. The focus would have been on child development. The Health Visiting IMR notes that this contact would not have included any directed discussion about maternal mood or domestic abuse. As there were no areas of concern identified, and there was positive interaction observed between Bishakha and Child A, no further assessment or contact was arranged. The next scheduled contact for Child A would have been school entry screening in the year following state school entry.
- 5.2.31 While it was appropriate not to conduct routine enquiry during the first Home Visit (because of the presence of Manav) this should have been followed up at subsequent contacts. It is therefore positive that the service has made changes since this time: since 2014 records of all contacts at home and for antenatal contact include reference to domestic abuse and, where this has not been discussed, practitioners now record the reason that this did not happen. Additionally, posters giving details of local domestic abuse outreach services are available in clinic settings and public areas across the service, and staff access training about domestic abuse.
- 5.2.32 No recommendations are made in relation to these issues in light of the changes to policy since 2012 and because the following recommendations were made in the Health Visiting Service IMR. These recommendations were welcomed by the Review Panel:
- *“CSH Surrey Breast Feeding Clinics offer the opportunity for privacy however this will be explicit within literature and discussions with parents so that there can be no misunderstanding about an expectation to feed in a public area”*
 - *“Continuing support from Learning and Development team to further develop the Domestic Abuse training offer across the service and*

incorporate within mandatory training for all clinical employees and to monitor DA training compliance across CSH Surrey”

- *“Availability of materials to support Domestic Abuse awareness is recognised as a current issue. Whilst posters can be duplicated, flyers, cards and discrete information cards are in more limited supply locally. CSH Surrey will continue efforts to source a regular supply for professionals, clinics and public areas”.*

Mental Health

5.2.33 Manav had a Depression Disorder (although it was not of a severe degree with psychotic symptoms) and he is likely to have had previous depressive episodes.

5.2.34 Manav had contact with three statutory health providers in relation to his mental health, with an intense period of contact in April and May 2016. This included his GP (the Medical Centre), NHS 111 (provided by Care UK) and the local IAPT service (Healthy Minds Surrey, provided by Virgin Care), as well as some limited contact with two private Mental Health Providers.

Contact with NHS mental health services

5.2.35 The NHS England report into Manav’s treatment concluded overall that:

“Although there were indications that Manav was a suicide risk, from the information made available to me, there was no indication that Manav had homicidal thoughts when he was assessed by professionals. However, risk assessment and management plans for suicide should always bear in mind the possibility of extension to others”.

5.2.36 However, in relation to his contact with statutory health providers a number of specific issues have been identified and are explored below. As noted above, this is relevant because depression and suicide ideation are commonly noted risk factors in domestic homicides.

General Practice

5.2.37 The NHS England report writer concluded that Manav was appropriately started on antidepressant medication by his GP, specifically a SSRI (Serotonin Specific Reuptake Inhibitor). SSRI’s are the first line antidepressant medication. The report writer also concluded that when Manav continued to present with anxiety symptoms, the GP selected and titrated an appropriate choice as a second line antidepressant (Mirtazapine). Additionally, the report writer noted that the prescription of Zopiclone as a sleeping pill, other than helping Manav with his sleep, would not have made any difference.

- 5.2.38 The report writer also noted that the GP directed Manav towards the IAPT service, which Manav latter accessed. This is explored below.
- 5.2.39 On the 25th April 2016, Manav told NHS 111 that he wanted to see a doctor to re-start on antidepressants but was not confident that he would get to see his GP in less than 3 weeks and felt that he could not wait that long. When interviewed, Manav repeated this same concern stating that he had made repeated attempts to get an appointment and referring to a range of patient feedback about the Medical Centre which is available as comments on NHS Choices.
- 5.2.40 It is unclear why Manav had this concern. In practice it appears that he could access his GP, and indeed did so when he attended the Medical Centre the day after he called NHS 111 (the 26th April 2016.) Nonetheless, the Review Panel discussed the issue of non-urgent appointments and received assurances that locally there may be a two or three week wait for a non-urgent appointment, but if a patient contacts their GP and has a concern, there is an expectation that they will receive a telephone call back on the same day from a GP. In these circumstances, the GP can provide advice and book an urgent appointment if needed. Additionally, some practices also offer Skype consultations. Therefore, no recommendations are made in relation to this issue.
- 5.2.41 The issue of GP's training and knowledge of domestic violence and abuse is discussed further below.

NHS 111 (provided by Care UK)

- 5.2.42 During Manav's contact with NHS 111, the Health Advisor inquired about various symptoms of depression. The identification of these symptoms would have assisted in making a diagnosis of depression as defined in International Classification of Diseases (ICD) 10. Mild and moderate depression requires presence of at least two of the three core symptoms along with other common symptoms like reduced concentration and attention; reduced self-esteem and self-confidence; ideas of guilt and unworthiness; pessimistic view of the future; ideas of self-harm or suicide; disturbed sleep and diminished appetite. Severe depression requires presence of all the three core symptoms with at least four of the other symptoms mentioned above.
- 5.2.43 In the records of Manav's assessment there is no reference to three core symptoms of depression by either the Health Advisor or the Clinical Advisor i.e. depressed mood, fatigability and loss of interest and enjoyment (anhedonia). However, some issues were considered: for example, Manav had stated that he was troubled by memories of severe stress and that normal life was becoming impossible on certain days. He had also said that while he had thoughts of suicide he had no plan or access to method.

- 5.2.44 In these circumstances, further enquiry would have most appropriately been undertaken by the Clinical Advisor. Had the Clinical Advisor recognized the severity of the symptoms they may have tried harder to persuade Manav to attend the acute psychiatric services in the A&E Department.
- 5.2.45 The IMR prepared by the provider of the NHS 111 service (Care UK) recognises this, stating that there was inadequate probing around suicidal ideations. The IMR noted that in retrospect there were opportunities in both calls to have raised safeguarding concerns, either for Manav or potentially (if there had been a fuller assessment) for Bishakha.
- 5.2.46 This was also identified by the NHS England review report writer who noted that the ‘troubled memories’ and the ‘severe stress’ could have been explored further. This is because once suicidal ideations have been expressed by a patient along with hopelessness, it is important to undertake a detailed clinical history to fully understand the risks. Suicide as a risk factor in domestic abuse is discussed in 5.1.21 to 5.1.23.
- 5.2.47 While the IMR provided by Care UK noted that the staff involved did not act in a way that would have been expected given their training, and that they will receive feedback on their handling of this case, it did not make any recommendations.

Any organisation participating in a DHR needs to be able to ensure that the implications of any case specific learning are considered beyond the professionals and / or area involved in a case. This is in order that the organisation can be confident that the issues identified were either localised or, if they have a wider reach, this is identified with appropriate remedial action being taken. The Review Panel therefore made the following recommendation:

Recommendation 7: Care UK to review the findings from this case and undertake a wider case audit to be assured about the standard of current practice in relation to probing around suicidal ideation and, if issues are identified, to develop an improvement plan to address these

- 5.2.48 The Review Team discussed a number of additional issues in relation to Manav’s contact with the NHS 111 provided (Care UK).
- 5.2.49 *Firstly, the suitability of the system used by NHS 111 providers (NHS Pathways) in relation to mental health:* In relation to this, the Review Team were informed that currently NHS Digital are developing an improved assessment tool for callers with mental health issues which would enable more direct referrals into the acute psychiatric services. No recommendations are made in relation to this as a result.

