LONDON BOROUGH OF REDBRIDGE

COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

FINAL OVERVIEW REPORT

AYESHA AGED 35

MURDERED IN NOVEMBER 2018 IN REDBRIDGE

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

16 MAY 2021

Domestic Violence Homicide Review Panel – LB Redbridge CSP
Ayesha aged 35, murdered in Redbridge November 2018

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INTRODUCTION

1. Early one morning in mid-November 2018, police were called to a family home in Redbridge, where Ayesha[1] aged 35 had been fatally injured by a crossbow arrow. Ayesha's unborn child survived the attack. Her former husband, Kasun aged 51, was arrested at the scene and subsequently charged with her murder. The first trial of Kasun for murder at the Central Criminal Court in April 2019 was halted for legal reasons. A second trial concluded in the following November when he was found guilty and sentenced to Life Imprisonment with a minimum of 33 years to be served.

2. This report of a domestic homicide review examines agency responses and support given to Ayesha prior to her murder. 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.

3. The key purpose for undertaking Domestic Homicide Reviews (DHR) is to enable lessons to be learned from homicides where a person is killed because of domestic violence. 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 to reduce the risk of such tragedies happening in the future.

4. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with the 'voice' of Ayesha at the heart of the process. Through the Chair, the Panel have offered Ayesha's family their heartfelt condolences upon their loss.

TIMESCALES

5. The Redbridge Community Safety Partnership (CSP) decided on the basis that there had been an intimate relationship that a DHR should be commissioned and partners were asked to secure and retain relevant records. Due to the pending criminal trial, the review began with the appointment of the Chair in March 2019. The police provided a briefing as the trial was imminent and facilitated a meeting with family at the Central Criminal Court in April. For legal reasons, that trial was not concluded and the Jury discharged by the Judge. The Crown Prosecution Service (CPS) directed that the DHR process should be paused until a second trial which concluded in November 2019.

6. The first Panel meeting was held that month when Terms of Reference (ToR version 3 - Appendix 1) were discussed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Ayesha and Kasun to be returned by 3 January 2020. The next meeting was set for 20 January for the purpose of reviewing the chronologies and commissioning of Individual Management Reviews (IMR) for return by 6 March. The third meeting set for April was cancelled due the Covid-19

[1] All names have been anonymised and children allocated initial letters

pandemic and the process temporarily placed on hold. In July, it was decided to draft the narrative section based on reports to hand and information from family. It was circulated for feedback in August and a second version circulated for review in September. There was an ongoing police misconduct investigation that limited further discussion until its conclusion in March 2021. A third version was discussed via a 'Teams' virtual meeting in April and a fourth version circulated for comment. The Chair presented a summary of the final version at the Community Safety Partnership Board on 13 May, with an anonymised version to be signed off by the co-chairs of the CSP before forwarding to the Home Office.

CONFIDENTIALITY

7. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

8. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased, her second husband, Imran and perpetrator will be referred to by first name. Initial letters have been allocated to children and are also listed in the glossary at the end of the report:

    Child A male aged 17
    Child B male aged 15
    Child C female aged 12
    Child D female aged 4
    Child E female aged 18 months
    Child F male born on day of homicide

9. The Government Security Classifications (GSC) system was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

10. Following discussion of a draft in the first Panel meeting, the ToR at appendix 1 were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. A third version was issued on 24 January 2020. This sets out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and may be seen in full in appendix 1. The main lines of inquiry were:
    1. Scope of review agreed from January 2012 to the date of homicide with any earlier event of significance to be included
    2. To manage interface with parallel investigations. The Chair attended the first murder trial in April 2019 and met Imran and again at the second trial hearing in the following November. There has been a Metropolitan Police Service internal disciplinary investigation concluding in March 2021.
    3. Identify relevant equality and diversity considerations, including Adult Safeguarding issues (see paragraph 21)
    4. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour from the perpetrator to

the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware of any abuse by the perpetrator and of any barriers experienced by Ayesha in reporting abuse, or best practice that facilitated reporting it (see paragraphs 15-16)

5. Take account of previous lessons learned in LB Redbridge
6. Identify how people in the LB of Redbridge gain access to advice and support on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague

METHODOLOGY

11. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by the London Borough of Redbridge (LBR) Community Safety Partnership (CSP) and, in March 2019, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel.

12. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).

13. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - Standing Together MOPAC Study of London DHRs October 2019
    - Redbridge Council website and related services

14. In addition, three historical DHR reports were studied for any parallel lessons or repeat lessons to be learned and none were identified.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

15. Following appointment, the Chair met with Ayesha's parents and sister, who had travelled from Mauritius, at the Central Criminal Court with the assistance of a French-speaking interpreter and a French version of the Home Office leaflet for families provided. The advocacy section was highlighted. He also met briefly with Imran to explain the DHR process and the Home Office leaflet provided. As he was a witness at the trial, they agreed to meet again which, due to the CPS direction, did not happen until the conclusion of the second trial in November 2019. The opportunity for Imran to attend the Panel to ask questions was left open. With the assistance of the Family Liaison Officer, Imran was provided with this version of the overview for comment. He made it known that, with responsibility for six children and a building business to run, he wished not to engage further with the review and to move on with his life.

16. The establishment where Kasun is being held was identified with a view to inviting his involvement but visiting was suspended during the pandemic. A request for a private video interview with the Chair facilitated by the Probation Service was not responded to, despite a reminder a few weeks later.

CONTRIBUTORS TO THE REVIEW

17. This review report is an anthology of information and facts from the organisations represented on the Panel, some of which were potential support agencies for Ayesha and Kasun:

    Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Group (CCG)
    Barking, Havering and Redbridge University NHS Trust (BHRUT)*
    Bart Health NHS Trust (in the form of a Serious Incident Review)*
    London Ambulance Service (LAS)
    London Borough of Redbridge (LBR) Children's Social Care (CSC)*
    Victim Support London*
    Refuge (Provided specialist domestic abuse advice and a cultural perspective)
    Metropolitan Police Service (MPS)*
    *IMR provided by a senior independent manager and shared with Panel members

THE REVIEW PANEL MEMBERS

18. *Table 1 – Review Panel Members*

Name	Agency/Role
Valerie Scanlan	LB Redbridge Senior Community Safety Officer
Eve McGrath	Designated Nurse for Adult Safeguarding, Barking and Dagenham, Havering and Redbridge CCG
Catherine Worboyes	LB Redbridge Children's Social Care Head of Child Protection
Daniella Capasso	Barking, Havering and Redbridge University NHS Trust, Named Midwife, Safeguarding & Lead Midwife for CDR & Harmful Practices
Andrew Meekings	Operations Manager Victim Support
Liz Gaunt	Detective Inspector, MPS Serious Crime Review Group

Julia Dwyer	Refuge, Senior Operations Manager
Naveeda Chaudri	Refuge, Service Manager for South Asian Specialist Service
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

19. Bill Griffiths is the author of the overview report. He is a former police officer who has had no operational involvement in LB Redbridge. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010. Set out for reference in appendix 2 are the full respective backgrounds and 'independence statements' for Bill Griffiths and Tony Hester who managed the review process and liaison with the CSP and Panel. Since 2013, they jointly have been involved in more than twenty DHRs.

