



**Domestic Homicide Review
Executive Summary
DHR 01**

Report into the death of a woman

On 31st December 2014

Independent Author

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Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death on 31st December 2014 of Nadine Aburas, a 28-year-old woman. Nadine resided in the Cardiff Bay area. Her boyfriend (herein known as P) was arrested and charged with her murder. P appeared before the Crown Court in October 2016 and was convicted of her murder and sentenced to imprisonment.

P was 44 years of age at the time of the incident. He was born in Saudi Arabia. At the time of the homicide P was a resident in Brooklyn, New York. P was employed in a local grocery store and had a second job as a taxi driver. There is no information available to establish how P came to settle in the United States of America.

It has not been established how long their relationship continued however it is apparent that Nadine first met P on an online dating website. Their relationship developed where they would visit each other both in Cardiff and New York.

On Wednesday 31st December 2014, during one such visit, the body of Nadine was discovered in a hotel room in Cardiff.

South Wales Police attended the hotel and commenced a murder investigation. The Police quickly identified that P was a suspect and it was later established that P had left the UK that day on a flight to Tanzania.

Detectives traced P's whereabouts and with the assistance of local authorities extradition proceedings were commenced. P was returned to the UK where he was detained pending trial for murder. During this process, South Wales Police detectives did not have the opportunity to formally interview P and obtain an account of his relationship with Nadine. The extradition process requires a necessity to have sufficient evidence to charge, therefore detectives were required to present circumstantial evidence in support of their extradition application.

Therefore, there is little information known regarding P's involvement in the death of Nadine other than what was discussed during the criminal trial. Furthermore, due to his status as a US citizen there is a paucity of information regarding his antecedents, background and involvement with US based authorities.

After a protracted criminal justice process at the Cardiff Crown Court, P pleaded guilty to the murder of Nadine. He was subsequently sentenced to life imprisonment.

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance¹ on 13th April 2011 and later revised in December 2016 establishes the statutory basis for a Domestic Homicide Review.

Under this section a Domestic Homicide Review means a review of the circumstances in which the death of a person age 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

- (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

¹ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

In compliance with the Home Office Guidance,² on 1st April 2015, South Wales Police notified the circumstances of the death in writing to the Cardiff Partnership Board. The Board accordingly notified the Home Office of the circumstances of the incident and the intention to conduct a Domestic Homicide Review on 8th May 2015. This is the first DHR to be conducted within Cardiff.

The Domestic Homicide Review Panel

The Review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the Panel members were:

- Safeguarding Advisor to the Cardiff and Vale University Health Board
- Safeguarding Officer, Welsh Ambulance Services Trust
- Domestic Abuse Coordinator, Cardiff Council
- Policy and Development Officer, Cardiff Council
- Senior Social Lettings Unit Manager (Social Inclusion), Cardiff Council
- Deputy Chief Executive, Bawso
- Public Protection Manager, South Wales Police
- Service Standards Manager, Safer Wales
- Business Support Officer, South Wales Police

None of the Panel members had any direct dealings with P or his family.

The Panel was chaired by an experienced Independent Chair and both the Overview Report and this Executive Summary was compiled by an experienced Independent Author. Neither the Author nor Chair had any dealings with P or his family prior to being involved with this Review.

Time Period

It was decided that the review should focus on the period from 1st April 2002 up until the time of death of Nadine on 31st December 2014, unless it became apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended. The Review also considered any relevant information relating to agencies contact with the Victim and alleged Perpetrator outside the timeframe as it impacts on the assessment in relation to this case.

Individual Management Reports

An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- Cardiff and Vale University Health Board
- Cardiff Council Children's Services
- South Wales Police
- Welsh Ambulance Services Trust
- Safer Wales
- BAWSO
- Cardiff Community Housing Association
- UK Border Force

² Home Office Guidance page 8

Process of the Review

Home Office Guidance³ requires that DHRs should be completed within six months of the date of the decision to proceed with the review. However there have been a number of contributing factors that has meant this deadline has not been met in this case. Contributing factors include the necessity to:

- Establish a new multi-agency process for conducting Domestic Homicide Reviews, that is distinct from Serious Case Reviews and which required approval from Cardiff's Public Services Board member organisations.
- Develop a commissioning framework to recruit Independent Chairs/Authors to facilitate Domestic Homicide Reviews

In addition there has also been a delay between the completion of the Overview Report, Action Plans, and submission to the Home Office Quality Assurance Panel. This has been hampered by periods of long-term sickness of key members of staff contribution to Action Plans and the Local Authority Officer who co-ordinates Domestic Homicide Review on behalf of Cardiff Council. However, Cardiff Council have provided regular updates on progress to the Home Office.