- 5.2.50 *Secondly, the interface between NHS 111 and other parts of the health system:* After Manav contacted NHS 111 he was advised to attend A&E in order to access Psychiatric Liaison staff there. In this case Manav advised staff that he did not want to do this but reiterated that he needed to see a doctor. However, in another scenario it is also possible to imagine that Manav may have agreed to attend A&E but would not have done so. In either case the NHS 111 system does not have a mechanism in place to allow referral of callers with their assessment records into the acute psychiatric services. If this mechanism did exist, in the second scenario this would have enabled NHS 111 to make a referral and for the psychiatric team to make contact should Manav have not attended (or even enabled an assessment to take place in an environment of his choosing).
- 5.2.51 An additional route available locally is for professionals to direct patients in crisis to the Community-Based Crisis Service (including the Mental Health Crisis Line) provided by Surrey and Borders NHS Partnership Trust. The Crisis Line is available to people from 5pm to 9am Monday to Friday, and 24 hours a day at weekends and bank-holidays. The service offers telephone and text support and advice to people experiencing mental health crisis or their carers. Out-of-hours GPs and social services would also direct people to use this service. There are also Home Treatment Teams.
- 5.2.52 However, at the time of the incident, direct referrals to this service were not accepted from other health or social care professionals with calls instead being triaged by the Crisis Line. This remains current practice at the time the report was written. As a consequence, as with the Psychiatric Liaison in A&E, when NHS 111 is in contact with a patient (as they were with Manav) they can give advice but are not able to make a direct referral.
- 5.2.53 The Review Panel felt that in relation to both Psychiatric Liaison and NHS 111 this an unnecessary barrier particularly if someone is in crisis.

It is important that patients experiencing mental health crisis are able to quickly access help and support, including a Crisis Line and, if appropriate, Home Treatment Teams. This should include ensuring that NHS 111 is able to engage directly with local Community-Based Crisis Services and share patient records, so all services would be well informed about a caller's recent history.

Recommendation 8: Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the Community-Based Crisis Service by developing a mechanism to allow for direct referrals

- 5.2.54 Another consideration in this case is that Manav declined to take up the advice from NHS 111 but reiterated that he needed to see a doctor. The issue of access to his GP is discussed above. However, in the Review

Panel meeting there was a discussion about the response of NHS 111. In these circumstances, NHS 111 are unable to book an appointment with someone's GP, instead having to advise them to contact their GP directly to book an appointment.

- 5.2.55 As with the issue with Psychiatric Liaison, as well as the Crisis Line and Home Treatment Teams, this may be an unnecessary barrier particularly if someone is in crisis.

It is important that patients experiencing mental health crisis are able to quickly access help and support, including their GP. NHS 111 should be able to book an appointment on their behalf with a GP if this is the most appropriate course of action.

Recommendation 9: Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the GPs by developing a mechanism to allow for direct referrals

IAPT (provided by Virgin Health Care)

- 5.2.56 Manav communicated feelings of hopelessness to IAPT staff.
- 5.2.57 Manav was appropriately offered subsequent appointments. The subsequent appointment on 13th May 2016 was with a trainee professional who assessed Manav on his own.
- 5.2.58 It is unclear from the Virgin Care IMR if the trainee professional who assessed Manav on 13th May 2016 explored the feelings of hopelessness, the financial and other stressors and the impact of these stressors on Manav. It is unclear if the trainee professional discussed the session with qualified staff, considering they were still in training. A detailed assessment might have better informed the professional whether Manav met the threshold for a referral to the Crisis Resolution and Home Treatment Team (CRHT). CRHT is a specialist mental health team consisting of psychiatrists, nurses and other allied staff who assess and provide treatment to patients who are acutely suicidal or are in mental health crisis. Although Manav was harbouring suicidal thoughts, there is no indication that he was acutely suicidal.
- 5.2.59 Virgin Care has subsequently changed their supervision arrangements. Assessments should be brought to supervision (rather than offer treatment immediately) when there are: any risks to self or others; any mental health diagnosis other than anxiety or depression; any secondary care treatment in the past; any CBT treatment in past including step 2; any drug and alcohol issues above normal use; anyone who does not have clear step 2 goals and when complex situations exist such as homelessness, domestic abuse or multiple social issues.
- 5.2.60 The Virgin Care IMR made the following recommendations:

- “Service to review adding prompts on impact of ethnicity/ culture to client/patient records”
- “Service to review how to encourage appropriate professional curiosity and more detailed examination and recording of issues which may impact upon the patient and the family such as the emotional and cultural impact of unemployment”.

5.2.61 The NHS England review report writer also identified that it was unclear if the staff member acknowledged and understood the significance of hopelessness as a suicide risk factor. They noted that a large body of research supports hopelessness as a key factor associated with increased suicide risk, and that the risk exists even after controlling for depression. When someone feels suicidal, the ideation may last for a short period if they can think of alternative ways to solve their problems. In depression, the impairment in problem solving reduces this capacity to look for alternative ways to deal with the stressors. The suicidal feelings may abate if the person has something to look forward to in the future. Hopelessness takes away these possibilities, and combination of impaired problem solving in depression, feeling trapped in current situation and hopelessness increases the suicide risk.

5.2.62 Virgin Care no longer provides IAPT services in Surrey.

Mental Health Commissioners have a responsibility to ensure that learning from Virgin Care’s contact with Manav is disseminated across IAPT services locally.

Recommendation 10: Mental Health Commissioners to review the learning from this case and seek assurance that current providers of IAPT services in Surrey have appropriate staff training, procedures and supervision in place in relation to the identification and assessment of risks to self and others.

Contact with private Mental Health Providers

- 5.2.63 Manav also had contact with two different Private Mental health Providers, a sole practitioner providing psychotherapy and hypnotherapy, as well as private psychiatric clinic.
- 5.2.64 Based on the information available, it appears that this was limited to an initial meeting with the Lone Practitioner, while a referral was made to, but no appointment had with, the Private Mental Health Provider (a Psychiatric Hospital). The Review Panel did not therefore make any specific recommendations for these providers but did not that this illustrates the role providers outside the NHS may have locally.

It is important that the learning from DHRs is disseminated as widely as possible, including to private health care providers.

Recommendation 11: Mental Health Commissioners to consider the learning from this case and run an engagement event with private mental health care providers in the county to facilitate the dissemination of the review's findings

Bishakha and mental health services

- 5.2.65 Bishakha had limited contact with mental health providers, speaking to her GP in September 2012, following the birth of Child A in April 2012. She was provided with appropriate advice, but no further action was taken. Although the Review Panel noted this contact, it did not make any further recommendations, as there is no indication that this affected Bishakha's confidence in engaging with her GP, with this contact described below.