PARALLEL REVIEWS

20. The Criminal Trial concluded in December 2019. An Inquest has been opened by the Coroner and closed following the criminal conviction. The police misconduct investigation concluded in March 2021 and the outcome set out later in this version.

EQUALITY AND DIVERSITY

21. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided
    Age – Ayesha was 17 and Kasun was 31 when they entered an arranged marriage in Mauritius. Some research suggests that a substantial age difference (in this case 14 years) can be seen to create a further power imbalance[2]
    Disability – Neither was known to have a disability
    Gender reassignment – neither party had been, nor were known to be considering, gender reassignment
    Marriage and civil partnership – their arranged marriage commenced in 1999 and they were divorced in 2014. At the time of the fatal incident, Ayesha was married to Imran
    Pregnancy and maternity – Ayesha was almost full term pregnant with Child F when she was murdered

[2] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009). *Partner Exploitation and Violence in Teenage Intimate Relationships*. London: NSPCC

Race – Ayesha and Kasun were both of South Asian heritage, having been born in Mauritius
Religion or belief – Ayesha was Hindu, converted to Christianity in her teens and then to Islam when she married Imran. Kasun was Hindu by faith
Sex – Ayesha was female and Kasun is male. Records show that the majority (74%) of victims of domestic homicide were female and that 80% of that number were killed by a partner or ex-partner[3]
Sexual orientation – the sexual orientation for each is believed to have been heterosexual

22. The Panel have discussed whether there is evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report. There is nothing observed 'in plain sight', however, stereotypical assumptions arising from their South Asian heritage cannot be ruled out. Ayesha's vulnerability as a female involved in an arranged marriage could have lead to stereotyping. Her situation should have prompted professional curiosity regarding possible honour based abuse. Her experience of the Criminal Justice System when she did seek assistance may have undermined her confidence and informed her responses when engaging with authority thereafter. These issues and the intersectionality of the applicable protected characteristics will be explored in the context of the report.

DISSEMINATION

23. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

[3] Office for National Statistics, Homicide in England and Wales - year ending March 2018, www.ons.gov.uk

BACKGROUND INFORMATION (THE FACTS)

24. Ayesha was born in Mauritius in 1983 and raised as a Hindu. She was fondly known by a family name. When aged about 13 she converted to Christianity and was devoted to prayer. Her family remember her as always "smiley and welcoming" and someone who loved to entertain for family celebrations and dress up for the occasion. She was exceptionally kind and could not do enough for others.

25. In 1999 when aged 17 she married Kasun, then aged 31. It was an arranged marriage and he was considered a "good catch" for her because he was a senior nurse at Newham General Hospital (NGH) in East London and owned property. Following the wedding in Mauritius and when pregnant with Child A, Ayesha moved in with Kasun to a house in LB Newham.

26. They had three children together, two boys and a girl, before moving to Redbridge in the neighbouring Borough of Redbridge. A local builder, Imran, originally from Pakistan, undertook some renovation work on the property next door and he and Ayesha struck up a friendship. When Ayesha and Kasun separated in 2012 due to Kasun's domestic abuse toward Ayesha, the friendship developed and, following the divorce from Kasun in 2014, Ayesha converted to Islam, married Imran and changed her name. Kasun returned to, and partially rented out, the Newham property.

27. Imran recalls Ayesha's account of her marriage to Kasun. He looked down on her from the beginning, judging her for coming from a poor family. Kasun paid off some of her family's debts and Ayesha was constantly reminded of that. She was required to cook for him and he would eat separately. When out of the house, he would walk 20 steps ahead of her. If she spent money that he had not approved in advance, he would be angry and 'punish' her by not speaking at all for periods up to two months.

28. He did not bond with the children and was very strict with them. He would supervise their mealtimes and would beat them for their table manners. When he and Ayesha argued about the terms of the divorce, Ayesha reported that Kasun said he: "Did not give a damn about the kids". He was solely concerned about the financial situation and was very resentful that Ayesha and the children would benefit from the house.

29. Following their marriage, Ayesha and Imran settled at the house in Redbridge with her three children and had two daughters together. Two male lodgers occupied rooms in the loft space. At the time of the fatal incident, Ayesha was almost full term with her sixth child, a son who was delivered relatively unharmed by Caesarian Section when she was airlifted from the scene to the Royal London Hospital (RLH) after Kasun had shot her with a crossbow arrow. Despite strenuous efforts, Ayesha was beyond saving and died from internal injuries caused by the arrow.

Timeline of what was known to agencies

2012

30. One morning in late February, Ayesha called the London Ambulance Service (LAS) to the Redbridge home because Kasun had threatened to harm himself and she said that this was connected to an ongoing divorce. The LAS contacted police who were first to arrive. It was established that Kasun had taken a cannula[4] home from his place of work and inserted it into his arm allowing blood to freely flow.

31. Kasun indicated that he had threatened to self-harm in order to dissuade his wife from completing the divorce process. He said he would not carry out the threat further. Following assessment, he was taken to King George Hospital (KGH) Emergency Department. That afternoon, the staff nurse on duty called police to report that Kasun had left the hospital without being discharged and that he was possibly suicidal. Officers attended the home again and found Kasun apparently safe and well. He had tidied up the house and was cooking a meal. He was clear that he did not require medical treatment and would not be returning to KGH. The incident did not lead to the generation of any other reports such as MERLIN[5] which would have been best practice. Given Kasun's occupation and potential access to medicines and drugs, it would have been prudent to have considered notifying his employer to reduce the possibility of further self-harm. Due to the passage of time and changes in procedures, the IMR author has not made any recommendation regarding this incident[6].

32. One afternoon about a week after that, Ayesha called police to the home. She told the call handler that she was going through a divorce and did not feel safe around Kasun. She alleged that he had taken her bedroom door key from her and when she arranged for a workman to come and fit a new lock, Kasun had turned him away. She added that her mother had told her that morning by telephone from Mauritius that Kasun had said to her: *The way I am feeling right now, I could kill someone, do you want me to go to jail?* It seems that there were no patrols available to respond to this this call as the expectation would have been that a risk assessment should be undertaken. The record does not show the reason this did not happen and the IMR author has insufficient information to take enquiries further.

33. The next morning, Kasun called police and alleged that Ayesha had become verbally abusive and he was concerned for his safety. He said they were currently going through a divorce and she was slamming doors and throwing things around. He asked for officers to attend to help calm the situation. Within 15 minutes of that Ayesha called from her car outside the home to enquire where the officers were. She said that she and her husband had an argument that morning. He had entered the room where she was sleeping with the children and started throwing things around so she had left.

[4] A thin tube inserted into a vein or body cavity to administer medication or drain fluid
[5] The police form for sharing incident reports with other agencies
[6] It is not known if his employer was notified

34. In a telephone call from Kasun which was made about the same time another officer ascertained that he had been advised by his solicitor to call police every time he had a disagreement with his wife. He alleged that during this disagreement his wife had indicated she could not wait for him to move out of the family home, leading him to fear she would call police to complain about him so he had decided to make the call himself. Meanwhile, Ayesha had made another call to report that she had missed police attendance because she had left the scene to visit her solicitor's office. A 'non-crime' domestic incident was recorded and Ayesha was invited to attend the local Police Station for advice.

