Domestic Homicide Review
Overview Report
DHR 01

Report into the death of a woman

On 31st December 2014

Report produced by Martyn Jones Bsc (Hons)
Independent Chair and Author
July 2018

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“No one has really asked who Nadine was.

She was a sister to six and an aunt to nine.

Nadine was a ray of sunshine to everyone in her life. There is a huge void in all our lives and she can never be replaced. She was very talented to the point we were in awe of her.

Nadine won over the hearts of everyone she met daily.

I couldn’t bear to think what must have even gone through her mind when he took her life.

We allowed him to come into our family.

He took our child.

He made us wait for two years to grieve for our child. He has destroyed us.

Please don’t let Nadine’s death be in vain.

Protect others

No other family should suffer the same as ours”

Mother of Victim

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
BAWSO	Black and Asian Women Stepping Out
CPS	Crown Prosecution Service
DHR	Domestic Homicide Review
DAIP	Domestic Abuse Investigation Procedure
INTERPOL	International Criminal Police Organisation
SIO	Senior Investigating Officer
FLO	Police Family Liaison Officer
G1	Police Emergency Response
IPCC	Independent Police Complaints Commission
JFK	John F Kennedy Airport
MARAC	Multi Agency Risk Assessment Conference
MOU	Memorandum of Understanding
NICHE	A Record Management System (SWP)
PNC	Police National Computer
SARC	Sexual Abuse Referral Centre
SWP	South Wales Police
UK	United Kingdom
US	United States
UKBF	United Kingdom Border Force
GP	General Practitioner (Doctor)
IMR	Individual Management Review
PPD1	Police Public Protection Referral Form
PPN	Public Protection Notification
WAST	Welsh Ambulance Service Trust
NYPD	New York Police Department

1 Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Nadine Aburas, a 28 year old woman, on 31st December 2014. Her boyfriend (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 life imprisonment.

2 Purpose of a Domestic Homicide Review

2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a Domestic Homicide Review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

(a) a person to whom 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"

2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

"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"*

2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013, Home Office - now revised again by 2016 guidance.

- Establish what lessons are to be learned from the 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.

- 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 victims and their children through improved intra and inter-agency working.

- To assist the victim's family in their meaningful healing process.

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight good practice.

3 Process of the Review

3.1 South Wales Police notified the Cardiff Partnership Board of the homicide on 1st April 2015. The Cardiff Partnership Board reviewed the circumstances of this case against the criteria set out in the Government Guidance and recommended to the Chair of the Partnership that a Domestic Homicide Review should be undertaken. The Chair ratified the decision. This is the first DHR to be conducted within Cardiff.

3.2 The Home Office was notified of the intention to conduct a DHR on 8th May 2015. An independent person was appointed to chair the DHR Panel and prepare and present the overview report.

3.3 Home Office Guidance recommends that reviews should be completed within 6 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 (formerly Cardiff Partnership Board) member organisations.
- Develop a commissioning framework to recruit Independent Chairs/Authors to facilitate Domestic Homicide Reviews.
- The protracted criminal justice process and parallel investigations all contributed to this delay.

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 involved in contributing to Action Plans and the Local Authority Officer who co-ordinates Domestic Homicide Reviews on behalf of Cardiff Council. However, Cardiff Council has provided regular updates on progress to the Home Office.

4 Independent Chair and Author

4.1 Home Office Guidance[4] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the Review Panel decides is relevant," and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the Cardiff agencies involved in the review."

4.2 The Cardiff Partnership Board appointed Mr Martyn Jones from the Winston Partnership Limited to be both the chair and independent author.

4.3 Mr Martyn Jones is a former Senior Detective Officer with South Wales Police having retired from the force in 2011. Mr Jones has many years experience in homicide investigation and at one time was the force lead in Public Protection matters across South Wales. Prior to this review process, Mr Jones had no involvement, either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. Mr Jones chaired meetings and personally met with family members and friends during the course of this review.

4.4 Mr Jones is a consultant to Winston Limited and works with Mr Malcolm Ross who is also a DHR author and has worked alongside Mr Jones in this review.

5 DHR Panel

5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Jones chaired the Panel. Other members of the Panel and their professional responsibilities were:

Name	Designation	Agency
Martyn Jones	Independent Chair & Author	
Malcolm Ross	Independent Chair & Author	
Natalie Southgate	Policy & Development Manager	Cardiff Council
Nicola Jones	Domestic Abuse Co-ordinator	Cardiff Council
Chris Fox	Senior Social Lettings Unit Manager (Social Inclusion)	Cardiff Council
Judy Brown	Safeguarding Nurse Advisor	Cardiff and Vale UHB
Angelina Rodrigues	Deputy Chief Executive	Bawso
Karen Maxwell	Service Standards Manager	Safer Wales
Sue Hurley	Independent Protecting Vulnerable Person Manager	South Wales Police
Helen Weston	Business Support Officer	South Wales Police
Rachel Jones	Policy, Partnerships and Citizen Focus Manager	Cardiff Council
Ian Smith	Safeguarding Officer	Welsh Ambulance Services Trust

5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

5.3 The Panel was supported by an Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness, and sought to identify lessons, to ensure that better outcomes for vulnerable people in

[4] Home Office Guidance 2016 page 12

these circumstances are more likely to occur due to this review having been undertaken.

6 Parallel Proceedings

6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- Cardiff Partnership Board advised HM Coroner on 17th August 2015, that a DHR was being undertaken.
- The Review commenced in advance of criminal proceedings having been concluded and therefore preceded with awareness of the issues of disclosure that may arise.
- South Wales Police advised the Panel that they had self-referred an internal issue to the Independent Police Complaints Commission regarding one of their officers involved in a management support role.
- The IPCC conducted an independent investigation following this self-referral. A copy of their report in redacted form was made available to the Review.

7 Time Period

7.1 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.

7.2 The Review also considered any relevant information relating to agencies contact with Nadine and P outside the timeframe, as it impacts the assessment in relation to this case.

7.3 This was Cardiff's first experience of a Domestic Homicide Review. It was a complex case from the beginning with very little information known about P who is a US citizen and resident in New York. Nadine had met P via a Muslim dating website. During the homicide investigation P fled the UK and travelled to Tanzania. He was later extradited back to the UK where he stood trial for Nadine's murder.

8 Scoping the Review

8.1 The process began with an initial scoping exercise held on 4th August 2015. This was prior to the first Panel meeting. The scoping exercise was completed by Cardiff Council to identify agencies that had been involved with Nadine and P prior to the homicide. Where there was no involvement or insignificant involvement, agencies were advised accordingly.