Health services – General Practice

- 5.2.66 No issues were identified in relation to the broader General Practice response, with the physical health care needs being met in a timely and clinically appropriate manner.
- 5.2.67 However, the Review Panel considered the Medical Centre's access to domestic violence and abuse training.
- 5.2.68 The CQC includes safeguarding training within their inspections of GPs. The last CQC report, published in January 2017, rated the Medical Centre as 'Good'.
- 5.2.69 It should be noted that prior to April 2018 GP surgeries were contracted by NHS England and from April 2018 Guildford and Waverley CCG, and North West Surrey CCG, have taken on Delegated Commissioning for their GP practices. This means the CCGs will be able to monitor the services including training.
- 5.2.70 With this context in mind, there is Level 3 Children Safeguarding Training (which includes domestic violence and abuse) available to GPs in Surrey. This is delivered quarterly, rotating at the acute hospitals, so GPs can attend any of these that they wish to. Additionally, during 2018/19 a 'Safeguarding Adults (Primary Care) Project is underway. A post holder will support and develop Safeguarding Adults Primary Care Safeguarding Lead arrangements across the Surrey and West Kent CCG area to strengthen a Safeguarding Leads Network in order to develop safeguarding adult arrangements and to share national and local best practice.
- 5.2.71 Lastly, information on the Surrey wide Domestic Abuse Training Programme has also been shared with every GP Surgery in Surrey.

- 5.2.72 While this is positive, there is limited provision specifically in relation to domestic violence and abuse. There are six CCGs in Surrey (East Surrey; Guildford and Waverley; North East Hampshire and Farnham; North West Surrey; Surrey Downs; and Surrey Heath). Only one, the East Surrey CCG, funds the IRIS programme. In this case, Bishakha and Manav's GP was located in the North West Surrey CCG area and would not have had access to this programme.
- 5.2.73 Although the learning in this case relates to North West Surrey CCG, it is relevant for all CCGs in the Surrey area, which are all represented on the Surrey Health and Wellbeing Board³⁶.
- 5.2.74 In making a recommendation, the Review Panel was mindful that the previous DHR in Elmbridge made a recommendation to consider commissioning the IRIS programme.

A range of effective interventions can make it easier for NHS services to play their part. This should include ensuring that GPs have access to training, support and a referral programme to support them asking about and responding to domestic violence and abuse.

Recommendation 12: The Surrey Health and Wellbeing Board to work with the Surrey CCGs to ensure there is a programme available to all GPs providing training, support and a referral pathway (including access to advocacy) to enable a consistent response to domestic violence and abuse

Employers

- 5.2.75 Manav worked in London at a large international bank. Although he had been working at the bank for a number of years, he was not an employee and was instead engaged as a contractor.
- 5.2.76 While Manav had talked about his worries about work to his family, it does not appear he had talked about these as explicitly with the bank, although the bank was aware of some issues that Manav was having with his work. For example, in January 2016 Manav told his manager that he was frustrated because there had been a lot of changes at work and he did not feel he was getting a lot done. Additionally, as told to Surrey Police during the murder enquiry, Manav's line manager had become concerned in April 2016 that he might have financial worries, while another colleague noted he often seemed stressed, was working on his house and was tired.
- 5.2.77 The bank was not aware of any specific concerns or any indicators of domestic violence.

³⁶ For more information, go to <https://www.healthysurrey.org.uk/about>.

- 5.2.78 While these reports indicate some potential concerns, the Review Panel felt that these contacts were unlikely to have triggered any further opportunities that realistically would have enabled any early intervention.
- 5.2.79 To explore the approach of the bank more generally (rather than case specifically) the chair (James Rowlands) spoke with a Human Resources representative. They provided information on the bank's employee wellbeing programme. It is beyond the scope of this review to assess the standard of this programme, however the information provided to the chair included details of a number of different initiatives and a range of support. These include mental health awareness e-learning and the training of Mental Health FirstAiders.
- 5.2.80 A specific issue in this case is Manav's employment status – he was not an employee of the bank but worked there as a contractor. In the discussion with the chair, the bank confirmed that contractors have different entitlements to employees. However, it was reported that with regards to the wellbeing support available, this would be dealt with on a case by case basis, and that a contractor in these circumstances could potentially access some of these employee initiatives or support options.
- 5.2.81 With reference to domestic violence policies, the Human Resources representative stated that the bank does not have a specific domestic violence policy for staff who experience or perpetrate domestic violence. However, it was reported that anyone affected by domestic violence and abuse would be supported on a case by case basis using existing staff policies and procedures.
- 5.2.82 Nationally, there has been an increased focus on the role of employers in relation to domestic violence. A recent report commissioned by the Vodafone Foundation³⁷ found that 6% of Human Resources leads in medium and large UK organisations agree that employers have a duty of care to provide support to employees on the issue of domestic abuse, and nearly three-quarters believe that companies can empower victims by giving them guidance on how to deal with domestic abuse. However, despite this awareness, only 5% of organisations have a specific policy or guidelines. The Review Panel noted that literature available online from two bodies working on this issue (the Corporate Alliance Against Domestic Violence³⁸ and the Employers' Initiative on Domestic Abuse³⁹) principally refers to 'staff' or 'employee' and it is not clear what, if any, guidance is

³⁷ Westmarland, N. (2017) *Domestic Violence and Abuse: Working together to transform responses in the workplace*. Available at: http://www.vodafone.com/content/dam/vodafone-images/foundation/55376_Vodafone_domestic_violence_report_AW5_V2.pdf [Accessed: 16th May 2018].

³⁸ For more information, go to: <http://thecorporatealliance.co.uk>

³⁹ For more information, go to: <https://eida.org.uk/about/>

available in relation to contractors engaged through an employment agency or on a self-employed basis.

This review has identified two specific issues. Firstly, that the large international bank where Manav was employed as a contractor does not have a domestic violence policy for staff who experience or perpetrate domestic violence and abuse. Secondly, that staff who are engaged as contractors (either through an employment agency or if they are self-employed) may fall outside of formal arrangements for staff wellbeing, including within any domestic violence policy or procedure.

Recommendation 13: The CSP to write to the bank involved in this review to encourage them to develop a domestic violence policy for staff who experience or perpetrate domestic violence and abuse

Recommendation 14: The CSP to share the findings from this review with the Corporate Alliance against Domestic Violence and the Employers' Initiative on Domestic Abuse and request further consideration of best practice in relation to staff who are employed as contractors (either through an employment agency or if they are self-employed)

- 5.2.83 Locally, Elmbridge Borough Council has recently updated its domestic abuse workplace policy, which has been approved by the council's Employee Consultative Group. The council also participated in a joint event with Surrey Police to encourage local businesses to develop domestic abuse policies and recently ran a Domestic Abuse 'Behind Closed Doors' awareness event for business. This is positive, and the Review Panel were encouraged by local work on this issue and did not make further recommendations.

5.3 Equality and Diversity:

- 5.3.1 The Review Panel identified the following Protected Characteristics of Bishakha and Manav as requiring specific consideration for this case, including their understanding of their experiences, how they sought help and /or how they might have impacted on agency responses.
- 5.3.2 **Sex:** As discussed above (1.4), Sex is a risk factor in domestic violence, with women being disproportionately affected by domestic homicide.
- 5.3.3 **Race:** Bishakha was from a British Asian background. According to the most recent data, BAME groups total 20% of the population of Elmbridge (of which 2% are British Asian)⁴⁰.

⁴⁰ Elmbridge Borough Council. (2017) *Elmbridge: Knowing Our Communities*. Available at <http://www.elmbridge.gov.uk/EasysiteWeb/getresource.axd?AssetID=3499&type=Full&servicetype=Attachment> [Accessed 15 May 2018].