35. The incident report records that appropriate advice was given to both parties regarding correct use of the emergency calling system. They had also advised Kasun that he should consider moving to an alternative address if possible. A DASH (Domestic Abuse Stalking and Honour-based violence) risk assessment was completed and graded as 'standard'[7] risk which was confirmed by a supervisor who assigned the report to the Community Safety Unit[8] (CSU) for follow up and advice.

36. A few days later in early March a CSU investigator attempted to make contact with Ayesha by telephone, however the call was not answered. In line with extant policy, the CSU forwarded a DA advice pack with covering letter explaining how she could obtain further advice or assistance. This is concerning practice because of the risk of discovery by Kasun who could escalate the abuse as a result. Practice since 2012 has moved on and the posting of an advice pack would not happen unless it could be verified Kasun was no longer resident.

37. Meanwhile, a further incident was reported late one evening when Kasun called police saying that his wife had gone out earlier with their three children and had not returned. He said that he had no idea where they were and gave details of the vehicle she was driving. He indicated that he would wait a while longer and then call back if he wanted to make a missing person report. An officer on duty was the same one that had spoken to Ayesha when she attended the local police station for advice, therefore the officer called her mobile number. Ayesha confirmed that she and the children were safe and well, having a meal together in a restaurant. She commented that Kasun had never looked after the children in the past and indicated that he had no reason to be concerned about their whereabouts.

38. One morning in mid-March Ayesha called police and said that she and Kasun had been arguing. He had been verbally aggressive but not violent. She told the call handler that Kasun was downstairs and that she was in an upstairs bedroom, locked in her room with her three children. She added that they were currently going through divorce proceedings. An officer attended within about 90 minutes and there was no sign of Kasun. Ayesha acknowledged that she had no firm basis for calling police and, the officer having noted the earlier similar call in February, gave her "strong words of advice" regarding correct use of the emergency system[9]. The result of the visit was recorded as: 'no cause for police action'.

[7] From: Standard (meaning 'low'), Medium and High
[8] Police officers trained in domestic abuse investigation
[9] Dissuading a victim from seeking support is concerning practice and is commented upon later

39. The IMR author has identified that the fact of the argument was sufficient basis for completion of a 'non-crime' domestic incident report and a MERLIN referral with risk assessment for the information of partner agencies. This was prior to the MASH (Multi Agency Safeguarding Hub) arrangements and the enhanced domestic abuse awareness officer training that followed and therefore the author has concluded that a recommendation is not required.

40. About five days later, the arguments escalated into violence. Police were called to the home by neighbours who could see a woman dangling from a first-floor window. Upon arrival they were met by Ayesha who alleged that Kasun had threatened to kill her and the children a couple of days earlier if she did not move out of the family home. That day he had tried to strangle her with a scarf and some yellow cable. She had barricaded herself in the bedroom before escaping via the window. Ayesha added that he also had a knife and was inside the house with their three children.

41. LAS paramedics were also in attendance and assessed that Ayesha had suffered a broken ankle as a result of the fall from the window. She also had a cut lip and swelling to her neck. She was taken to Whipps Cross Hospital (WCH) for treatment.

42. Kasun emerged from the house and gave himself up to the officers. Later interviews established that Child A (then aged 11) had seen his father in the bathroom on top of his mother, with a cable around her neck and appeared to be strangling her. With his brother Child B (then 9) they struggled with their father who ran downstairs, possibly for a knife, which allowed Ayesha to lock her bedroom door and escape the house.

43. The CPS approved a charge of attempted Grievous Bodily Harm (GBH) with intent for the strangulation and one of GBH for the broken ankle. Kasun was granted bail by the Court and is believed to have returned to the Newham address that he owned. Ayesha was offered assistance with moving which she declined. A panic alarm was fitted and the locks were changed. Ayesha was provided with a personal alarm for when outside of the house.

44. A MERLIN referral was made to Children's Services and evaluated by the Screening Team before referral to the Child Protection and Assessment Team (CPAT). The referral was appropriately rated scale 4, on the Barnardos Risk Assessment Matrix due to the seriousness of the domestic violence incident. The Screening Team Manager in post at the time appropriately applied the threshold and recommended in line with the London Child Protection Procedures, that a Strategy Meeting be convened and progressed with a Section 47 enquiry. This did not happen but, given the seriousness of the incident the police were actively involved as a result of the criminal actions by Kasun and there is evidence of collaboration and information sharing between all relevant agencies.

45. A referral was made to Victim Support and, later in March[10], a Victim Contact Officer (VCO) conducted a DASH risk assessment by telephone. Ayesha disclosed that the threat to kill her would have been completed had her sons not intervened and Kasun was angry with them for "ruining everything" which suggests he had a plan. Kasun's anger appeared focused on the financial issues in the divorce. Ayesha was provided with advice on further

[10] It is not known why there was a delay in the referral but possibly due to Ayesha being treated for her injury

support. When the VCO spoke to Ayesha again towards the end of March, she said that no further support was required and the file was closed.

46. The DASH assessment questionnaire scored 12 and extant policy required that an assessment above 10 should result in a referral to an IDVA (Independent Domestic Violence Advocate)[11]. Victim Support should then work with the IDVA if available and the police to agree the most appropriate agency to lead on the case. That would also possibly result in a referral to the Redbridge MARAC (Multi Agency Risk Assessment Conference) for further risk management and safety planning to be considered. This was a missed opportunity highlighted by the Victim Support IMR author who has also flagged up that a safeguarding referral with respect to the children should have been completed.

47. On that day, Ayesha was granted a non-molestation order to the effect that Kasun could not be close to the home or the children's schools and he could not make contact with them or Ayesha. The divorce she had initiated in February progressed to the next phase.

48. The panic alarm that had been fitted was activated once in April and again in May to which officers responded within minutes but both activations had happened in error.

49. In mid-September, a children's community nurse reported to police that she had visited the home address the previous afternoon and believed that the male who answered the door should not have been there as he had been arrested for assaulting the child's mother and there was a restraining order (probably a bail condition) in place. The child referred to him as 'Dad'. The nurse did not see the mother but could hear some noise upstairs that the child confirmed was her mother. It was later established that 'Dad' was in fact Imran who had established a positive relationship with the children leading to that soubriquet.

50. Before that mistake had been realised and given the earlier level of violence on record, officers had been immediately sent to the home where it was established that Kasun was not there and Ayesha was safe and well. The next morning, a supervisor from the Violent Crime Unit (VCU) sent officers again with the instruction to conduct more thorough enquiries, including a search of the address for Kasun's presence. This demonstrated positive action by both Children's Services and police, driven by welfare concerns for Ayesha and children albeit subsequently found to be unsubstantiated. However, the records for both services lacked clarity and the mistaken impression would later emerge that Kasun and Ayesha had in fact re-joined their relationship.

51. Near the end of September, it was noted that the case was progressed appropriately in line with guidance and legislation. There were no safeguarding concerns identified, Ayesha confirmed there had been no further contact with Kasun and the case subsequently closed to Children's Services.