9 Individual Management Reports

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

- South Wales Police
- Cardiff & Vale University Health Board
- Cardiff Council Children's Services
- Welsh Ambulance Services Trust
- Safer Wales
- Home Office Border Force
- Bawso
- Cardiff Community Housing Association

Guidance was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved, to support professionals to carry out their work to the highest standard;
- To identify how those changes will be brought about;
- To identify examples of good practice within agencies.

9.2 Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

9.3 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

10 The Area

10.1 Cardiff is the capital and largest city in Wales. The 2011 census identified an estimated population of 861,400 living in both the confines of the city and within the peripheral urban zone. The city is the county's chief commercial centre, the base for most national, cultural and sporting institutions. The Welsh Government's debating chamber, the Senedd, is located at Cardiff Bay. This is the main building for democracy and devolution.

10.2 Cardiff has an ethnically diverse population due to its past trading connections, post-war immigration and large numbers of foreign students who attend university in the city. The ethnic make-up of Cardiff's population at the time of the 2011 census identified that almost 53,000 people from a non-white ethnic group reside in the city. This diversity and especially that of the city's long established Muslim community is celebrated during a series of cultural exhibitions and events.

10.3 Cardiff Council is the governing body for the city. Governance and accountability for community safety sits with Cardiff Public Services Board, chaired by the Leader of Cardiff Council.

11 Summary

11.1 On Wednesday 31st of December 2014, the body of Nadine was discovered in a hotel room in Cardiff.

11.2 South Wales Police attended the hotel and commenced a murder investigation. The Police quickly identified that P was a suspect and it was established he had left the country on a flight that day.

11.3 Detectives traced P to Tanzania 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 application.

11.4 Therefore, this review had very little information 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.

11.5 Nadine was born in Tripoli in Libya in March 1986. Her father is a Libyan citizen and her mother is a Welsh national born in Cardiff. Nadine's parents first met in 1974 during her father's visit to Cardiff whilst employed as a sea captain. The family initially lived on various commercial container ships before settling in Libya.

11.6 Nadine at that time, had two brothers, who were also born in Tripoli. They all attended local schools and were well established within the local community in Tripoli. In 1992 their parents' relationship deteriorated. At this time, the USA commenced bombing strikes in Tripoli. Nadine's mother decided to return to the UK. With the assistance of the British consulate, Nadine (who at the time was 7 years old) and her two brothers accompanied their mother to the UK where they were found accommodation in the St. Mellons area of Cardiff.

11.7 Nadine's mother broke off all contact with her father. The family settled in Cardiff and over time, four additional members of the family were born.

11.8 Nadine integrated herself well into western culture. In 2010, she entered into a marriage agreement with a local Muslim gentleman but this lasted only four months after Nadine decided to end the relationship. In 2012 she met P via an online Muslim dating website.

11.9 P, also a Muslim, was a resident of New York in the USA.

11.10 Their relationship developed to visits in Cardiff where he was subsequently introduced to family members.

11.11 Additionally, Nadine visited New York where she met the ex-wife of P and his young son.

11.12 In December 2014 and during a visit to the UK, P had a disagreement with Nadine's brothers that resulted in an altercation. The incident occurred in Nadine's flat in Cardiff and the emergency services were called but cancelled whilst on route. P decided to leave the flat and book into a city centre based hotel. Later that same day Nadine decided to join P at the hotel.

11.13 Hotel staff report that both P and Nadine left the hotel for dinner and then returned at around 11.10pm that evening. That is the last sighting of Nadine being alive. P left the hotel at around 12.15am to visit a local casino. On returning to the hotel witnesses claim P had been drinking.

11.14 At 3.00am on Wednesday 31st December 2014, P presented himself to hotel duty staff and enquired about travel directions to London. He informed staff that his sister was asleep in the room and that she was not to be disturbed. P subsequently travelled to London and later obtained a flight to Tanzania.

11.15 During his journey, P contacted the hotel to inform staff he had killed Nadine and that they needed to check the hotel room. At 12.33pm on Wednesday the 31st December 2014, hotel staff contacted the Police. Police Officers attended at the hotel to find the body of Nadine. Cause of death was strangulation.

12. Terms of Reference for the Review

12.1 The aim of the Domestic Homicide Review 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;
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice

Process

12.2 An Independent Chair/Author was commissioned to manage the process and compile the report. Membership of the Domestic Homicide Review Panel included representatives from relevant agencies.

Individual Needs

12.3 Home Office Guidance[5] requires consideration of individual needs and specifically:

"Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted."

12.4 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

12.5 The Review gave due consideration to all, of the Protected Characteristics under the Act.

12.6 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

12.7 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

[5] Home Office Guidance 2016 page 36

Family Involvement

12.8 Home Office Guidance[6] requires that:

"Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation, to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

12.9 The 2016 Guidance[7] illustrates the benefits of involving family members, friend and other support networks as:

a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;

b) giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victim's and perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.

d) enabling families to inform the review constructively, by allowing the Review Panel to get a more complete view of the lives of the victim and/or perpetrator in order to, see the homicide through the eyes of the victim and/or perpetrator. This approach can help the Panel understand the decisions and choices the victim and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information, as well as testimony to the emotional effect of the homicide. The Review Panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.
g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

12.10 In this case, the Overview Report Author contacted the Senior Investigating Officer (SIO) from South Wales Police at an early stage. A letter dated 15th August 2015 was delivered by the SIO. This letter explained the Review process and was an open invite

[6] Home Office Guidance 2016 page 18
[7] Home Office Guidance 2016 Pages 17 - 18

for all family members to contribute to the Review. Both the Report Author and the SIO then made a joint introductory visit.

12.11 The Review was explained in more detail including the terms of reference and the timeframe. It was apparent that the family were confronted with a pending criminal trial for which no date had been set by the court to hear the case. Additionally, the family had received a visit from a representative of the IPCC who explained their role in terms of a parallel investigation. It was agreed that the DHR would continue its activities to secure information and identify early learning and that further family interviews would be deferred. The Author provided contact details to facilitate communication if the family had any immediate concerns. Regular contact was made.

12.12 On 28th January 2016 the Overview Report Author again wrote to the family and provided an update on the progress of the Review. This was supported by a series of telephone calls to provide added reassurance and support.

12.13 It was clear the family were experiencing some considerable frustration and distress regarding the delay in setting a date for the criminal trial. There were continuous defence arguments to support an adjournment in the process. It was accepted that this was beyond their control and that of the Police. The Police Family Liaison Officer had regularly updated them on progress and developments.

12.14 The Home Office were informed of the delay of the Review on three separate occasions. Correspondence dated 28th January 2016, 11th April 2016 and 27th September 2016 outline the reasons for the delay based on the criminal process and the IPCC investigation. These extenuating circumstances were accepted by the Home Office and are included in a response dated 28th September 2016.