- 5.3.4 Tragically, it is not possible to know from Bishakha's perspective how her Race may have affected her situation. However, it may be that this provided a context to her experiences, including her willingness or confidence in accessing help and support. Bishakha's family and friends have talked about how she would have wanted to solve any issues herself. While that may have reflected the 'can do' attitude those who knew her described, it is possible that this may have been influenced by other factors. For example, there is evidence that cultural barriers may be an issue for second generation South Asian women, with notions of shame preventing help seeking. A similar analysis could be applied to the way in which the issues with Manav were dealt with as a 'family problem'. While this may have enabled Bishakha to draw on support from family members, there is evidence that suggests that some British Asian women may be reluctant to seek help outside the immediate family, including for fear of shame⁴¹.
- 5.3.5 Although it is not possible to know if these issues were indeed a factor in Bishakha's decision making, and if so to what extent, the Review Panel considered the lessons that could be learnt from this case relating to local provision for BAME communities more generally. Two issues in relation to domestic violence were considered, firstly awareness raising and secondly, access to specialist services.
- 5.3.6 *In relation to awareness raising:* Elmbridge Borough Council has not run any specific communications with different communities to encourage reporting. However, the council does undertake domestic abuse awareness communications throughout the year including encouraging local businesses to display the Surrey Domestic Abuse helpline number in their toilets, something the council also does in its own buildings. These materials are drawn from the wider SADA partnership's awareness raising campaign⁴². None of these materials relate specifically to BAME communities.

Awareness raising activity should address the needs of the local population, including BAME communities.

Recommendation 15: The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of BAME communities locally

⁴¹ Thiara, R. K. and Aisha, K.G. (2009) *Violence Against Women in South Asian Communities: Issues for Policy and Practice*, London: Jessica Kingsley Publishers.

⁴² For more information, go to: <https://www.healthysurrey.org.uk/your-health/domestic-abuse/professionals/awareness-materials/>.

- 5.3.7 Another aspect of awareness raising is professional development. SADA partner agencies have developed a multi-agency learning and development framework⁴³. There is no content relating specifically to BAME communities.

Local training should be available to ensure professionals have the skills and confidence to identify and responding to domestic violence and abuse. This should include provision for BAME communities.

Recommendation 16: The CSP to work with the SADA partnership to develop its training programme to ensure that this addresses the needs of BAME communities locally

- 5.3.8 *In relation to service provision:* although there is an established specialist service (Citizens Advice Elmbridge (West) and North Surrey Domestic Abuse Outreach Service), there is no BAME specialist provision locally.
- 5.3.9 Consequently, the Review Panel considered the question of provision of specialist BAME led services. A report by Imkaan defines such organisations as “*independent, specialist and dedicated services run by and for women from the communities they seek to serve*”, which:
- “Work in ways that are not only about individual women and girls’ safety, and/or the safety of their children, but are also about Black, Minority and Ethnic (BME) women’s autonomy, freedom and self-determination.
 - Recognise the continuum of violence against women and girls and seek to offer support around every aspect of women’s needs, ensuring a holistic, needs led response.
 - Work across the spectrum of risk and need, understanding the fluctuating nature of risk and are adept at recognising ‘hidden’ risk indicators.
 - Are skilled in identifying indicators and experiences of specific forms of Violence Against Women and Girls (VAWG) that may be missed within a mainstream domestic violence organisation.
 - In offering a range of services, are able to access women who may not even recognise their experiences as violence.

⁴³ For more information, got to: <https://www.healthysurrey.org.uk/your-health/domestic-abuse/professionals/awareness-training>.

- Create flexible and diverse support systems, sensitive to the fact that for many BME women, refuge and support services may be unfamiliar and/or stigmatized⁴⁴.

5.3.10 As it is unknown either way whether Bishakha experienced a wider pattern of domestic violence and abuse, it is not possible to know whether access to a specialist BAME specialist organization would have been something Bishakha would have wanted. However, the Review Panel considered whether having a local specialist BAME led organisation might have meant that, if Bishakha had been experiencing domestic violence and abuse, she would have felt more able to access help and support. While this is a hypothetical question, it is reasonable to speculate that Bishakha (or someone else in her situation) might have felt that support from a specialist BME service was useful, as it would be provided in an environment where staff had the knowledge and expertise about various forms of violence in specific individual, family and community contexts. This raises the question of whether specialist BAME provision should be available locally.

It is important for a local authority to be aware of their local population, including the level of need and the requirement for specialist BAME led provision. However, for boroughs in Surrey, it is neither possible nor desirable to work alone in this regard. There are opportunities to work on a county wide basis to ensure BAME led specialist services are developed.

Recommendation 17: The CSP to scope the requirement for specialist BAME led provision in the borough

Recommendation 18: The CSP to work with other bodies in Surrey, including the Office of the Police and Crime Commissioner for Surrey, to ensure that there is access to specialist BAME led services

- 5.3.11 *Religion and Belief.* As with the discussion around Race, Bishakha and Manav's Religion and Belief (they were Hindu) may have also been relevant. However, there is only one specific reference to religion (a plan to mark the new home by a religious ceremony), and this was not identified as a significant issue by family or friends.
- 5.3.12 The panel concluded that the other Protected Characteristics of Disability; Pregnancy and Maternity; Sexual Orientation; Gender Reassignment; and Marriage / Civil Partnership were not relevant in this case.
- 5.3.13 The panel also considered Socio-Economic status. Elmbridge is a relatively wealthy borough, for example it has a significantly higher number

⁴⁴ Imkaan (2016) *Capital Losses: The State of the BME ending violence against women and girls sector in London*. Available at: <http://imkaan.org.uk/resources> [Accessed 16th May 2018].

of properties in Council Tax bands G and H⁴⁵ than other Surrey boroughs and districts⁴⁶.

- 5.3.14 Despite some financial pressures in their relationship, Bishakha and Manav were well off. They were also able to access resources from their respective families. While Socio-Economic status could be an enabling factor (for example, it allowed Bishakha and Manav to access private health care) it may have also served as a stressor (e.g. a perception of the importance of sustaining a particular lifestyle or work) or a barrier (e.g. feeling that local services were not targeted to someone with a high income). It also meant that, with the exception of health services, neither Bishakha or Manav had much contact with statutory services.

Awareness raising activity should address the needs of the local population, including those victim/survivors who may face specific barriers as a result of their Socio-Economic status.

Recommendation 19: The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of victims across the spectrum of Socio-Economic status

- 5.3.15 As a final consideration, it is important to note that the experience of domestic violence and abuse can be informed by multiple aspects of someone's identities. Using Bishakha's experience as an example, her Race (and potentially Religion and Belief), Sex and Socio-Economic status could have intersected, impacting on her perception of both her experience and her consideration of options. This is an important reminder that agencies should consider someone's unique needs and experiences in the round.
- 5.3.16 The consideration of Race (and potentially Religion and Belief), Sex and Socio-Economic status is also relevant in relation to Manav and may have potentially underpinned or informed the decisions he made. This may have affected his engagement with services in a number of ways. For example, he was clearly concerned about people finding out about his mental health problems. This may mean that he felt there was some stigma attached to accessing mental health support and wellbeing, although he clearly felt able to access these services to some extent, as discussed above.

⁴⁵ The amount of Council Tax someone has to pay depends on which property band their home is in. Bands G and H are the highest of the 9 Council Tax Bands. For more information go to: <http://www.elmbridge.gov.uk/council-tax/charges/>.

⁴⁶ Elmbridge Borough Council. (2017) *Elmbridge: Knowing Out Communities*. Available at <http://www.elmbridge.gov.uk/EasySiteWeb/getresource.axd?AssetID=3499&type=Full&servicetype=Attachment> [Accessed 15 May 2018].