2013/14

[11] The IDVA service was taken on by Refuge from November 2015

52. In mid-April 2013, at Snaresbrook Crown Court, Kasun was acquitted of the two assault charges. This was not an outcome that would be considered consistent with the evidence and the IMR author called for the Case File to ascertain any lessons. As a result, the Chair interviewed the Investigating Officer (IO). He confirmed that all relevant evidence was heard by the Jury, including Ayesha providing testimony and from an interpreter that had taken the witness statement from Ayesha's mother regarding the veiled threat to kill in February 2012. Video interview evidence from Children A and B was also admitted into evidence by the Judge, subject to the usual caveats regarding their tender age.

53. In his defence, Kasun advanced the hypothesis that it was him telling her that morning that he was finally leaving her that caused Ayesha to have a mental health episode in which she was trying to take her own life with the cable and her scarf. Kasun was trying to prevent her harming herself and he only left the bathroom to find a knife so that he could cut the scarf which was tight around her neck. She had influenced the children to be consistent with her version of events when interviewed. Her jumping from the window was continuance of the attempt to take her own life. The IO felt that the verdict was against the weight of evidence and the Jury had given the benefit of doubt to the accused.

54. In late October 2013, when pregnant with Child D, Ayesha disclosed to a midwife at Queens Hospital the history of domestic abuse by Kasun, described as her 'ex-partner'. She denied current fear of him. This was correctly referred by BHRUT and a Child and Family (C&F) assessment was conducted which did not result in action other than to refer the disclosure to the local MASH (Multi Agency Safeguarding Hub).

55. The screening Senior Practitioner incorrectly analysed the information held on file and despite the confirmation that the male reported in the previous referral was not father, an assumption was made and recorded that Ayesha had "not been open and honest with professionals regarding her relationship with father". The screening Senior Practitioner in post at the time goes on to conclude that the concerns reach level 4 of the Barnardos Domestic Violence Matrix and that a strategy meeting should be considered: "given mother hiding the fact that she rekindled relationship with father and high level of DV reported in the past".

56. This was referred to the police from the MASH and the police IMR notes that an intelligence report contained the information that Ayesha was: "in fear of Kasun and worried that he might come after her as he knew her address and there was no injunction in force"[12]. By this time, the Social Worker concluded there was no ongoing role and no intervention was required.

57. In January 2014, Ayesha and Kasun were formally divorced. In the divorce settlement, Ayesha could live in the house with their children but Kasun retained joint ownership. It is understood that he also resigned from his position with the NHS during 2014. Having married Imran in an Islamic ceremony in June 2014, Ayesha gave birth to Child D.

<u>2015/16</u> No reports

[12] No action was taken by police because of the social services closure decision

2017

58. In February 2017, Ayesha gave birth to Child E.

59. In late November 2017 a member of the public residing on an adjacent street behind Ayesha's home found a rucksack secreted behind an electricity junction box compound. It contained a set of new-looking keys, PVA glue, binoculars, Vaseline, bin bags, large shopping bag, duct tape, Allen keys and barrel lube. There was also a box of unopened prescription medication[13] in Kasun's full name. With the rucksack was a set of collapsible ladders.

60. Police officers took possession of the property. Following the fatal incident in November 2018, this discovery was linked to the perpetrator. The circumstances were referred for investigation to the Department for Professional Standards (DPS). Following the eventual conclusion of this investigation in March 2021, the IMR author has been able to set out and comment on what happened.

61. Having attended the location and collected the items, the two officers returned to the police station and, instead of recording the found property as required, they disposed of it in the refuse bins in the rear yard. Apart from the original record on the CAD (computer Aided Dispatch) system, no report of the find or the circumstances were made on any of the police indices. No further enquiries were made and no reports generated.

62. MPS Policy and guidance for dealing with items of property found in the street is clear. For property found in the street, enquiries are to be conducted to ascertain if the property is proceeds of crime or evidence. If it cannot be adduced that the property is evidence or proceeds of crime, the following items are required to be recorded and retained:

    Cash or any amount of foreign currency
    Property likely to be of significant sentimental or monetary value (Over £5000),
    Property which is easily traceable to a loser/ owner
    Property that poses a hazard or security risk
    Property that contains personal/sensitive information
    Property found in a licensed taxi (Hackney Carriage)
    If the finder is under 18 or employed by any police service
    If the item was found/left within a police building or vehicle.

63. In this find, the medication and keys would fit the 'hazard or security' risk criterion. The policy regarding medication states that a risk assessment should be conducted, consideration given as to whether the loser requires medical care and to deploy resources as appropriate. With a prescribing pharmacy and distinctive patient name on the medication container, it should have been a straightforward task to trace the named person and undertake a risk assessment, as well as ascertain that this might have been essential medication to someone with diabetes. If no further action is required following enquiries, the medication and keys would be marked in the record as: 'for destruction' and disposed of in line with policy.

[13] Generally prescribed for the treatment of diabetes

64. Had the officers correctly made a record it is feasible, but by no means certain, that it could have led to Kasun being identified through the prescription and that may have led to questioning about the purpose of the items found.

65. The DPS concluded that there was a case to answer for misconduct in relation to both officers in relation to their handling and disposal of the items recovered. The matter was referred to East Area (EA) Professional Standards Unit (PSU) to progress the case as a matter of misconduct in relation to Duties and Responsibilities – Code 6, Code of Ethics 2014.

66. A Misconduct Meeting was held in February 2021 in respect of both officers during which they admitted to not recording property recovered in November 2017 according to MPS policy. Each officer expressed remorse in light of what happened some 12 months after that. They were asked about the condition of the property but indicated that it was three years prior, therefore they had limited memory of the state of the property. The outcome of the misconduct meeting was to deal with the breach by way of 'management action' to ensure they handle property according to MPS policy in the future. Apart from 'no further action', sanctions available to the misconduct meeting were: written warning and final written warning. The Police Regulations changed in February 2020 to a 'Reflective Practice Review Process'. When considering an appropriate sanction, the likelihood that the error would be repeated must be taken into account. It is understood that the local management action decision did have in mind the revised regulations when concluding that 'management action' was appropriate in this case.

2018

67. In March 2018, the same member of the public found and referred to police a second discovery from the same place of concealment of more suspicious items: two crossbows, crossbow arrows, a harpoon and a bottle of acid. These items were recorded correctly by the officers but the find was not linked to the one four months earlier because there was no cross-reference available on any searchable police system. Although the informant had mentioned the earlier find to the call operator over the telephone, the member of the public did not mention the earlier find to the officers attending to collect the items. Nothing within this find could have been linked to Ayesha, her address or to Kasun.

68. The IMR author has noted that these items were seized and dealt with in accordance with MPS policy by booking them into the property stores. The weapons were made safe and a Crime Related Incident (CRI) report was created in relation to this find because it was suspected they might be stolen property. The items were not linked to the items found at the same hiding place four months earlier, which may not have been the case if the earlier find been recorded in the same way. As there were no identifiable items within the second cache found there were limited lines of enquiry which the Officers could follow to trace the owner and this resulted as a 'record only' entry on the service-wide Crime Report Information System (CRIS). This left a permanent and searchable record for intelligence purposes, indeed, it was later found and linked by the homicide investigation team. The performance of these two officers was reviewed by the DPA investigation and no further action was recommended.

69. In late August, Ayesha called police with concern about Kasun's recent contact with their children. She said she had been in "an abusive marriage" that ended in separation eight years ago and divorce two years after that. Kasun had no contact with her and the children and did not provide financial support. When asked, she confirmed there was no injunction or order in place at the time.