12.15 On 17th October 2016 the criminal trial was finally heard at the Crown Court. The case was adjourned the following day after P changed his plea from not guilty to guilty to murder. There was an earlier acceptance by the defence of manslaughter based on diminished responsibility; this was rejected by the court. The case was next heard on 3rd November 2016 where P was sentenced to life imprisonment.

12.16 The family gave a televised interview outside the Crown Court after the sentencing hearing that was broadcast on the main BBC Wales news. The case received widespread regional and national media coverage.

12.17 On the 6th December 2016 the Overview Report writer met with family members at the Bawso offices in Cardiff. This was arranged and facilitated by a senior member of Bawso to add value to the Review process, by identifying any opportunities for welfare and cultural support. Such issues were identified and managed with the support of Bawso, a third sector specialist BME violence against women, domestic abuse and sexual violence agency.

12.18 Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report.

12.19 A formal request was made to P to participate in this Review but to date he has declined to do so.

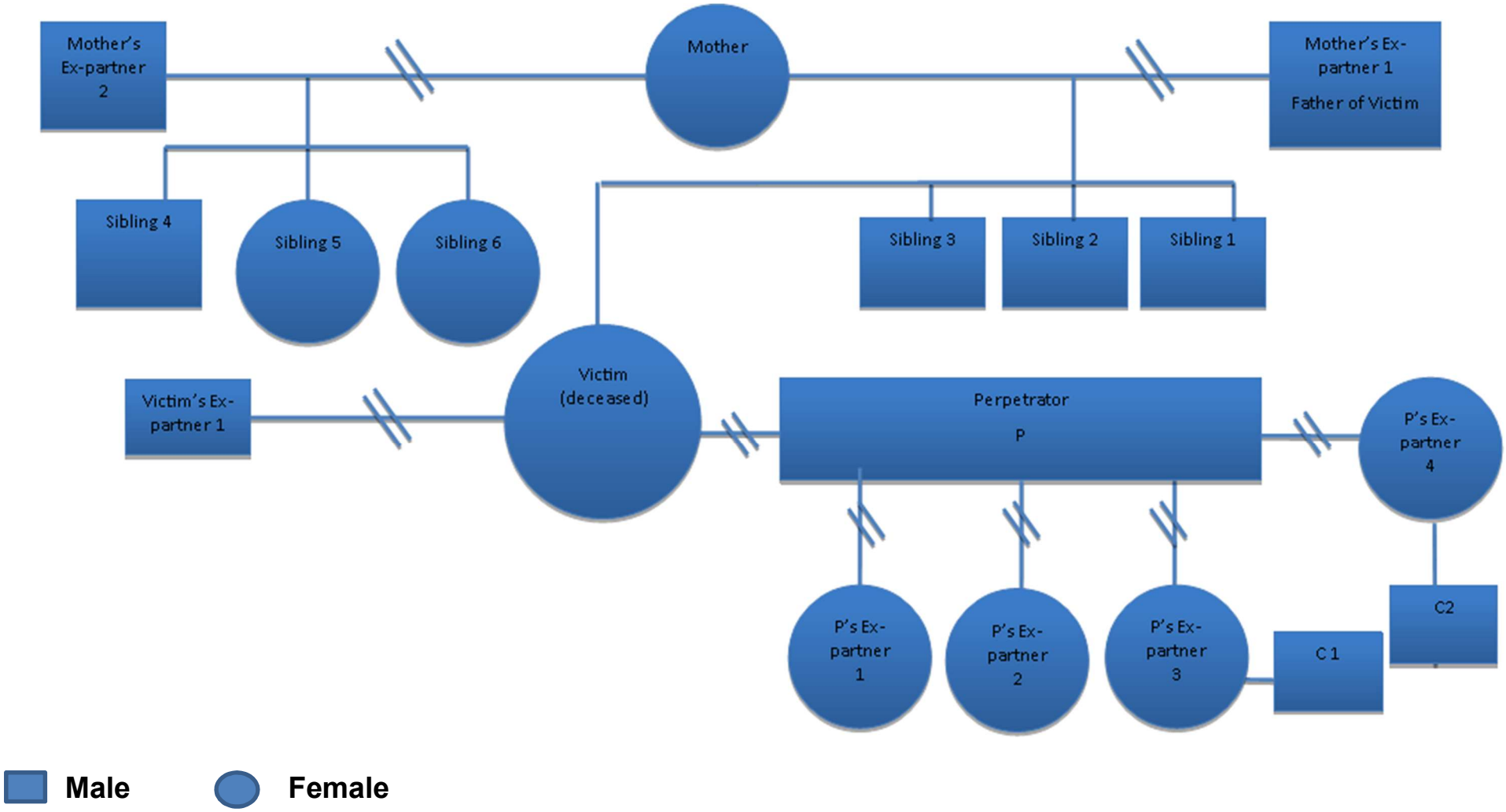
Subjects of the Review

12.20 The following genogram identifies the family members in this case represented by the following:

Known as	Description of relationship to Victim

Mother	Mother of victim
Ex-partner 1	Father of victim
Ex-partner 2	Step-father of victim
Siblings 1,2,3	Brothers of victim
Siblings 4	Half-brother of victim
Sibling 5,6	Half-sisters of victim
Ex-partner 1v	Victim's ex-partner
Perpetrator (P)	Ex-partner of victim
P's Ex-partners 1p,2p,3p,4p P's Children C1, C2	Ex- partners of perpetrator Children with ex-partners

Genogram


Mother's Ex-partner 2
Mother
Mother's Ex-partner 1
Father of Victim
Sibling 4
Sibling 5
Sibling 6
Sibling 3
Sibling 2
Sibling 1
Victim's Ex-partner 1
Victim (deceased)
Perpetrator
P
P's Ex-partner 4
P's Ex-partner 1
P's Ex-partner 2
P's Ex-partner 3
C 1
C2
Male
Female

13 Summary of Key Events

13.1 As outlined previously in this report, Nadine was born in Tripoli in Libya in March 1986. Nadine is one of seven children within a family that initially settled in Libya but then returned to the UK where they live to date. Nadine's father still resides in Libya. He has been described as a person with influence who enjoyed a professional career as a sea captain. Nadine's mother resides in Cardiff as a single mother with the remaining six siblings.

13.2 The first recorded partnership intervention is dated April 2002 where Bawso provided support to the family, by providing temporary accommodation in a refuge after a domestic related incident between Nadine's mother and her then partner. The family received support to relocate within Cardiff in accommodation that kept the family unit together.

13.3 In February 2003, Cardiff Council Children's Services Team provided support in relation to a report that Nadine was missing from home after an altercation with her mother. Nadine was 16 years old at the time. Nadine later presented herself to Kensington Police Station in London where local Social Service support was found. Nadine later returned to Cardiff where she was subsequently reunited with her family.

13.4 Cardiff Children's Services Intake and Assessment Team reviewed and provided family support. Their involvement ceased in June 2003.