This was a complex case from the beginning. There were parallel investigations ongoing with the Independent Police Complaints Commission (IPCC), the Coroners process and the Crown Court trial. The criminal trial took over 18 months to complete due to defence legal representations. The Review Panel only had possession of Police information obtained from the New York Police Department post trial. The IPCC shared the findings of their investigation again only after the trial had concluded.

These extenuating circumstances were reported to the Home Office who accepted the situation and responded accordingly.

Terms of Reference for the Review

The aim of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Family Involvement

Home Office Guidance⁴ requires the family, friends and colleagues who have details or knowledge of Nadine or the Perpetrator to be given the opportunity to contribute to the review process. In this case, the Overview Author had regular contact with Nadine's mother. Visits to the family home included discussions with Nadine's two sisters, two brothers and two aunts.

³ Home Office Guidance 2013 page 15

⁴ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2011 Revised 2013 www.homeoffice.gov.uk/publications/crime/DHR-guidance

All had significant comments to make and contributed considerably to the process. Their views were faithfully recorded and are included within the Overview Report.

Summary of Key Events

Nadine was born in Tripoli in Libya in March 1986. Nadine is one of seven children. Her father still resides in Libya. Nadine's mother resides in Cardiff as a single mother with the remaining six siblings.

The family had initially moved to Libya on the basis that Nadine's father was a sea captain and he had secured work in that country. Nadine's parents split up which resulted in the family returning to the UK. Nadine's father remains in Libya.

The first recorded partnership intervention is dated April 2002 where it is recorded that Bawso provided support to the family in Cardiff by providing temporary accommodation in a refuge. This support continued where the family relocated to other more permanent accommodation within Cardiff that kept the family unit together.

Between 2003 and 2006, Nadine received support from various agencies. There are recorded episodes of support for mental health issues which were delivered and offered on a long term basis.

In June 2006, Nadine aged 19 years entered, into an Islamic partnership with a local Muslim man. This was not arranged but mutually agreed by both partners. This arrangement only lasted four months and was ended by Nadine.

In April 2010, Nadine reported a sexual assault to South Wales Police. Nadine provided the Police with a written statement of complaint. Specialist bespoke support services were put in place to take the investigation forward and to support Nadine. The Police along with these agencies report that after repeated attempts to encourage engagement, Nadine did not to respond.

In July 2010, Nadine contacted the Police and provided Police Officers with a written statement withdrawing her complaint. The Police did trace two suspects. They were both interviewed and both denied the allegation. Although the investigation was concluded Nadine was risk assessed as "High" and Police watch markers were placed on her home address.

In September 2010, Nadine reported to South Wales Police that she had been assaulted by her two brothers. The Police investigated this matter and arrested the two brothers. The Crown Prosecution Service was consulted and advised that no criminal proceedings should follow. This was based on the varying accounts provided by those involved in the incident. The Police took positive action in response to the complaint. Nadine was advised of the decision of the CPS not to prosecute.

Shortly after this incident, again in September 2010 Nadine contacted South Wales Police to complain of harassment. The complaint centred on mobile phone calls and text messages received from a girlfriend of one of her brothers. The Police responded. On the basis that the harassment had discontinued, Nadine informed the Police that she did not wish to take the complaint forward.

In May 2013, the UK Border Force recorded the arrival of P at Heathrow Airport. P had travelled from the US and on arrival informed a Border Force Officer that he was visiting a girlfriend, Nadine, in Wales. He was granted leave to enter the UK as a visitor for six months. There are three further visits recorded by the Border Force of P entering the UK at Heathrow Airport. These are September 2013, December 2013 and December 2014.

On each occasion, P was granted leave to remain as a visitor for six months to visit his girlfriend in Wales. The Border Force report there was no information available to suggest that P posed a danger or risk to the public.

In September 2014, Nadine contacted South Wales Police to disclose she had started an online relationship with P and that in July of that year she had visited him in New York. During the visit, Nadine disclosed that P had raped and assaulted her. Nadine also stated that P was threatening to post explicit photographs of her on the social website Facebook, and send them onto family members. This was in response to Nadine's intentions to end the relationship.