70. Kasun had started turning up at the children's school and near to her house and she said that over the past few months he was getting close to the children and even speaking to them in the street. She said that he had asked their daughter (Child C then aged 12): "Do you remember me?" and added, "I haven't forgiven your mother". Ayesha told the operator that she was not frightened of Kasun and she had been in contact with social services for advice. She said she had tried talking to him to try to arrange some proper visitation rights but he would just walk away from her and the situation was very uncomfortable.

71. The call handler, an experienced sergeant who was acting in the capacity of call handler as opposed to any supervisory role for the shift, advised Ayesha to consider handing Kasun a letter if it was difficult to have a conversation with him and added that he would refer the content of her call to 'local safeguarding' for them to provide follow up advice. The call was referred to a supervisor and Ayesha was contacted that evening; however, her phone went to voicemail. The matter was then closed with the rationale recorded that there did not appear to have been any domestic incident between Ayesha and her ex that required reporting. She was explicit that she was not in fear of the male and appeared to have contacted police for advice around visitation with the children. Social services had also been said by the caller to have been consulted for advice.

72. The IMR author has listened to the full recording of the call and spoken to the call handler and the supervisor who decided not to dispatch officers and closed the record. Ayesha did not mention the extent of previous violence Kasun had used prior to the separation. She was clearly seeking a way to facilitate communication towards a formal child contact arrangement. The officer did have DA awareness and acknowledged the potential risk undertones of what Ayesha was saying regarding Kasun being spotted around the school and her home therefore did refer the call for safeguarding follow up.

73. By listening to the calls, the IMR author has gained the impression that Ayesha was very much holding back from providing information, and queries whether the police "Strong words of advice" in 2012 around correct use of the emergency call system, may have hindered Ayesha's communication with police somewhat.

74. The dispatch supervisor based his decision on the call notes, in particular the suggestion that there was no unreported domestic argument or violence, that social services were involved and supporting the caller who was clear that she had no concerns for her safety. He did attempt to verify the facts with the follow-up call that was unanswered but then decided to close the call. The IMR author has commented about the high volume of emergency calls and that it is only feasible to conduct fast-time intelligence checks for officer safety purposes. In the absence of the caller raising safety concerns it would be unrealistic to conduct in-depth intelligence checks when making a decision such as this.

75. The dispatch supervisor has reflected on this decision with the benefit of hindsight and considers that it would have been prudent to forward this call to dispatch for consideration of further safeguarding contact, in line with the callers wishes and to also enable full safeguarding assessment regarding the children. No further recommendation is made by the IMR author as this incident has been dealt with as part of the review process as a case of individual reflection and learning.

76. Nonetheless, the Panel members with experience of the local MASH (enhanced in Redbridge with a dedicated DV Hub) strongly felt that if the safeguarding referral had been persisted with, the CSU would have become aware and a MERLIN report would have been generated and shared via the MASH. Further supposition identified that a Children's Social Care (CSC) social worker would have been appointed to make contact with Ayesha and conduct a DASH risk assessment, also involving Child C's school and historical records linked to this incident. It was pointed out that MASH staff have frequently set this in motion with less justification. Moreover, this was stalking behaviour with the attendant high risk of serious harm and homicide that stalking often indicates. With this speculation, an additional missed opportunity has been identified.

The fatal incident

77. Early on a morning in mid-November 2018, a neighbour contacted police to report the sounds of screams for help from Ayesha's home. Imran was about to leave for work and Ayesha asked him to place a discarded cardboard box in the garden shed as she was expecting visitors. As Imran approached the shed, Kasun emerged armed with two large hunting type crossbows fitted with telescopic sights and loaded with arrows. Imran instinctively took flight and shouted warnings to Ayesha and the five children as he ran through the house and outside in the street where he called for help.

78. Ayesha attempted to escape with her children up the stairs and made it to where the staircase turned to the left. From the foot of the stairs, Kasun deliberately aimed and fired the crossbow. A 40cm arrow entered Ayesha's left hip and passed through internal organs on an upward trajectory. The older children grappled with Kasun and managed to disarm him. At this point, the police arrived and detained Kasun as he fled empty-handed from the house. Ayesha was found collapsed in a bedroom and emergency life support provided until taken over by paramedics and the helicopter lift to the RLH was organised. The two crossbows, one still loaded ready to fire, were later recovered from the garden.

79. Clinicians at RLH managed to deliver Child F by emergency Caesarean Section but Ayesha was beyond saving and died at about the same time from loss of blood due to the multiple internal injuries caused by the crossbow arrow which had traversed her abdomen and entered her liver.

80. At the trial, Kasun acknowledged that he had conducted covert surveillance from the garden shed that morning and intimated that he had planned to attack Imran. He claimed the shooting of Ayesha was an accident. Kasun had spent more than two thousand pounds on the purchase of the hunting crossbows and associated equipment, given that he had 'lost' the two that had been found and handed to the police in March. It is understood

that some of the arrow tips he purchased are barbed for use in hunting boar and other animals. They cannot be purchased in the UK and Kasun obtained them via the internet. The arrow that was fired and killed Ayesha was 'standard', whereas the second crossbow recovered was loaded with the barbed hunting-arrow tip.

81. The gravity of this domestic homicide is reflected in the sentence of Life Imprisonment with a minimum of 33 years to be served. The trial Judge commented on the need for tighter legislation to govern the acquisition of crossbows.

82. The children were taken into care for a short period and, following assessment, were returned to Imran with ongoing support provided by Children's Social Care.

ANALYSIS

83. This was a planned and well-resourced attack by Kasun. His possession of two cumbersome loaded crossbows supports the hypothesis that he intended to kill both Ayesha and Imran. The recovery of the secreted surveillance materials some 12 months earlier and similar weapons to those used four months after that, clearly shows that the domestic homicide stereotype that: 'he just snapped', does not apply here. His defence that the shooting of Ayesha was accidental; that both Imran and Ayesha were on the stairs and he had fired at the wooden bannister[14] in order to scare Imran so that he would not run away, did not gain traction with the Jury.

84. A recent study[15] of Intimate Partner Femicide (IPF) uses Foucauldian analysis to track the eight stages that were present in almost all the relationships' progression to homicide. To inform the learning for this review, evidence from its narrative will be compared to the research findings:
Stage one: Pre-relationship history of stalking or abuse by the perpetrator
There is no evidence of prior partner stalking or abuse by Kasun available to this review.
Stage two: The romance developing quickly into a serious relationship
This was an arranged marriage, approved by Ayesha's parents when she was 17, to a man 14 years her senior and included having to emigrate to the UK, with no friends, and family support only available remotely in Mauritius
Stage three: The relationship becoming dominated by coercive control
The main elements of coercive control[16] by Kasun were: <u>psychological</u> – an arranged marriage has explicit parental approval that provides the husband with a version of 'power by proxy', in this case heavily exercised in behaviours such as the woman walking behind, eating separately from her, avoiding child care duties and inhibiting support from friends and family. Added to this is the 14-year age difference which, from the 2009 MSPCC research referenced ealier, can be seen to create a further power imbalance; <u>physical</u> – the children were beaten in Ayesha's presence to improve their table manners and she was physically attacked by Kasun in 2012; <u>financial</u> – Kasun judged Ayesha for coming from a poor family, completely controlled her access to funds, expressed anger at her spending

[14] The bannister was at the foot of the stairs and some distance from Ayesha who was at the turn in the stairs when the shot was fired by Kasun. A firearms expert tested the weapon and confirmed that it fired straight and that the safety catch worked correctly
[15] Monckton-Smith 2019
[16] See full definition in ToR appendix 1

and punished her by not speaking for extended periods; emotional – having isolated Ayesha from sources of support, Kasun exerted his position for coercive control with the above behaviours so that she was emotionally impoverished.