13.5 In February 2006, Nadine aged 19 years, received specialist medical support for psychotic related illness. This was in relation to episodes of tearfulness and refusal to engage in conversation with medical professionals. Cardiff and Vale University Health Board provided specialist support that included an assessment by a Consultant Psychiatrist. This assessment recommended further support from a Community Psychiatric Nurse and the discontinuance of prescribed medication.

13.6 Between February 2006 and July 2006 there are numerous reports of support including home visits by the CPN and visits to the Community Mental Health Team. There are reported incidents of some failed contact attempts. However, it is clear that local mental health services were delivered and offered on a long-term basis.

13.7 During the course of this support, Nadine openly discussed both family and personal relationship issues that formed the basis of this specialist mental health support. In addition, it is clear that Nadine enjoyed an open and professional relationship with her female General Practitioner. Recorded visits are well documented and regular in nature.

13.8 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.

13.9 Nadine's mother describes this relationship as unfortunate and not one she was particularly supportive of. Nadine's mother felt that Nadine was not suited to this relationship and went on to describe her as "A Tinkerbell looking for a Peter Pan."

13.10 In April 2010, Nadine contacted South Wales Police to report a sexual assault that had occurred a week earlier. The incident was recorded and allocated a NICHE Occurrence Enquiry Log number. This is a centrally based command and control recording system utilised by South Wales Police to manage both incidents and record and monitor the progress of criminal investigations. Nadine provided the Police with a written statement

of complaint. Two Public Protection Department referral forms were completed in respect of the allegations and forwarded to relevant partner agencies.

13.11 The referrals were made to the Cardiff Women's Safety Unit and the Cardiff Sexual Advice Referral Centre (SARC). SARC provides specialist bespoke support to victims of crime. The centre enables members of staff from both the statutory and voluntary sector to provide support with appropriate services, even where the victims do not wish to report to the Police. Between May and June 2010, staff at the SARC made six attempts to contact Nadine to offer their services. On all six occasions, it is reported that Nadine did not respond.

13.12 In May 2010, the case was referred to the local Multi Agency Risk Assessment Conference (MARAC). This is a formal partnership arrangement to facilitate the risk assessment process where the level of risk is indicated as being very high. The purpose is for partnership agencies to share information with a view to identifying risk and jointly agree and construct a management plan to provide professional support. The meeting agreed supportive actions including victim based specialist support.

13.13 Between April and July 2010 there is documented contact between the Police and Nadine regarding the progress of the case. Nadine had contacted the Police to request amendments to her witness statement. The Police record twenty-three attempts to contact Nadine, fourteen of which were visits to her home with no success to address this issue. Simultaneously a referral was made to Safer Wales who provide support irrespective of whether criminal proceedings are being progressed. Nadine did not engage with that service.

13.14 At the MARAC in May 2010, an action was raised for Safer Wales to take steps to encourage Nadine to support the Police investigation. Attempts were made to contact Nadine without success. This included a support letter but again agencies report that Nadine did not respond.

13.15 In July 2010, Nadine made contact with the Police to state she did not wish to pursue the complaint. A witness statement withdrawing the complaint was made. The Police however pursued their investigations and traced and interviewed both suspects. Both denied the allegation. Police watch markers were placed on Nadine’s home address. Nadine was risk assessed as "High". The criminal investigation was concluded with no further action.

13.16 It is worth noting that Safer Wales had attempted to make contact with Nadine in August 2010 regarding Nadine’s involvement in another case as a potential witness in an unrelated assault case. Safer Wales report that in this instance attempts to contact Nadine had no response.

13.17 On 1st September 2010, Nadine reported being assaulted by her two brothers. Nadine complained that they had attempted to strangle her and had thrown her around the kitchen. The call to the Police was made instantly and in fact the Police operator could hear male voices in the background.

13.18 There was a prompt response to this call. Police Officers attended the address within the recognised Grade 1 emergency time parameters and arrested Nadine's two brothers on suspicion of common assault.

13.19 The subsequent investigation revealed admissions by one brother to assaulting another although denials to any form of assault on Nadine. The Crown Prosecution

Service was consulted and advised that no criminal proceedings should follow. The Police informed Nadine of this decision.

13.20 At the time of this incident South Wales Police adopted a Domestic Abuse Investigation Procedure (DAIP). This procedure is documented and available to all staff through the force intranet system.

13.21 This Domestic Abuse Investigation Procedure was first implemented in October 2007 and is in operation today.

13.22 The Procedure outlines advice to Police Officers that essentially can be described as follows;

- Every officer must take firm and positive action against those who commit domestic abuse and the provision of caring support to those who suffer it.
- The requirement for positive action in response to domestic abuse cases incurs obligations at every stage of the Police response.
- All cases of domestic abuse must be rigorously investigated and, where evidence exists, a prosecution should ensue. (Despite, in some cases, not having a statement from the complainant)

13.23 The Procedure also directs Police Officers to National Guidance on Investigating Domestic Abuse 2008.

13.24 This guidance contains information on the necessity of sharing information with partner agencies.

13.25 Section 6.2.7 of the Guidance outlines the necessity to share information of domestic abuse with agencies to properly "assess, manage and reduce the risk that is inevitably associated with such cases."

13.26 In relation to the incident reported on the 1st September 2010, it is recognised that South Wales Police took positive action in responding to this incident. This incident met the criteria of Domestic Abuse and a PPD1 now referred to as PPN should have been submitted to notify partner agencies of the incident. However, no such document was submitted; this has been addressed and a far more robust process is now in place to prevent this from re-occurring.

13.27 On the 2nd September 2010, Nadine again made contact with South Wales Police to report a complaint of harassment. Nadine complained that as a result of reporting the assault by her brothers she was now receiving mobile phone calls and text messages from a brother's girlfriend that she perceived to be harassment. She did not know the girlfriend's address.

13.28 The call was graded by South Wales Police as a Grade 2 call, however, due to a high volume of calls, no Police officer was immediately despatched to meet with Nadine. There is recorded evidence of subsequent Police contact that same night with Nadine to offer reassurance that they would respond. Despite subsequent numerous attempts to make contact with Nadine to arrange that attendance, Nadine did not respond and, as a consequence, Police Officers were unable to meet with her. Between 3rd and 21st September continued attempts were made by the police to meet with Nadine to no avail. When the police finally managed to meet Nadine on the 22nd September she

confirmed that she had not received any further calls or text messages. She decided that she did not wish any further Police action. It is recorded that Nadine was advised that if the calls started again she should contact the Police quoting particular Police incident reference numbers.