6. Conclusions and Lessons to be Learnt

6.1 Conclusions:

- 6.1.1 Bishakha was a caring daughter, sister and mother. She was also a loyal friend and successful businesswomen. Her death was a tragedy and has affected her family and friends deeply.
- 6.1.2 For many of those close to Bishakha, this tragedy is made more difficult because it appears so inexplicable. Those closest to Bishakha knew that Bishakha and Manav were having difficulties, not least because of Manav's issues at work and his mental health, and that this had led to some tension and relationship conflict. However, no one had any concerns that domestic violence and abuse was an issue or imagined that a homicide might be the outcome.
- 6.1.3 That has been a challenge for the Review Panel. It may be that there was no prior history of domestic violence and abuse. Alternatively, it may be that Bishakha had experienced domestic violence and abuse from Manav but had, for a number of reasons, not disclosed this to friends, families or agencies. Sadly, it is not possible to know.
- 6.1.4 However, whatever the situation, this homicide was not 'out of the blue'. There were ongoing difficulties between Bishakha and Manav and, in the run up to the homicide, there was a confrontation relating to separation. This latter issue is a well-established risk indicator in domestic homicide.
- 6.1.5 Manav's mental health was also deteriorating in the early part of 2016. While he and Bishakha sought help for this, and he accessed a range of services, it seems that the extent of his suicide ideation was not fully identified. Manav's deteriorating mental health, particularly around feelings of hopelessness, could have been more fully explored. If this had happened, this might have led to him receiving a more comprehensive assessment and possibly treatment. This is also important given that mental health is a risk indicator in domestic homicide.
- 6.1.6 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Bishakha and Manav's lives that might help explain the circumstances of the homicide. Second, to use this case to consider a wider range of issues locally, including provision for victims of domestic violence and abuse from BAME communities.
- 6.1.7 The Review Panel would like to extend their sympathies to all those affected by Bishakha's death.

6.2 Lessons To Be Learnt:

- 6.2.1 The most important learning in this case relates to mental health provision. Manav sought support from a number of different health providers. For the most part the response was appropriate. However, the review has identified important learning for both NHS 111 and IAPT services relating to both assessment, the management of risk and onward referral into secondary care.
- 6.2.2 The review of this case has also thrown a light on aspects of the local partnership response, suggesting that existing work could be further developed. This includes developing work in primary care, as well as work with fee charging schools to build on the existing response to domestic violence and abuse.
- 6.2.3 Examples of good practice have been identified, including the existing work locally around employer policies relating to domestic violence and abuse. It is also clear that Bishakha, Child A and Manav were, for the most part, able to access timely and appropriate health provision.
- 6.2.4 This review has identified wider learning relating to domestic violence and abuse. This has included exploring issues of male entitlement, as well as increased awareness of triggers that could indicate a domestic homicide risk, and how the intersection of different aspects of someone's identities (including Race, Sex and Socio-Economic status) might impact their experiences and the help and support they seek. In this case it is hard to know whether, if Bishakha had experienced a wider pattern of domestic violence and abuse, she would have faced barriers associated with her Socio-Economic status or her Race. The Review Panel has considered both issues and also the specific matter of specialist provision for BAME communities more generally. This has led to recommendations for work on these issues locally and across Surrey. That work should include ensuring that awareness raising campaigns and services are accessible, as well as equipping professionals to respond appropriately to domestic violence and abuse in these communities.
- 6.2.5 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is true for agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

7. Recommendations:

7.1 IMR Recommendations (Single Agency):

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

SECamb

- 7.1.2 In line with a concurrent DHR in Kent and Medway, following the success of the SECamb Domestic Abuse pilot, consideration would be given into scoping with other agencies [about] how SECamb can feedback into the Multi-Agency Risk Assessment Conference (MARAC) in the absence of a Domestic Abuse coordinator / specialist.
- 7.1.3 The SECamb Safeguarding Team and Safeguarding Lead will also look into additional training for those working for the Helicopter Emergency Medical Service (HEMS) to support their VP referral writing to ensure sufficient information is recorded for the local authority to record and address their concerns. Given the chaotic nature of incidents attended by HEMS, acquiring information for social care can be distracting when addressing an immediate clinical need, however SECamb will strive to work with HEMS in order to improve quality referrals in future and how to work with SECamb colleagues for information sharing following an incident such as the one centred around this IMR.

Maternity Services

- 7.1.4 The importance of the routine enquiry into the presence or potential for pregnant women to be the victim of domestic abuse should continue to be asked at the booking in appointment and at 28 weeks and 34/36 weeks to identify if the domestic abuse has started in pregnancy or escalated.
- 7.1.5 The importance of contemporaneous record keeping needs to remain a high priority in order for the potential risks to mother and her unborn to be clearly identified within the patient health records, so an appropriate multi-agency plan can be formulated to safeguard and support the victim.
- 7.1.6 The value of asking the routine enquiry questions prior to discharge home from the postnatal ward to be explored.

Health Visiting

- 7.1.7 CSH Surrey Breast Feeding Clinics offer the opportunity for privacy however this will be explicit within literature and discussions with parents so that there can be no misunderstanding about an expectation to feed in a public area.

- 7.1.8 Continuing support from Learning and Development team to further develop the Domestic Abuse training offer across the service and incorporate within mandatory training for all clinical employees and to monitor DA training compliance across CSH Surrey.
- 7.1.9 Availability of materials to support Domestic Abuse awareness is recognised as a current issue. Whilst posters can be duplicated, flyers, cards and discrete information cards are in more limited supply locally. CSH Surrey will continue efforts to source a regular supply for professionals, clinics and public areas.

Virgin Care

- 7.1.10 Service to review adding prompts on impact of ethnicity/ culture to client/patient records.
- 7.1.11 Service to review how to encourage appropriate professional curiosity and more detailed examination and recording of issues which may impact upon the patient and the family such as the emotional and cultural impact of unemployment.

7.2 Overview Report Recommendations:

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

These recommendations should be acted on through the development of an action plan, with progress reported on to the Elmbridge CSP Partnership within six months of the review being approved.

- 7.2.2 **Recommendation 1:** The SADA partnership to assure itself that the local training strategy, and professional development for Domestic Abuse Champions / Mentors, adequately:
 - Reflects the gendered dynamics of domestic violence, including the concept of 'aggrieved entitlement'
 - Enables professionals to identify potential triggers associated with escalation, including financial issues, depression and suicide ideation.
- 7.2.3 **Recommendation 2:** The Home Office to undertake further research into cases where there no known precursors of domestic violence abuse, and/or the victim/perpetrator have had little contact with statutory services, to develop a profile of these cases.
- 7.2.4 **Recommendation 3:** The Surrey LSCB to work with all schools, including fee charging schools, to promote the inclusion of information on domestic

violence abuse and the help and support available in school literature, including welcome packs for new parents.