Stage four: A trigger to threaten the perpetrator's control

It is generally recognised that separation leading to loss of control is a time of heightened risk. This was evidenced during the events that defined the separation and divorce between 2012 and 2014. Subsequently, things seemed to settle and Kasun took no apparent interest in either his former wife or the welfare of their children. Imran confirmed that Kasun was angry about the divorce settlement in which Ayesha had the house but he appeared to Imran to have come to terms with the situation.

Stage five: Escalation - increase in the intensity or frequency of the partner's control tactics

An escalation by Kasun occurred or was revisited at some point in 2017 prior to the first discovery of concealed covert surveillance and burglary items. Notwithstanding that discovery, his tactics remained covert and unwavering, in fact, seemed to escalate to the purchase of lethal weapons.

Stage six: A change in thinking/decision to act

Kasun's investment in expensive crossbows prior to the second discovery of concealed items and further expenditure when he had to replace them supports the hypothesis that he had decided to take the lives of both Ayesha and Imran using near silent weapons capable of causing death from a distance.

Stage seven: Planning

There is strong evidence of planning and preparation that derives from these 'finds' and there is the attempted grooming of Child C in the weeks leading up to the fatal incident, presumably to gain her trust whilst obtaining intelligence about the family movements. It is also evidence of stalking, a high risk factor for serious harm and homicide.

Stage eight: Homicide

The research suggests, as is found in this review, it is not unusual for the extreme level of violence to appear to have no direct relation to the level of violence evidenced earlier in the relationship. Kasun's expensive choice of unwieldy, yet lethal, weapons points to an overwhelming determination to assuage his honour by completing his 'journey to homicide'.

85. An earlier study 'Exploring the relationship between stalking and homicide', identified 'The Homicide Triad'[17], and the coincidence of three groups of characteristics, namely, the offender's emotional or psychological state, the presence of acknowledged high risk markers and the triggers which create escalation. The findings of this study prompts further speculation for this review that Kasun:
    1. Over the years since the divorce, had become increasingly obsessed[18] with the divorce financial settlement
    2. Had embarked on a 'journey to homicide' that included the high risk markers of stalking/surveillance together with the acquisition of expensive weapons
    3. Had experienced the triggers of, probably, honour-based humiliation and, certainly, revenge

[17] Monckton Smith, Szymanska, Haile 2017

[18] Webster dictionary: a persistent disturbing preoccupation with an, often unreasonable, idea or feeling; an idea or thought that continually preoccupies or intrudes on a person's mind

86. From the safeguarding perspective, there were few opportunities to disrupt the stages identified in the IPF study. The early arguments between Ayesha and Kasun in February/March 2012 resulted in police being called through the emergency system a number of times and it appeared to some officers that, from both sides of the relationship, the calls were so that records could be made for use in the divorce proceedings. The couple were advised about the correct use of the emergency system. A domestic abuse incident was placed on file and the risk correctly assessed; however, the opportunity was missed to consider honour as a factor. A domestic abuse advice pack was sent to the home.

87. "Strong words of advice" were administered following another call by Ayesha about a week later, possibly based on the assumption above that an emergency system was being utilized to gather evidence in a divorce case. On this occasion, an opportunity was missed to make a domestic abuse incident record and to share information with partner agencies.

88. A few days after that, Kasun's attempts to control Ayesha became physical with an attempted strangulation attack, thwarted by the intervention of their sons, leading to Ayesha feeling forced to flee for her life via the first floor bedroom and breaking her ankle in the process. Police action was prompt and led to Kasun being prosecuted by the CPS. The fact that Kasun was acquitted at his trial does not detract from the circumstances of the attack, with independent corroboration, nor the injury caused to Ayesha when she tried to flee the danger she was in.

89. There was a missed opportunity by Victim Support to refer Ayesha to an IDVA and, based on the DASH assessment at the time, to consider a referral to the MARAC. Best practice also would have seen a safeguarding referral to CSC. This event slightly pre-dates the introduction of the MASH (Multi Agency Safeguarding Hub) wherein such processes are now coordinated. This can also be seen as a missed opportunity by the police, perhaps due to the mistaken belief that bringing a charge is an outcome that negates the need for a MARAC referral.

90. The children's community nurse visit in September 2012 raised suspicion that Kasun was present at the home when on bail for the assault charges. Notwithstanding that the nurse was mistaken and she had in fact encountered Imran, there was an appropriate response from the police to ensure Ayesha's safety. Ambiguous recording of this event later influenced a social worker into believing that Ayesha had rekindled her relationship with Kasun.

91. After Kasun's acquittal and the divorce, there followed a long period[19] of apparent tranquility as Ayesha and Imran were married and had their two children to join three elder siblings at the Redbridge home. With hindsight, it can be seen that things from Kasun's perspective were far from tranquil as he embarked on his 'journey to homicide' using covert tactics.

92. The discovery in November 2017 of what might be described as 'a burglary kit' that also contained information that could identify Kasun, secreted in the vicinity of Ayesha's home,

[19] Little is known to the review about Kasun in the period January 2014 to August 2018

is a missed opportunity that could have been avoided if police officers had not discarded the property but instead made a proper retrievable record and conducted the enquiries about the medication recovered that should have identified Kasun. Following that verification, an intelligence connection to Ayesha's address was also feasible because he had been resident there at the time of recorded incident of assault in March 2012. Given the nature of the find, it would be reasonable to infer that Kasun had been conducting covert surveillance in the vicinity of his former home, possibly with the intent to commit burglary there. Moreover, Redbridge has one of the highest reported burglary rates in London and the find was in a well-known burglary 'hot spot'. There would be grounds for his arrest and interview under s25 Theft Act 1968: Going equipped for burglary or theft.

93. The second discovery in March 2018 at the same location of crossbows and other weapons contained no identifying information and, other than the coincidence of the discovery, there was nothing to connect it to the first one or to Ayesha in any way. However, had the earlier research been conducted, the discovery of deadly weapons would have prompted further risk assessment. That said, Kasun would have been alerted by the earlier inquiry so the likelihood is low that he would have used the same hiding place.

94. These two 'finds' came to the notice of the homicide investigation when an intelligence check on the keyword 'crossbow' picked up the CRI report relating to the second find. An interview with the finder revealed the earlier contact that had no such record. However, using the date of the first call, the CAD (Computer Aided Dispatch) record was retrieved and this is how investigators identified the precise list of property, including the clear link to Kasun via his medication.