13.29 This incident as reported did not by definition meet the criteria of a Domestic Abuse incident. Nadine did not return the calls to the Police to allow them to take a formal complaint and progress an investigation. This was not an incident for which there was a concern for her safety, and it was therefore not proportionate to remove her phone and consider an evidence-led prosecution. Additionally, it was presented to the Panel by the Police representative that it is important for a victim to feel in control and to go against her wishes could have exacerbated a problem. However if the text messages had contained “threats to kill” then it would have been a different matter. Each case must be considered on its merits but in these circumstances the allegation was not sufficiently serious to warrant progressing without a complaint.

13.30 It is noted that from the period between July 2011 and July 2012 Health Services record various episodes of healthcare issues where services were offered and provided. Some of these records outline opportunities of missed appointments and non-attendance.

13.31 On 12th May 2013 the Home Office records P arriving at terminal 3 at Heathrow Airport. P had travelled from Newark, USA and was granted leave to enter the UK as a visitor for 6 months.

13.32 Home Office records indicate that P had sought to enter the UK to visit his girlfriend Nadine in Wales. The record shows that P had disclosed he had previously met Nadine in Dubai some 6 to 8 months previously. This conflicts with information provided by family members as well as the International Travel History that has been obtained.

13.33 As a USA national, P was not required to hold a visa to visit the UK as a visitor. On arrival, he would have to satisfy the Border Officer:

- Of his identity and nationality
- That his intention was to merely visit
- That he was able, to fund his trip without recourse to public funds.
- That he intended to leave the UK at the end of his visit.
- That his presence in the UK was conducive to the public good.

13.34 The Landing Card does not show any adverse information that was known about P and the decision to grant leave to enter appears justified.

13.35 On 2nd July 2013, Nadine disclosed to South Wales Police that she was being followed by a male person who had approached her asking questions, which made her feel uneasy. Nadine also disclosed that the male person took hold of her and pulled her towards him. The incident was graded G1 emergency and Police officers responded within the required time parameters. A local Policing Operation code named "New York" was called to swamp the locality with all available Police resources. Nadine remained in contact with Police until their arrival. The male person is reported to have vacated the locality prior to their arrival. Nadine accompanied Police Officers to search

the locality but with no success. The Police response to this incident was prompt in nature and in accordance with recognised policies and procedures. There is no information to link P to this incident.

13.36 There are three further visits recorded by the Home Office for P arriving at Heathrow Terminal 3:

- On the 18th September 2013 P arrived from JFK airport New York. As P had previously visited the UK and complied, the decision to grant leave to enter therefore appears justified.

- On the 31st December 2013 P arrived at the Heathrow Terminal 3 having travelled from New York. The circumstances and situation of arrival are exactly the same as that outlined for the September visit.

- On the 27th December 2014 P arrived at the same terminal having travelled from the USA. The circumstances and situation of arrival is again the same as that outlined previously.

13.37 On the 15th September 2014 Nadine contacted South Wales Police to disclose that she had started an on-line relationship with P and that in July of that year she had visited him in New York. During the visit Nadine further 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.

13.38 The disclosure was made to South Wales Police at 21:47hrs on Monday the 15th September 2014. The Police responded positively and immediately took steps to instigate a formal criminal investigation. During this telephone conversation, the Police operator also identified, that Nadine had further disclosed another allegation of rape that had occurred at her home address in Cardiff in 2013 during a visit by P.

13.39 The incident was recorded on the Police database. Nadine was identified as a repeat victim of rape and that her call was categorised as a sexual offence, with officers attending via a Grade 2 response. A Grade 2 response means that a response is required from the Police within the hour.

13.40 At 22:45hrs that evening Police records show that Nadine was spoken to by a Police Officer; Nadine's initial account of the disclosures had been recorded in a witness interview booklet. The Police were satisfied that Nadine was safe and supported by family members. Further enquiries would be pursued and a referral had been made to the Police Public Protection Department by the submission of a PPD1 form.

13.41 The written initial account additionally identified that Nadine had disclosed that P had attempted to strangle her and that P routinely threatened to kill her. It was further disclosed that P would self-harm and had sent Nadine pictures of his injuries stating "This is what you have done to me". It was also disclosed that P was an alcoholic. There were also allegations that P had beaten Nadine during a visit in New York in front of P's 10 year old son.

13.42 Nadine was risk assessed as High. Police warning markers were placed on her home address and her case was referred to MARAC for further review and assessment of continued support.

13.43 South Wales Police Domestic Abuse Unit reviewed the initial referral but did not assign this case to MARAC, the rationale being;

- The suspect 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 any information to bring to the meeting about him.
- The suspect would not have immediate access to the victim; he had no links to Wales.
- There were no drug and alcohol issues.
- Nadine was engaging with the Police and had a supportive family.

13.44 Nadine was referred to an Independent Domestic Violence Advocate who could support her if she so wished.

13.45 Police Watch was not instigated as the alleged perpetrator P was resident in New York, meaning that in the circumstances it was not deemed appropriate to ask officers to attend the property at regular intervals and/or install monitoring equipment.

13.46 A Detective Officer was appointed to investigate the abuse disclosures. Various appointments were made to interview Nadine utilising SARC facilities.

13.47 Between the 15th September 2014 and the 10th October 2014 there are numerous recorded attempts by various agencies to make contact with Nadine to proceed further with her disclosures. Members of South Wales Police, SARC and Bawso detail failed contact attempts.

13.48 At the time, Senior Detectives from South Wales Police had met and reviewed the investigation regarding safeguarding issues involving Nadine and options to take the investigation forward. Due to the fact that P resided in New York and that there was not a fully recorded account from Nadine, investigative options were limited.

13.49 On Wednesday the 8th October 2014 the Police Detective Officer in charge of the investigation recorded that he had received a text message from Nadine stating she did not want to pursue the complaint further and would not be interviewed. There followed a conversation where the officer stated Nadine confirmed her desire not to proceed further. The officer was satisfied that Nadine was not being coerced into making that decision and that Nadine had agreed to contact SARC for further assistance. There is no information available to confirm that SARC was contacted.

13.50 The Police investigation then became focused on alerting the US Authorities regarding the allegations made against P.

13.51 On the 31st October 2014 South Wales Police records a senior officer taking steps to notify the US Authorities. This involves the process of the submission of INTERPOL forms that would include 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 South Wales Police to the Independent Police Complaints Commission (IPCC).

13.52 On the 7th November 2014 Children's Services from Cardiff Council record receiving an expression of interest from Nadine to foster children. Between the 7th November

2014 and the 12th December 2014 there are four recorded contact attempts to Nadine both in terms of phone calls and written correspondence. The file was closed on the 12th December due to a lack of response from Nadine.

13.53 South Wales Police records indicate that during early December 2014, Nadine's brother had picked up her mobile phone and discovered that P had sent a naked image of Nadine to her phone with the comment "I am going to post these around Facebook you hoe, you mother fucking hoe." This information came to light during the murder investigation although it puts into context the following sequence of events. It is pertinent to mention that this information was not shared and or reported to the police at the time. This behaviour constituted criminal offences and if reported could have been dealt with.