South Wales Police took positive action and obtained a written account from Nadine. Specialist support services were also put in place. The written account identified that Nadine had disclosed that P had attempted to strangle her and that P had routinely threatened to kill her. Although the Police assessed the risk to Nadine as High, there was no referral to the Multi Agency Risk Assessment Conference (MARAC) on the basis that:

- The Suspect P lived in a country which was a great distance away therefore would not be involved with any partner agencies there, so they would not have information to bring to the meeting about him.
- The suspect would not have immediate access to the victim as he had no links to Wales.
- There were no drug or alcohol issues.
- Nadine was engaging with the Police and had a supportive family.

South Wales Police and relevant support agencies made numerous attempts to contact Nadine to take forward the investigation whilst at the same time offer specialist support. In October 2014, Nadine contacted the Investigating Officer to state she had decided not to proceed with her complaint. The Officer was satisfied that Nadine was not being coerced into making this decision. Nadine was informed of the specialist support and encouraged to contact partnership agencies. There is no information available to confirm that this offer was taken up.

At this time, Senior Detectives from South Wales Police had met to review the investigation regarding safeguarding issues involving Nadine and options to take the investigation forward. Since P resided in New York, and there was not a fully recorded account from Nadine, investigative options were limited. The Police investigation then became focused on alerting the US Authorities regarding the allegations made against P.

In October 2014, South Wales Police recorded a senior officer taking steps to notify the US Authorities. This involved the process of the submission of INTERPOL forms that included intelligence that South Wales Police had in relation to P and his alleged conduct towards Nadine. Due to an administrative error, this document was not submitted and formed the basis of a self-referral from the Police to the IPCC.

In December 2014, P arrived in the UK and travelled to Cardiff to meet Nadine. There followed an incident at the home address of Nadine where it was alleged that P was assaulted by a brother of Nadine. This brother had seen inappropriate text messages sent by P to Nadine. During the confrontation it is alleged the assault took place. Both the Police and Ambulance Service attended the address. Attending paramedics report that on arrival at the address they spoke with a male person via an intercom facility. They were informed their services were not required. The Police attendance was temporarily delayed due to operational demand. Police Officers report that when they eventually visited the address some three hours after the initial call there was no response.

It is now apparent that P left the address and obtained accommodation at a local hotel. Later that night Nadine joined him. Hotel staff report that P left the hotel for a short period

unaccompanied. When P later checked out of the hotel he informed hotel staff not to disturb his sister who was staying in the room.

The following day the body of Nadine was found. The subsequent post-mortem determined that the cause of death was strangulation.

Analysis and Recommendations

The Review Panel has identified that Nadine had experienced significant episodes of abuse that for a variety of reasons were not pursued to any form of eventual judicial outcome. Nadine was a repeat victim of domestic abuse and categorised rightly as 'High Risk'.

A combination of failed contact attempts especially with professional services who offer specialist bespoke support could have provided confidence and reassurance to Nadine to engage and cooperate. Conventional methods of contact have clearly been unsuccessful.

Local policies and procedures appear to have been complied with in the risk assessment of Nadine as a vulnerable person. Whilst this appears acceptable in terms of statutory responsibility, the issue remains as to why Nadine chose not to cooperate more fully and support agencies.

The family have a strong view that Nadine was suffering from post-traumatic stress syndrome caused by the influence and relationship with P. Both Nadine's mother and sisters state Nadine was withdrawn, spent long periods of the day alone and even discussed moving away from Cardiff. Nadine feared the stigma of having private intimate photographs of herself being circulated within social media. It was this stress that caused Nadine not to co-operate.

The IPCC investigation concluded that the failure to submit the INTERPOL form would not have had any impact on the chain of events that led to Nadine's death. The IPCC investigation was undertaken with enquiries not only being conducted locally but internationally. The IPCC did, however, identify a clear lack of guidance for officers and support staff on the most appropriate way to investigate domestic incidents and safeguard victims when a suspect resides in another country.

Furthermore, the IPCC concluded by identifying that national guidance relating to the way in which international enquiries are being managed is currently being reviewed by the College of Policing.

After the criminal trial, the Review Panel was provided with information that P was a serial offender involved in domestic violence. He had at least four ex-partners who previously had individually filed complaints to the NYPD.

One of these complaints involved an allegation of alleged strangulation that resulted in the NYPD recording a breach of a Protection Order and an arrest option being available. The Panel are unaware of the exact circumstances of this incident but this does suggest that P posed a significant risk to future partners. This information does not appear to have been shared with relevant Border agencies and the Panel remain concerned and curious as to how a US citizen can leave the US when an arrest option is still open for a public protection matter.