95. Ideally the CAD system would be available to be searched in the same way as the MPS crime and intelligence databases. CAD is the older of these systems and has not been set up to be searchable, other than with a CAD unique reference number. This is unsurprising given the volume of calls to the police emergency and non-emergency telephone numbers. A replacement system is planned and it may be possible to influence the design as learning from this review.

96. When Ayesha used the emergency contact system to report to police that Kasun had been approaching her children in August 2018, she was seeking advice to manage visitation rights and did not raise concerns for her safety. It was understood that social services were providing support, consequently, risk assessment questions were not asked and a safeguarding referral did not happen that, on reflection, would have been prudent and could have resulted in a 'stalking red flag' being revealed. It is considered curious that Ayesha did not mention the fact that Kasun had tried to kill her in 2012 and she may well have felt inhibited in full disclosure due to the 'strong words of advice' she was given by officers in 2012 about correct use of the emergency telephone system. The decision not to persist with the safeguarding referral but to close the CAD record led to the missed opportunity to generate a MERLIN within the CSU and thereby alert specialist CSC social workers and Child C's school to the need for engagement with Ayesha and a full risk assessment.

97. From a strategic perspective, there could be learning from further examination of how Kasun obtained his weapons and ammunition of choice, in particular the barbed arrow heads that are not available in the UK.

CONCLUSIONS AND LESSONS LEARNED

98. The Panel conclude that the scale of obsessive focus that Kasun applied to his plan to kill both Ayesha and Imran from his covert hiding place in their garden was known only to him. He was undeterred by setbacks, for example, when two of his crossbows were impounded, he simply replaced them and carried on with his mission. His determination was probably motivated by honour, a known high-risk factor, but there is no evidence that this was noted by anyone involved in safeguarding.

99. Opportunities to disrupt his course of action were limited and the only examples that were anywhere near concurrent are the police failure to deal correctly with property found that was identifiable to Kasun earlier in November 2017 and Ayesha's reporting to police of Kasun's approaches to their daughter in August 2018.

100. With the benefit of hindsight, the failure to correctly record the property found on the occasion of the first report could be seen as influencing the final outcome. This was not an example of forgetfulness, inexperience or lack of training, rather, it seems a deliberate act to avoid 'paperwork', albeit that pressure of work may have contributed to the decision. The fact that this find was within a known burglary 'hot-spot'[20] seems not to have triggered their enthusiasm for further enquiries. The officers have acknowledged this failure of duty and been subject of 'management action'.

101. The Panel are not mandated to apportion blame and there is not a clear causative element in this failure of duty. Nonetheless, the learning point for the police may be more one of understanding the operating culture that allowed such a neglectful act or omission to occur. The Panel also debated the fact that Kasun's full name is very obviously of South Asian origin and whether this revealed possible conscious/unconscious bias that influenced their decision. Again, local knowledge countered that the majority of the community in that area are of South Asian origin with such names commonplace.

102. The second find was dealt with correctly and served to reinforce the importance of proper recording because the finding of weapons, albeit thought to be stolen, would have provided a line of enquiry to identify Kasun and his secreting of the 'burglary/surveillance kit' some months earlier. Had the CAD system been searchable for the record of property found at the first find, a linking the two finds would have been possible even when the failure to record on CRIS occurred. The MPS are implementing an upgraded CAD system that could have this change included and the IMR author has proposed a recommendation arising directly from this review for consideration.

103. In the later contact with police, Ayesha made it clear to an experienced officer she was seeking advice about childcare arrangements and that support was in place. She did not mention earlier domestic abuse. Nonetheless, the officer used professional judgement to recommend a safeguarding referral. The supervising officer closed the CAD record when Ayesha did not respond to a follow-up call. This officer did not have access to listen to the call and has acknowledged that a safeguarding referral was not developed and forwarded

[20] Source: Panel members with local knowledge of crime data

as it could have been. The Panel have identified this as a missed opportunity to generate a MERLIN to involve social services and education in a risk assessment.

104. In summary, the following Learning Points have been identified for recommendations to be implemented as the result of this review:

1. The basic requirement for police officers to properly record and investigate property found in the street needs reinforcement, possibly by use of this example as a Case Study
2. When a proposal for safeguarding action is not resolved by a contact centre, it should be referred to local Borough policing for risk assessment
3. The command and control system for the police should be searchable along with other information databases such as CRIS and CRIMINT
4. Consideration should be given to a review of the law regarding acquisition of crossbows and ammunition and a licensing regime.

RECOMMENDATIONS

105. IMR authors were invited to make recommendations for their agency to implement:

Barking, Redbridge and Havering Trust

1. The trust will continue to ask routine DV questions at booking
2. The trust will continue to update staff though supervision and one to ones surrounding areas of DV and lessons learnt from case
3. The trust will continue to provide a high level of DV training via Level 3 Safeguarding which is both relevant and informative to all clinical staff

Victim Support

1. All front line staff to undertake DV risk assessment training to ensure staff are able to engage well with clients, and complete needs assessments with confidence and quality of completion
2. Managers are to demonstrate via records, that the completion of safeguarding forms and needs assessments as well as quality of service provided to continue to be monitored by management
3. VS now operates a Safeguarding Operational Group (SOG). The group undertake quarterly safeguarding audits that are sent through to the National Call Centre Safeguarding Manager and chair of the SOG. The audits are discussed during the quarterly meetings. Above the SOG there is a Safeguarding Panel which is comprised of the Senior Management Team - Chief Officer, all the Service Directors, the Director of Support services, the Assistant Director of People and The SOG chair as the National Call Centre Manager and chair of the SOG as well as a representative from the board of trustees. The SOG is a sub-group of the safeguarding panel and is a national group of Duty Safeguarding Officers who share good practice, promote and develop work that ensures children and adults approaching VS are safeguarded from harm.

Child Protection and assessment Team, Redbridge Children;s Services

1. Service wide training provision on conscious/unconscious bias and how this impacts on practice.

106. Taking the IMRs into account as well as the above Learning Points, the Panel have identified these recommendations for inclusion in the Action Plan at Appendix 3:

    1. Metropolitan Police Learning and Development Command to design and provide reinforcement training on found property handling to all patrol officers and supervisors using the learning from this review as a case study
    2. Metropolitan Police Command and Control (MetCC) Senior Leadership Team (SLT) to review the policy on contact centre handling of unresolved safeguarding calls to ensure that they are passed to BOCU level for assessment and decision
    3. MetCC SLT refer the learning from this case to the implementation team for the new Command and Control system to explore whether it may be possible in future to ensure a property reference number is added in the result field to calls for all property found incidents prior to CAD being closed down
    4. Home Office to review the law on crossbow acquisition and consider a licensing regime for crossbows and ammunition.