13.54 P had arrived in the UK on 27th December 2014 where he subsequently met with Nadine and visited her home.

13.55 At 18:53hrs on Tuesday 30th December 2014, the Police were contacted to request an ambulance to attend the home address of Nadine. The Police operator identified the address as having a domestic violence critical incident marker. The incident involved an allegation of assault so both Police and ambulance resources were deployed. The incident was Graded G2 that requires units to attend within the hour.

13.56 The incident involved an allegation of assault. It was later established that one of Nadine's brothers had visited her only to be confronted by P. This is the brother who previously had witnessed the inappropriate text messages. A confrontation between both males resulted in P being punched in the face. It is alleged that P sustained facial injuries including bleeding to his nose and cheek.

13.57 At 19:09hrs on Tuesday 30th December 2014, Police records confirmed that the Ambulance Service had attended the address and spoken to a person via an intercom facility. Ambulance records show that they did not provide any medical support but left the address after being informed by a male person their services were not required. Police units were deployed to the address but, due to heavy demand on local resources, no visit was made to the address until 22:38hrs where Officers reported they had failed to get a response. Further Police visits were made to the address at 01:26hrs and 09:21hrs the following day, again with no response.

13.58 At 12:33hrs on Wednesday 31st December 2014, Police officers attended a hotel where they found the body of Nadine.

14 Analysis and Recommendations

Specialist Support and Intervention

14.1 It is clear from various partnership agency reports 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 as high risk.

14.2 There were a number of failed contact attempts especially with professional services that could have offered specialist bespoke support. This may have provided confidence and reassurance to Nadine to engage and cooperate. These conventional methods of contact have clearly been unsuccessful.

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

14.4 As part of this review, Nadine's mother, aunt, sisters and friends have been consulted. Nadine's mother and sisters have stated that Nadine had disclosed to them that she had little confidence in the Police. Nadine's mother explained it was Nadine's belief that the Police would not take her seriously especially after the disclosures she made in relation to the rape allegation that occurred during a visit to the US. This somewhat contradicts the information held by the Police who clearly had taken the information seriously. It was the Police that confirmed for Nadine that the circumstances that she provided constituted the offence of rape. The family further disclosed that Nadine was a deeply private person who would receive calls from the Police on her mobile phone in their presence, but would move into another room to continue with the conversation. This disclosure confirms that the Police were in contact with Nadine.

14.5 Furthermore, specialist support services from Bawso and SARC were also made available, in particular SARC support. However, Nadine chose not to respond to the appointments. The Panel has seen no evidence to suggest why Nadine would report incidents and then not to engage with either the Police or supporting agencies. On the occasions when Nadine did engage there were positive results and therefore it is difficult to comprehend why she had no confidence in the Police. It cannot be ignored that Nadine also chose not to engage with MARAC and SARC.

14.6 Nadine's mother has stated that after her visit to the US where it is alleged the rape and assault incident took place, Nadine was traumatised. Along with visible facial injuries Nadine displayed symptoms of post-traumatic shock. She was withdrawn, spent long periods of time in bed and it was difficult to engage with her. Nadine's mother suggests that this was the reason why her daughter did not engage with specialist support services. The visit to the US was in July 2014 and Nadine reported her concerns to the Police some 2 months later in September 2014 when she was concerned that P was going to post inappropriate photographs of her over the internet. No agency had the opportunity to identify that Nadine was suffering from PTSD. There is no information to confirm that she had ever been diagnosed with the same.

14.7 The author of this report made contact with senior personnel from both SARC and Bawso to further discuss their role in this Review.

14.8 SARC is well established within Cardiff providing a vital service to victims of sexual violence. There is an acceptance that the engagement of BME women is disproportionate. Staff at the SARC fully recognise the complex issues that prevent BME women from disclosing sexual violence and accessing support. Local initiatives are being considered to improve services but this remains a strategic long-term challenge.

14.9 Bawso work closely with colleagues within SARC. Efforts to enhance collaboration are being made especially in terms of further developing expertise in responding to sexual violence within BME communities.

14.10 A research document titled 'Between the Lines, Research Briefing – Service Responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence' brings together research material and provides options to improve services. The research first published in May 2015 is dynamic in nature with phase two currently being planned. This work provides an ideal platform for the Cardiff Public Services Board (formerly the Cardiff Partnership Board) to consider both a strategic and tactical overview of specialist services to BME women and girls.

The Panel makes the following recommendations.

Recommendation 1

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

Recommendation 2

The Public Services Board considers the 'Between the Lines' research document as a means to improve engagement with BME victims.

14.11 Events post September 2014 are significant in terms of the increased risk to Nadine from P. The Review has identified that in relation to the disclosures made regarding the rape allegations, six Police Officers and three members of Police support staff had direct involvement with Nadine. This is in addition to support workers from both statutory support services and the voluntary sector.

14.12 The DHR identified that within an hour of Nadine reporting P to South Wales Police in respect of a rape allegation the following procedures were followed:

- Contacted by an attending Officer who recorded her initial account.
- The same Officer completed the Public Protection Department referral form.
- Recorded that Nadine's preferred method of contact would be by way of mobile phone.
- Assessed that Nadine was not in immediate danger as the alleged aggressor P was a resident in New York.

- The allegation was historic in nature and that there were no opportunities to recover immediate physical evidence.

14.13 Nadine's risk assessment was then reviewed in accordance with local policy for possible referral to MARAC. A decision was taken not to refer the matter on the basis that P was not a resident of the UK. Whilst there is no evidence of contact with the Home Office that may have identified P's travelling habits to the UK and the likelihood of another visit, (which of course, did occur), the officers however did speak with the victim. The Police must have trust and confidence in victims and Nadine confirmed to the Police that not only had P returned home but she had also terminated their relationship. It was naturally assumed that had there been further unwanted contact, Nadine would have contacted the Police which she had done on many previous occasions.

14.14 The DHR identified that South Wales Police had checked P's details on various Police databases as part of their risk assessment process and had placed various domestic violence markers on Nadine's home address. These markers were identified during calls received to Nadine's house on the 30th December 2014.

14.15 South Wales Police could not place a "wanted marker" for P on the Police National Computer for offences linked to Nadine's disclosure. This decision was influenced by the veracity of the disclosure made. There was no recorded witness statement and the Police were in possession of information that Nadine wished to withdraw her complaint. The Police however did initiate a course of action to submit an INTERPOL enquiry form for submission to the US as an alternative option. This was intended to share information and potentially identify additional lines of enquiry.

14.16 This document was not submitted and formed the basis of a self-referral to the IPCC. A Senior Police Officer was subject to investigation. This matter is addressed in the parallel investigation section of this report.