- 7.2.5 **Recommendation 4:** The Surrey LSCB to work with all schools, including fee charging schools, to deliver Operation Encompass and ensure that procedures and training to support staff and children are in place.
- 7.2.6 **Recommendation 5:** The Surrey LSCB to work with all schools, including fee paying schools, to develop a programme with local specialist domestic abuse services to promote access to effective and high-quality resources for age appropriate teaching about healthy relationships in classroom settings.
- 7.2.7 **Recommendation 6:** The Department for Education to ensure that the good practice, resources and training developed following the consultation around Sex and Relationship Education and PSHE includes fee charging schools and to work with the sector around its development and implementation.
- 7.2.8 **Recommendation 7:** Care UK to review the findings from this case and undertake a wider case audit to be assured about the standard of current practice in relation to probing around suicidal ideation and, if issues are identified, to develop an improvement plan to address these.
- 7.2.9 **Recommendation 8:** Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the Community-Based Crisis Service by developing a mechanism to allow for direct referrals
- 7.2.10 **Recommendation 9:** Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the GPs by developing a mechanism to allow for direct referrals
- 7.2.11 **Recommendation 10:** Mental Health Commissioners to review the learning from this case and seek assurance that current providers of IAPT services in Surrey have appropriate staff training, procedures and supervision in place in relation to the identification and assessment of risks to self and others.
- 7.2.12 **Recommendation 11:** Mental Health Commissioners to consider the learning from this case and run an engagement event with private mental health care providers in the county to facilitate the dissemination of the review's findings.
- 7.2.13 **Recommendation 12:** The Surrey Health and Wellbeing Board to work with the Surrey CCGs to ensure there is a programme available to all GPs providing training, support and a referral pathway (including access to advocacy) to enable a consistent response to domestic violence and abuse.

- 7.2.14 **Recommendation 13:** The CSP to write to the bank involved in this review to encourage them to develop a domestic violence policy for staff who experience or perpetrate domestic violence and abuse
- 7.2.15 **Recommendation 14:** The CSP to share the findings from this review with the Corporate Alliance against Domestic Violence and the Employers' Initiative on Domestic Abuse and request further consideration of best practice in relation to staff who are employed as contractors (either through an employment agency or if they are self-employed)
- 7.2.16 **Recommendation 15:** The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of BAME communities locally.
- 7.2.17 **Recommendation 16:** The CSP to work with the SADA partnership to develop its training programme to ensure that this addresses the needs of BAME communities locally.
- 7.2.18 **Recommendation 17:** The CSP to scope the requirement for specialist BAME led provision in the borough.
- 7.2.19 **Recommendation 18:** The CSP to work with other bodies in Surrey, including the Office of the Police and Crime Commissioner for Surrey, to ensure that there is access to specialist BAME led services.
- 7.2.20 **Recommendation 19:** The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of victims across the spectrum of Socio-Economic status.

Appendix 1: Domestic Homicide Review

Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Bishakha, Manav and Child A following the death of Bishakha in May 2016. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Bishakha, Manav and Child A during the relevant period of time: 20/05/2011 to 21/05/2016 (inclusive). To summarise agency involvement prior to 20/05/2011.
3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
6. To commission a suitably experienced and independent person to:
 - a) chair the Domestic Homicide Review Panel;
 - b) co-ordinate the review process;
 - c) quality assure the approach and challenge agencies where necessary; and
 - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
8. On completion present the full report to the Elmbridge Community and Safety Partnership and ensure that recommendations are incorporated into the county-wide action plan.

Membership

9. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
10. The following agencies are to be on the Panel:
 - a) Surrey Downs Clinical Commissioning Group
 - b) Community Health Services
 - c) General Practitioner for the victim and [alleged] perpetrator
 - d) Hospital (Kingston Maternity services)
 - e) Local Authority Adult Social Care Services
 - f) Local Authority Children's Social Care Services
 - g) Local Authority Community Safety
 - h) Claremont Fan Court School
 - i) North Surrey Domestic Abuse Outreach
 - j) Surrey & Borders Partnership NHS Foundation Trust (mental health)
 - k) Surrey Police
 - l) Elmbridge Borough Community Support Services – Equalities
11. The Panel recognise that the particular issues in this case are ethnicity and faith and therefore [a BAME specialist service] will be invited to act as expert on this area to advise the Panel.
12. There are no other investigations so no consideration of parallel or joint reviews is necessary.

Collating evidence

13. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
14. Chronologies and IMRs will be completed by organisations known to have had contact with Bishakha, Manav and / or Child A during the relevant time period and produce an Individual Management Review (IMR).
15. Further agencies may be asked to completed chronologies and IMRs if their involvement with Bishakha, Manav and / or Child A becomes apparent through the information received as part of the review.
16. Each IMR will:

- a) set out the facts of their involvement with Bishakha, Manav and / or Child A
 - b) critically analyse the service they provided in line with the specific terms of reference
 - c) identify any recommendations for practice or policy in relation to their agency
 - d) consider issues of agency activity in other areas and review the impact in this specific case
17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Bishakha, Manav and / or Child A in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to Bishakha, Manav and / or KN, this review should specifically consider the following points:
- a) Analyse the communication, procedures and discussions, which took place within and between agencies.
 - b) Analyse the co-operation between different agencies involved with Bishakha, Manav and / or Child A
 - c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
 - d) Analyse agency responses to any identification of domestic abuse issues.
 - e) Analyse organisations' access to specialist domestic abuse agencies.
 - f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
 - g) Analyse the potential impact of ethnicity and/or faith on service accessibility.

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

Development of an action plan

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

20. Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

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

21. Sensitively attempt to involve the family of Bishakha in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Victim Support Homicide Service who are currently engaged with the family⁴⁷.
22. Invite Manav to participate in the review, following the completion of the criminal trial and liaising closely with Surrey Police to ensure that there is no impact on the criminal justice proceedings.
23. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Media handling

24. Any enquiries from the media and family should be forwarded to the Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.
25. The Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

⁴⁷ *Postscript:* after initially receiving support from the Victim Support Homicide Service, since April 2017 the family have been supported by AAFDA.

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

Disclosure

29. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

30. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:

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

Appendix 2: Single Agency Recommendations and Action Plan

SECAMB

Recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion / Outcome
In line with a concurrent DHR in Kent and Medway, following the success of the SECAMB Domestic Abuse pilot, consideration would be given into scoping with other agencies [about] how SECAMB can feedback into the Multi-Agency Risk Assessment Conference (MARAC) in the absence of a Domestic Abuse coordinator / specialist	SECAMB to attend MARAC and present cases where appropriate	SECAMB	SECAMB aware of MARAC referral process Surrey Police to make SECAMB aware of MARAC meeting dates	December 2019 December 2019	October 2018: If SECAMB raise a case as a professional referral we would, of course attend to present the case, otherwise, I think we are some way off being able to attend each of the meetings in our region particularly given the amount of preparation required to review each case.
The SECAMB Safeguarding Team and Safeguarding Lead will also look into additional training for those working for the Helicopter Emergency Medical Service (HEMS) to support their VP referral writing to ensure sufficient information is recorded for the local authority to record and address their concerns		SECAMB / Air Ambulance Kent	SECAMB update working relationship with HEMS Safeguarding processes to be	November 2019	SECAMB have re-vamped and updated working arrangements with HEMS. Safeguarding forms are now electronic and the way the forms are presented to the operational teams have changed.

			improved		Essentially when the crew click to report a safeguarding matter a series of prompts by way of questions are raised. This should ensure that all the required information that will be useful is able to be considered. AK have raised an internal incident related to this. This ensures that all operational members of staff are aware of the issue and it will be discussed at the team meetings
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Maternity Services

Recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion / Outcome
The importance of the routine enquiry into the presence or potential for pregnant women to be the victim of domestic abuse should continue to be asked at the booking in appointment and at 28 weeks and 34/36 weeks to identify if the domestic abuse has started in pregnancy or escalated					No response received. Information requests sent: 20/11/18, 16/11/18, 09/11/2018 and 20/09/18
“The importance of contemporaneous record keeping needs to remain a high priority in order for the potential risks to mother and her unborn to be clearly identified within the patient health records, so an appropriate multi-agency plan can be formulated to safeguard and support the victim					No response received. Information requests sent: 20/11/18, 16/11/18, 09/11/2018 and 20/09/18
The value of asking the routine enquiry questions prior to discharge home from the postnatal ward to be explored					No response received. Information requests sent: 20/11/18, 16/11/18, 09/11/2018 and 20/09/18

Health Visiting

Recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion / Outcome
<p>CSH Surrey Breast Feeding Clinics offer the opportunity for privacy however this will be explicit within literature and discussions with parents so that there can be no misunderstanding about an expectation to feed in a public area</p>	<p>Not specified in document provided to the Head of Safeguarding, so agreed action unknown.</p>	<p>CSH</p>	<p>Not specified in document provided to the Head of Safeguarding, so agreed action unknown</p>	<p>Unspecified</p>	<p>This response was completed by the Interim Head of Safeguarding on 16th November 2018 who was not present when the DHR occurred.</p>  <p>IMG_0011.JPG</p> <p>CSH has in place a parents guide to our breastfeeding policy. This is available in all clinics as above image. We are a UNICEF Baby Friendly organisation at Level 3. This is therefore an expectation to achieve this level of status.</p>
<p>Continuing support from Learning and Development team to further</p>	<p>Not specified in document</p>	<p>CSH</p>	<p>Not specified in document</p>	<p>Not specified in document provided</p>	<p>We have a training offer in place that includes DV. This</p>

<p>develop the Domestic Abuse training offer across the service and incorporate within mandatory training for all clinical employees and to monitor DA training compliance across CSH Surrey</p>	<p>provided to the Head of Safeguarding, so agreed action unknown</p>		<p>provided to the Head of Safeguarding, so agreed action unknown.</p>	<p>to the Head of Safeguarding, so agreed action unknown.</p>	<p>is an online offer and a face to face offer. We also have a DV lead in the safeguarding team with a Named Nurse lead. Learning and develop training compliance and these are reported via governance arrangements.</p>
<p>Availability of materials to support Domestic Abuse awareness is recognised as a current issue. Whilst posters can be duplicated, flyers, cards and discrete information cards are in more limited supply locally. CSH Surrey will continue efforts to source a regular supply for professionals, clinics and public areas</p>	<p>Not specified in document provided to the Head of Safeguarding, so agreed action unknown.</p>	<p>CSH</p>	<p>Not specified in document provided to the Head of Safeguarding, so agreed action unknown.</p>	<p>Not specified in document provided to the Head of Safeguarding, so agreed action unknown.</p>	<p>Each clinic has a DV poster as outlined in image below</p>  <p>IMG_0012 DV.JPG</p> <p>We have a range of leaflets and credit cards that are provided for service users and continued to be resourced and sourced, albeit that there are no ring fenced resources for this work.</p>

IAPT service (provided by Virgin Care)

Recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion / Outcome
Service to review adding prompts on impact of ethnicity/ culture to client/patient records	EBC contact new provider to ensure fully aware of recommendations	EBC/IAPT	New IAPT provider to take recommendations into account and provide written response to EBC	January 2018	<i>Virgin Care are no longer providing this service within the Elmbridge area. New providers for Surrey can be found at: http://www.surreydownsccg.nhs.uk/conditions-and-treatments/mental-health-wellbeing/</i>
Service to review how to encourage appropriate professional curiosity and more detailed examination and recording of issues which may impact upon the patient and the family such as the emotional and cultural impact of unemployment	EBC contact new provider to ensure fully aware of recommendations	EBC/IAPT	New IAPT provider to take recommendations into account and provide written response to EBC	January 2018	<i>Virgin Care are no longer providing this service within the Elmbridge area. New providers for Surrey can be found at: http://www.surreydownsccg.nhs.uk/conditions-and-treatments/mental-health-wellbeing/</i>

Appendix 3: DHR Recommendations and Action Plan

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion / Outcome
<p>Recommendation 1: The Domestic Abuse Management Board (DAMB) to assure itself that the local training strategy, and professional development for Domestic Abuse Champions / Mentors, adequately:</p> <ul style="list-style-type: none"> ○ Reflects the gendered dynamics of domestic violence, including the concept of ‘aggrieved entitlement’ ○ Enables professionals to identify potential triggers associated with escalation, including financial issues, depression and suicide ideation 	Countywide	CSP to write to DAMB	DAMB	DAMB acknowledge recommendation DAMB to undertake necessary work	March 2019	
<p>Recommendation 2: The Home Office to undertake further research into cases where there are no known precursors of domestic violence abuse, and/or the victim/perpetrator have had little contact with statutory services, to develop a profile of these cases</p>	National	CSP to write to the Home Office requesting further research	HO/EBC	Elmbridge CSP to share action plan with Home Office Home office to acknowledge need for research Home Office to commission research Home Office to provide report	March 2019	
<p>Recommendation 3: The Surrey LSCB</p>	Countywide	CSP to write to	Surrey	LSCB acknowledge	September	

to work with all schools, including fee charging schools, to promote the inclusion of information on domestic violence abuse and the help and support available in school literature, including welcome packs for new parents		LSCB	LSCB	recommendation	2019	
Recommendation 4: The Surrey LSCB to work with all schools, including fee charging schools, to deliver Operation Encompass and ensure that procedures and training to support staff and children are in place	Countywide	CSP to write to LSCB	Surrey LSCB	LSCB acknowledge recommendation	September 2019	
Recommendation 5: The Surrey LSCB to work with all schools, including fee paying schools, to develop a programme with local specialist domestic abuse services to promote access to effective and high-quality resources for age appropriate teaching about healthy relationships in classroom settings	Countywide	CSP to write to LSCB	Surrey LSCB	LSCB acknowledge recommendation	September 2019	
Recommendation 6: The Department for Education to ensure that the good practice, resources and training developed following the consultation around Sex and Relationship Education and PSHE includes fee charging schools and to work with the sector around its development and implementation	National	CSP/EBC to write to DfE	DfE/EBC	Letter sent	September 2019	