The Author of this report has formally written to P, with an invitation for him to contribute to the Review, but to date no response has been received.

List of Recommendations

The following recommendations are made:

Recommendation 1

The Public Services Board reviews the current contact arrangements with all victims of domestic abuse and sexual violence and considers the current levels of failed contact attempts as identified in this Review. Particular acceptance and focus should be placed on victims who may display post-traumatic stress as a reason for non-engagement.

Recommendation 2

Furthermore, the Public Services Board considers the ‘Between the Lines’ research document to improve engagement with BME victims.

Recommendation No 1 is designed to capture the failed contact attempts identified during the course of this Review. Particular emphasis, is placed on those victims who may display symptoms of post-traumatic stress. The Public Services Board may wish to consider the findings contained in the research document “Between the Lines”.

Recommendation 3

The Public Services Board will ensure the findings of the report are circulated to relevant organisations and partners to consider.

This recommendation acknowledges that the findings require a national consideration of the issues and cannot all be addressed locally in isolation.

Recommendation 4

The Home Office, in conjunction with Police colleagues, reviews its processes and considers routinely adding those who pose a risk to domestic violence victims onto their watch lists.

This recommendation is currently subject to review by the UK Border Force.

Recommendation 5

The Home Office and the UKBF work with the US Authorities and conduct a bespoke review of the circumstances of P’s departures from the US and visits to the UK and look at opportunities for the sharing of information and the potential arrest and detention of P.

This is a sensitive subject area and one in which the family are keen to explore. Operational procedures conducted by US based law enforcement agencies and Border controls are beyond the reach and scope of this DHR.

Recommendation 6

South Wales Police actively engages with the College of Policing to review the national guidance relating to the way in which international enquiries are managed. Emphasis should be placed on improving intelligence and information management for those matters specific to Public Protection. Issues highlighted within both this DHR and the IPCC report are used as part of the review process.

This recommendation again supports the IPPC outcome report. Cardiff has an opportunity to take the lead in Wales in actively supporting this College of Policing review.

Recommendation 7

The Public Services Board requests further clarification from the Home Office for paragraphs 99 and 100 of the new Home Office Guidance for the Conduct of Domestic Homicide Reviews December 2016. In particular, regarding the term *'The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest'*. It is recommended that the Home Office produce a sample template letter that could be used nationally informing the perpetrators that their medical information is to be disclosed, as well as advising health agencies of this process irrespective that permission has not been obtained from the perpetrator. This is critical to those perpetrators who have been convicted and are serving substantial prison sentences.

P has chosen not to participate in this Review so ultimately does not consent for his medical records to be made available to the Review Panel. P was subject to considerable psychiatric assessment during the course, of his criminal trial. This information may well have assisted the Panel in the review process.

Conclusions

To conclude, this review can be separated into the following key areas:

Nadine was the victim of a catalogue of incidents that could be defined as domestic abuse. Various agencies were sensitive to the needs of Nadine and there is documentary information available to substantiate not only identification of the need but offers of support. Nadine chose not to engage and it is only during the review period and after consultation with close family members that an explanation was offered. PTSD may well have been a contributory factor. Due to confidentiality issues, various partnership agencies could not at the relevant time, have engaged with family members and identified this condition.

Partnership agencies were confronted with a suspect who originated from outside the UK. There was very little information known about him. If they had information, then there may well have been a more proactive approach in perpetrator management that strengthened safeguarding responsibilities. The fact that Senior Detectives from South Wales Police met to discuss investigative options and international intelligence sharing opportunities, reinforces the predicament they found themselves in.

The perpetrator was subject to an arrest for domestic violence alleged by an ex-partner in the US. However, he was able to leave that country, negotiate UK Border controls, and enter the UK as a visitor. P then committed murder, fled the UK and was extradited back to stand trial. His alleged conduct towards the ex-partner in the US has striking similarities with the circumstances of Nadine's death, in that strangulation is identified in both incidents.

Extensive family consultation has taken place. Family members have had the opportunity to review the report in private and they have offered comment and suggested amendments where appropriate. The family intend meeting the Review Panel to discuss the report.

It is the family's wish that Nadine is identified within the DHR and with all accompanying reports. They do not wish her to be identified by way of a pseudonym.

Martyn Jones

Independent Chair and Author

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