14.17 This takes us to the issue of border control and the availability of information and intelligence to the Home Office when managing border controls. Numerous government departments and agencies own entries on the watch list, and Border Force manages the appropriate operational response if an individual is encountered at the UK Border.

14.18 The Review Panel requested information from the Home Office and posed a series of questions regarding the operational use of a Memorandum of Understanding (MOU) with particular emphasis on implementing the watch list facility in managing potential perpetrators of domestic violence.

14.19 It was established that the MOU agreed by the UK and the USA covers the sharing of personal data and intelligence. The MOU provides an ability to spontaneously disclose information. However, there is no obligation to share information and each case is shared on its merits. In this case, the US authorities had not shared any information with the UK Home Office, and neither had the Police or the National Crime Agency asked for an entry to be added to the watch list.

14.20 In terms of developing the sharing of information to mitigate risk in public protection and supporting local public protection arrangements, the Home Office confirmed that it has well established gateways to share information with UK Police forces for public protection with an MOU and the watch list being the initial mechanism to achieve this.

14.21 The Review Panel therefore agreed on the following recommendation to acknowledge that the findings require a national consideration of the issues and cannot all be addressed locally in isolation.

Recommendation 3

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

Perpetrator Management

14.22 The Review Panel was initially confronted with a paucity of information regarding P, especially in terms of his antecedent history and involvement with US agencies. South Wales Police had to negotiate a complex process of application to US law enforcement authorities to obtain information. Due to the live criminal justice process, the Panel only had sight of this information post-trial. P was formally written to in August 2015 with an invite to participate in the Review, however P has not responded.

14.23 The Panel established that P was born in Saudi Arabia in December 1970. There is no information available as to how and when he came to settle in the US. At the time of the homicide he was a resident in Brooklyn, New York. P was employed in a local grocery store and had a second job as a taxi driver. He had recently separated from his partner 4. P was the father of two children with separate partners identified as partner 1 and partner 4.

New York Police reported incidents with P are recorded as follows:

- January 2001 recorded incident of domestic violence with ex-partner 1 (wife)
- August 2002 reported incident of domestic violence with ex-partner 1 (wife)
- August 2004 recorded incident of domestic violence with ex-partner 2
- May 2009 criminal conviction of unauthorised use of a vehicle.
- May 2009 criminal conviction of reckless endangerment linked to the unauthorized use of a vehicle.
- August 2009 criminal conviction of unauthorized use of a vehicle.
- August 2009 criminal conviction of reckless endangerment linked to the unauthorized use of a vehicle.
- January 2012 recorded incident of domestic violence with ex-partner 3. There was an order of protection put in place until January 2013.
- July 2012 recorded incident of domestic violence with ex-partner 3
- July 2012 recorded incident of domestic violence with ex-partner 3
- August 2012 recorded incident of domestic violence with ex-partner 3

14.24 On 8th January 2012, ex-partner 3 alleged that P had put his hand over her mouth and the other hand over her throat preventing her from breathing. At the time an order of protection for ex-partner 3 was in force which P evidently had violated.

14.25 Although this order of protection expired on 23rd January 2013, the New York Police Department still has an open case for violating this order of protection and documentation received from NYPD stated P will be arrested when encountered.

14.26 Information from the US regarding P suggests he was a serial offender of domestic violence who at the time of the death of Nadine could have been arrested by the US authorities for the violation of the Protection Order.

14.27 P also had a history of self-harm and suicidal behaviour. In August 2004 New York Police filed a domestic violence report that P was intoxicated and had self-harmed with a kitchen knife. The report stated P was removed to a hospital for psychological evaluation.

14.28 In context, P posed a risk to public protection. He was able to leave the US on numerous occasions when information from the NYPD suggests an arrest option was available for the breach of the Protection Order. There is no information available to suggest that this information was shared between border agencies. P had been identified as a risk to victims of domestic abuse in the US. He left the US unchallenged on numerous occasions and entered the UK where allegedly he continued this abuse on Nadine. He then murdered Nadine and fled the country.

14.29 The Review Panel makes the following recommendations

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.

Recommendation 5

The Home Office works 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.

14.30 Nadine's mother explained that she introduced a dating website to her daughter as a means of finding a new partner. A Muslim dating site was preferred in the hope that someone who shared their cultural beliefs could be identified. It was on this website that Nadine first made contact with P. Neither Nadine nor her mother could have known P's background. It is accepted that those who manage this type of dating service cannot be responsible for the profile design of participants. However, the issue of integrity and authenticity of participants is of public interest. The Panel therefore wished to highlight this as a recommendation (The Home Office and the dating website industry work together on a national campaign to raise awareness of public protection issues and seek a collaborative approach to mitigate risk) in this report. However, following discussions with the Home Office representatives, the Panel acknowledge that this cannot be actioned by any one organisation and must be dealt with at the UK Government level.

Parallel Investigations

14.31 In August 2015, the Coroner for Cardiff and the Vale of Glamorgan was formally notified of the DHR. Details of the Review were explained including an invite to participate if considered appropriate. The formal Coronial process was concluded at the conclusion of the criminal trial.

14.32 In March 2015 the Independent Police Complaints Commission conducted an independent investigation into actions of South Wales Police following a complaint of domestic abuse made by Nadine in September 2014.

14.33 The matter had been independently referred by South Wales Police.

14.34 A redacted copy of the final IPCC report was made available to the DHR.

14.35 The terms of reference for the review were as follows:

- To establish whether South Wales Police identified this as a domestic violence case in line with Force and national policies and procedures. To determine if South Wales Police properly followed any such guidelines, policies and procedures.

- To determine if the Force took reasonable and appropriate action including conducting risk assessments, in respect of the welfare and personal safety of Nadine.

- To identify what measures South Wales Police had put in place to minimize the risks to Nadine.

- To ascertain why a requisite assessment form was not completed as required.

14.36 A Senior Police Officer within South Wales Police was identified as being subject to investigation.

14.37 In April 2016 the Chair and author of this review met with the IPCC Commissioner and the IPCC investigator. The purpose of the meeting was to share information and agree a way forward especially in terms of managing family liaison.

14.38 The IPCC fully cooperated with the DHR.

14.39 It was ascertained that the IPCC would also review the Force's responsibility to exchange information with international law enforcement partners.

14.40 A detailed and thorough IPCC investigation was undertaken with enquiries not only being undertaken locally but nationally and internationally.

14.41 The IPCC interviewed Police Officers and Police Support Workers within South Wales Police and consulted with the National Crime Agency (NCA).

14.42 The IPCC investigator also consulted with officers from NYPD.

14.43 The scope of the investigation was limited to the rape allegation in September 2014 and the subsequent enquiries made regarding P.