<p>Recommendation 7: Care UK to review the findings from this case and undertake a wider case audit to be assured about the standard of current practice in relation to probing around suicidal ideation and, if issues are identified, to develop an improvement plan to address these</p>	<p>Single Agency</p>	<p>Identify suitable cases involving suicidal ideas and produce a cohort of cases for auditing</p> <p>Use of 5 cases identified by the Senior BI Analyst for an audit levelling session.</p> <p>Selective audit of 10% of cases over three-month period which involve clinicians assessing a caller with suicidal ideas by the medical leads. Following audit review discussion between regional medical leads as to competency and potential support and training required</p>	<p>Care UK</p>	<p>Suitable cases identified 1/11/2018</p> <p>Use 5 cases for audit 31/12/2018</p> <p>Selective audit by 1/2/2019</p>	<p>March 2019</p>	<p>In progress</p>
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	<p>for Clinical Advisors. Utilisation of West Midlands CAS mental health Nurses to develop short training module in “recognising the high risk patient”.</p> <p>Consideration of implementation of training including Mental Health First Aid for substantive clinical staff to support talking to patients with mental health problems.</p> <p>Review of Aastra support tool on Out Of Hours platform as to suitability for clinical advisors within 111 system and if appropriate</p>		<p>Implement training for by 1/3/2019</p>		
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		submitting change request to Business Systems for implement on 111Adastra platform.				
Recommendation 8: Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the Community-Based Crisis Service by developing a mechanism to allow for direct referrals	Countywide	CCG work with NHS111 and SABP	CCGs	Pathway for direct referrals between 111 and SABP SPOC established	April 2019	In progress
Recommendation 9: Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the GPs by developing a mechanism to allow for direct referrals	Countywide	CCG work with NHS111 and SABP	CCGs	Pathway for direct referrals between 111 and SABP SPOC established	April 2019	In progress
Recommendation 10: Mental Health Commissioners to review the learning from this case and seek assurance that current providers of IAPT services in Surrey have appropriate staff training, procedures and supervision in place in relation to the identification and assessment of risks to self and others	Countywide	CCG to take recommendations to IAPT to pick up on risk	CCGs	N/A	No date given	In progress
Recommendation 11: Mental Health Commissioners to consider the learning from this case and run an engagement	Countywide	CCG to establish relevant	CCGs	Discussion takes place at CQRM	No date given	In progress

event with private mental health care providers in the county to facilitate the dissemination of the review's findings		recommendations CCG to discuss with Mental Health Provider at CQRM meeting		meeting		
Recommendation 12: The Surrey Health and Wellbeing Board to work with the Surrey CCGs to ensure there is a programme available to all GPs providing training, support and a referral pathway (including access to advocacy) to enable a consistent response to domestic violence and abuse	Countywide	CSP to write to Surrey Health and Wellbeing Board	Surrey Health and Wellbeing Board	Surrey Health and Wellbeing Board acknowledge recommendation Update provided	September 2019	
Recommendation 13: The CSP to write to the bank involved in this review to encourage them to develop a domestic violence policy for staff who experience or perpetrate domestic violence and abuse	Single Agency	CSP to write to the bank outlining the recommendation	EBC	Letter sent Acknowledgement received Action taken by the bank	Nov 2018	
Recommendation 14: The CSP to share the findings from this review with the Corporate Alliance against Domestic Violence and the Employers' Initiative on Domestic Abuse and request further consideration of best practice in relation	National	CSP to share the findings from this review with the Corporate	EBC	EBC to write to Corporate Alliance	February 2019	In progress

to staff who are employed as contractors (either through an employment agency or if they are self-employed)		Alliance against Domestic Violence and the Employers' Initiative on Domestic Abuse				
Recommendation 15: The Elmbridge CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of BAME communities locally	Local / Countywide	CSP to explore joint needs assessment with SADA	EBC/DAMB	Letter received by SADA Partners to meet and discuss campaign	March 2019	In progress
Recommendation 16: The Elmbridge CSP to work with the DAMB to develop its training programme to ensure that this addresses the needs of BAME communities locally	Local / Countywide	CSP to write DAMB CSP representative to attend DAMB	EBC/DAMB	Needs assessment undertaken	March 2019	In progress
Recommendation 17: The CSP to scope the requirement for specialist BAME led provision in the borough	Local	Work with SADA to undertake needs assessment and explore specialist provision	EBC	Needs assessment Scoping undertaken	March 2019	In progress

<p>Recommendation 18: The Elmbridge CSP to work with other bodies in Surrey, including the Office of the Police and Crime Commissioner for Surrey, to ensure that there is access to specialist BAME led services</p>	<p>Local / Countywide</p>	<p>Work with SADA to undertake needs assessment with SADA</p> <p>Write to OPCC</p>	<p>EBC</p>	<p>Letter received by PCC</p> <p>Needs assessment undertaken</p>	<p>March 2019</p>	<p>In progress</p>
<p>Recommendation 19: The Elmbridge CSP to work with the DAMB to develop its awareness raising campaign so that this addresses the needs of victims across the spectrum of Socio-Economic status</p>	<p>Local / Countywide</p>	<p>CSP to review campaigns and look at best practice regarding targeted campaigns</p> <p>CSP to liaise with DAMB</p>	<p>EBC/DAMB</p>	<p>CSP representative attend DAMB</p> <p>Discuss action at DAMB</p>	<p>March 2019</p>	<p>In progress</p>

Appendix 4: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
A&E	Accident & Emergency
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic
CCR	Coordinated Community Response
CCG	Clinical Commissioning Group
CSH	Central Surrey Health
CQC	Care Quality Commission
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
EDT	Emergency Duty Team
FLO	(Surrey Police) Family Liaison Officer
GAD-7	Self-administered patient questionnaire for Generalised Anxiety Disorder
GP	General Practitioner
HEMS	(SECAmb) Helicopter Emergency Medical Service
IAPT	Improving Access to Psychological Therapies Service
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety
IAPS	Independent Association of Prep Schools
IAPT	Improving Access to Psychological Therapies
ISC	Independent Schools Council
ISI	Independent Schools Inspectorate
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
PSHE	Personal, social, health and educational
PHQ-9	Self-administered patient questionnaire for depression
SAB	Safeguarding Adults Board
SADA	Surrey Against Domestic Abuse
SAFE	(STADV) Safety Across Faith and Ethnic Communities
SECAmb	South East Coast Ambulance Service
SSRI	Serotonin Specific Reuptake Inhibitor
STADV	Standing Together Against Domestic Violence
VP	Vulnerable Person

Appendix 5: Home Office Letter

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Annabel Crouch
Policy Manager
Organisational Development
Elmbridge Borough Council

15 May 2019

Dear Ms Crouch,

Thank you for submitting the Domestic Homicide Review (DHR) report for Elmbridge ('Bishakha') to the Home Office Quality Assurance Panel. The report was considered at the panel meeting on 24 April 2019.

The Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a sensitive, detailed report despite the limited agency contact with the victim and perpetrator. The Panel particularly commended the articulation of the financial pressures within the relationship and the input of family, friends and the perpetrator to the review helps a reader understand the victim and the challenges she faced within her marriage. The Panel also commended the breadth and expertise on the review panel. The Panel would also like to highlight that attaching the DHR to the child's social care report was considered an example of best practice.

There were, however, some aspects of the report which the Panel felt may benefit from additional comment, further analysis, or be revised, which you will wish to consider:

- Paragraph 5.1.24 concludes that there is little practice guidance into cases with this profile. The Panel felt it would be helpful to specifically set out what that profile is and to whom any practice guidance that is developed would be targeted at;
- In relation to recommendations for the Local Safeguarding Children's Board (LSCB) to work with schools, you may wish to also consider a specific recommendation for the LSCB to work with the Independent Schools Inspectorate in relation to independent schools;
- The Panel felt the recommendations and actions in the action plan could be made more pro-active. For example, there is little confidence that writing letters is likely to result in practice changes;
- The list of agencies to whom the completed report will be disseminated (1.13) should also include the Police & Crime Commissioner.

The Panel does not need to review another version of the report, but I would be grateful if you could email us at DHREnquiries@homeoffice.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Charlotte Hickman

Joint Chair of the Home Office DHR Quality Assurance Panel