Author

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16 May 2021

Domestic Violence Homicide Review Panel – LB Redbridge CSP
Ayesha aged 35, murdered in Redbridge November 2018

Glossary

ACN	Adult Coming to Notice
ASC	Adult Social Care
BDHR	Barking and Dagenham, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University NHS Trust
CAD	Computer Aided Dispatch
CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
CSU	Community Support Unit
DA	Domestic Abuse
DV	Domestic Violence
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
GP	General Medical Practitioner
GSC	Government Secure Classifications
gsi	Government Secure Internet
IMR	Individual Management Review
IO	Investigating Officer
LAS	London Ambulance Service NHS Foundation Trust
LB	London Borough
LBR	London Borough of Redbridge
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MetCC	Metropolitan Police Command Centre
MPS	Metropolitan Police Service
NHS	National Health Service
pnn	Police National Network
SLT	Senior Leadership Team
ToR	Terms of Reference

Name references used

Ayesha (35)	Deceased
Kasun (51)	Perpetrator and Ayesha's first husband
Imran (42)	Ayesha's second husband

Child A male aged 17
Child B male aged 15
Child C female aged 12
Child D female aged 4
Child E female aged 18 months
Child F male born on day of homicide

Distribution List

Name	Agency	Position/ Title
Stephen Clayman	Metropolitan Police	Basic Command Unit Commander
Adrian Loades	Redbridge Borough Council	Corporate Director of People
John Goldup	Independent Chair	Independent Chair of Redbridge Local Safeguarding Children Board
Daniella Capasso	Barking, Havering and Redbridge University NHS Trust	Named Midwife, Safeguarding & Lead Midwife for CDR & Harmful Practices
Stephen Hiyes	Barking and Dagenham, Havering and Redbridge CCG	Designated Nurse for Adult Safeguarding
John Richards	Redbridge Borough Council	Head of Safer Communities
Catherine Worboyes	Redbridge Borough Council	Head of Child Protection
Valerie Scanlan	Redbridge Borough Council	Senior Community Safety Officer
Andrew Meakings	Victim Support	Operations Manager
Julia Dwyer	Refuge	Senior Operations Manager
Liz Gaunt	Metropolitan Police	Detective Inspector Specialist Crime Review Group
Bill Griffiths	Independent Chair	Independent Chair of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Awaits	NHS England	
Quality Assurance Panel	Home Office	-
Jeetinder Sarmotta.	Crown Prosecution Services	Legal and Stakeholder Manager
Dame Cressida Dick	Metropolitan Police Service	Commissioner

Domestic Violence Homicide Review Panel – LB Redbridge CSP
Ayesha aged 35, murdered in Redbridge November 2018

Appendix 1

Context of review

On a morning in mid-November 2018, police were called to a family home in **Redbridge,** where **Ayesha** aged 35 had been fatally injured by a crossbow arrow. Ayesha's unborn child survived the attack. Her former husband, **Kasun** aged 51 was arrested at the scene and subsequently charged with her murder. Kasan also owned property in LB Newham**.**

Ayesha was married to **Imran** aged 42 with whom she lived Redbridge. She had five children before the fatal incident:
Child A aged 17 with Kasun
Child B aged 15 with Kasun
Child C aged 12 with Kasun
Child D with Imran
Child E with Imran

The second trial of Kasun for murder at the Central Criminal Court concluded in November 2019 and he was found guilty and sentenced to Life Imprisonment with a minimum of 33 years to be served.

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

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

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

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified. [Note: agreed on 18/11/19 that period of review would be 01/01/2012 to 12/11/1918 - date of homicide]

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale

for completion [Note: agreed on 18/11/19 that the Refuge representative would research specialist advice and a South Asian specialist adviser has joined the Panel]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: the criminal trial has concluded; any misconduct issues have yet to be established and the Coroner's decision awaits]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [Note: Ayesha has Hindu heritage, had converted to Islam upon her second marriage and was full-term pregnant at the time of the homicide. Kasun has Hindu heritage. The Refuge representative is an Independent Domestic Violence Adviser]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Note: no record at MARAC/MAPPA]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2018, if so, how it could be best managed within this review [Note: there are five children from the two marriages and one unborn child who was then born by Caesarian Section. Some were present during the fatal incident. The Redbridge Children's Safety Partnership have assessed that a SCR is not warranted in this case]

7. To determine whether this case meets the criteria for a Safeguarding Adult Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Note: there is no evidence that a SAR is required]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she was looking after, prior to the homicide from the perpetrator (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced by Ayesha in reporting abuse, or best practice that facilitated reporting it [Note: the Chair met Ayesha's parents at the first trial in April and they did not attend the second. He has met Ayesha's husband and secured his participation in the review]

9. To identify how the review should take account of previous lessons learned in the LB Redbridge and from relevant agencies and professionals working in other Local Authority areas [Note: in hand with Redbridge Community Safety and the Chair]

10. To identify how people in the LB of Redbridge gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Note: in hand with Redbridge Community Safety and the Chair]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Ayesha, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1 January 2012 relating to Ayesha and Kasun. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with [insert names]
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of [insert names]

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

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

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

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

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with Ayesha''s 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

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
- emotional

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

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

Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Rebridge CSP as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had not had personal or operational involvement within the London Borough of Redbridge, nor direct management of any MPS employee there.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

Appendix 3

ACTION PLAN

Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting recommendations**	**Target Date**	**Date of completion and outcome**
Learning Point 1: The basic requirement for police officers to properly record and investigate property found in the street needs reinforcement, possibly by use of this example as a Case Study						
1 Metropolitan Police Learning and Development (L&D) Command to design and provide reinforcement training on found property handling to all patrol officers and supervisors using the learning from this review as a case study	London-wide	Review Officer (RO) to submit proposal to DSU Foley for Service Level Recommendation (SLR) consideration. Send SLR letter to business lead for L&D L&D design and provide training across Service	MPS L&D Command	Accepted as SLR May 2021 SLR request made May 2021 Awaits L&D acceptance Design of training and delivery plan	May 2021 May 2021 June 2021 September 2021	Training rolled out by March 2022 **Ongoing**
Learning Point 2: When a proposal for safeguarding action is not resolved by a contact centre, it should be referred to local Borough policing for risk assessment						

2 MetCC SLT to review the policy on contact centre handling of unresolved safeguarding calls to ensure that they are passed to BOCU level for assessment and decision	London-wide	RO to submit proposal to DSU Foley for SLR consideration. RO to refer recommendation to MO12 for consideration and action. Business lead for MO12 DSU Gary Warby to review process and write policy for approval	MPS MetCC	May 2021 May 2021 June 2021	May 2021 May 2021 June 2021	Policy change implemented by September 2021 **Ongoing**
Learning Point 3: The command and control system for the police should be searchable along with other information databases such as CRIS and CRIMINT						
3 MetCC SLT refer the learning from this case to the implementation team for the new Command and Control system to explore whether it may be possible in future to ensure a property reference number is added in the result field to calls for all property found	London-wide	IMR continuation letter referred to business lead for MO12 Recommendation accepted by Director of change Dan Claydon Recommendation to be submitted to Statutory recommendation panel	MPS MetCC	March 2021 May 2021 June 2021		**Ongoing**

incidents prior to CAD being closed down		with Commander Tucker for sign off. Built into the design for the replacement system is a supplemental information reference tab which includes a F66 (Property reference) tab. The learning from this review is with the design team to ensure full roll out of property reference recording when new system is available		March 2022		
Learning Point 4: Consideration should be given to a review of the law regarding acquisition of crossbows and equipment						
4 Home Office to review the law on crossbow acquisition and consider a licensing regime for crossbows and ammunition	National	Home Office to use the circumstances of this DHR to commission a review of the law	Home Office	To initiate review when DHR received at HOQA Panel To secure transcript of Trial Judge's remarks to inform review	June 2021 July 2021	Awaits Home Office assessment