14.44 In terms of investigative action with regards to the rape allegation the IPCC determined that:

- Evidence shows that South Wales Police followed all relevant lines of enquiry, in that they were dealing with a historic allegation, having limited information and no evidence to substantiate Nadine's report.

- In light of this the Officer's ability to gather alternative evidence was limited, and therefore it was the opinion of the IPCC lead investigator that the identification of an INTERPOL form can be viewed as a positive step in that it had the potential to identify new lines of enquiry for the investigation.

- The Police Investigating Officer had also provided documentary evidence that Nadine had also been referred to SARC for specialist support.

- The INTERPOL form was a method by which new lines of enquiry could be identified. This was not intended to be a safeguarding measure but as outlined, an additional step of establishing new lines of enquiry for the investigation.

- The Senior Police Officer subject to investigation took responsibility for the management of this document. The IPCC found that there was no evidence to suggest that the delay in submitting the INTERPOL form was due to a deliberate act or omission. The INTERPOL form was never submitted due to an administrative error.

- The IPCC also stated that the failure to submit the form would not have had any impact on the chain of events that led to Nadine's death.

- This is based on the process of dissemination from the NCA to the NYPD and confirmation from NYPD that officers in New York are not able to take any action against an alleged perpetrator in the absence of a formal complaint.

- The INTERPOL form is not a safeguarding measure and would not therefore have had any influence on the risk assessment for Nadine.

14.45 The IPCC did however identify a lack of clear 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.

14.46 The IPCC concluded by identifying that national guidance relating to the way in which international enquiries are being managed is currently being reviewed. The College of Policing is currently carrying out this review.

14.47 In view of this parallel investigation and the identification of a national review into the management of international investigations the Panel would recommend that:

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.

15 Family Views

15.1 As stated above, in accordance with the Home Office Guidance, members of Nadine's family were written to at an early stage of the process, explaining the purpose of the Review and offering them the opportunity to contribute should they wish to do so. They were signposted to Advocacy After Fatal Domestic Abuse (AAFDA) support networks and opportunities within Bawso.

15.2 Nadine's mother, sisters and aunt were visited and consulted with. Details of what they told the Overview Author are recorded within this report. Former partners of P reside in the US and have not been contacted.

15.3 The family specifically asked the DHR to look at the following;

- What did the authorities know about P?

- Is there anything that could be done to alert users of web-based dating sites of potential serial abusers?

15.4 Attempts have been made to answer both these matters. The DHR has had to rely on information from SWP and the Crown Court regarding P's involvement. There is no locally based information source available.

15.5 As stated above, P and his solicitor were written to at the beginning of this Review process inviting P to participate. He did not reply to the letter.

15.6 The Prison Service are reluctant to disclose the location of P within the prison system. His current place of detention is unknown to the Review Author. Additionally, P is not willing to assist in the disclosure of his medical records, which would include psychiatric assessments carried out pre-trial. This places the DHR in a position of difficulty to further review and assess potential agency involvement. The National Probation Service is also unable to help in these circumstances.

15.7 This Overview Report is therefore submitted without the benefit of the views of P and without any details of his medical or mental history that may have assisted in formulating conclusions.

15.8 The family were provided with a copy of this report and when they were in a position to do so they were asked to comment on any issues they had identified. The family's response is contained in the conclusions section.

16 Home Office Guidance 2016[8]

16.1 As stated earlier in this report, the perpetrator in this case declined to be seen by the report author or provide access to medical records. It is thought that those records may hold significant information that would have been valuable to this Review.

16.2 The revised Home Office Guidance on Domestic Homicide Reviews was published on 8th December 2016. Section 10 of the guidance – Data Protection, deals with the release of medical information and requires the Department of Health to:

"encourage clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and

b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

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.

[8] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office December 2016

The Department of Health recognises that DHRs have a strong parallel with child Serious Case Reviews. Guidance advises doctors that they should participate fully in these reviews when the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent. The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's." (Paragraphs 99 and 100 refer)"

16.3 This new section of the guidance appears to be the avenue by which medical information regarding perpetrators such as P in this case, could be made available to the Review process even when the perpetrator declines to give permission. The Panel are of the opinion this needs further explanation by the Home Office, especially relating to those who have not been resident in the UK. Some Panel members consider that to do so without permission is still breaching the Data Protection Act and even Human Rights legislation.

16.4 It is considered that before any proactive action is taken regarding this part of the new guidance, a more detailed explanation is required as well as a sample template letter that could be used nationally so that every DHR approaches this sensitive issue from an identical position. Therefore, the following recommendation is presented.

Recommendation 7

The Public Services Board requests further clarification from the Home Office of 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.

17 Conclusions

17.1 This Review clearly identified that Nadine was the victim of a catalogue of incidents that constitute domestic abuse. Various agencies were sensitive to the needs of Nadine and there is documentary information available to substantiate not only identification of this need but offers for support. Appropriate support sensitive to cultural and religious beliefs were available within SARC.

17.2 Specialist support workers and experienced Police Investigators were also available to provide support. Nadine was properly assessed as High Risk. South Wales Police recently launched 'Operation Liberty'. This initiative seeks to reinforce to staff that Public Protection is the priority for the Force. Firm emphasis is placed on the need to take positive action which will not always mean arrest. The persistence of South Wales Police in their attempts to make contact with Nadine following her contact with them, is testament of their determination to provide this service. It is regrettable that in some cases victims choose not to engage with the Police which was the case involving Nadine.

17.3 There was a partnership approach in place to provide support although it has to be accepted that local agencies had little or no information regarding P who originated from outside of the UK. If they had this information, then there may well have been a more proactive approach in perpetrator management that strengthened safeguarding responsibilities.

17.4 Failed contact attempts appear to be a consistent theme, although the Panel accepts family representation that post-traumatic stress may have been a significant contributory factor as to why Nadine did not to keep appointments for support. This issue is included in one of the recommendations.

17.5 Post traumatic stress is an anxiety disorder caused by very frightening or distressing events. Victims often experience nightmares, flashbacks, isolation and feelings of guilt. There may well be anxiety when some victims often relive the traumatic event. Nadine's mother describes these symptoms having identified them when Nadine returned from the US - a trip where the alleged incident of rape took place. Nadine's mother was unaware of the support network on offer at the time. Nadine was determined and independent; she may well have had a personal intention to deal with issues herself.

17.6 If the authorities were in possession of a formal complaint then P would have been subject to arrest, investigation and potentially entry into the criminal justice system. Victim support would have followed for Nadine. However, no such complaint was in place and P entered the UK unchallenged and further assaulted and ultimately murdered Nadine.

17.7 The Review identified that P had a history of domestic abuse in the US, some incidents of which are clearly violent. However, he entered the UK on numerous occasions and was treated as a visiting tourist. This was at a time when there was an arrest option available to US authorities for the breach of an Order designed to protect a previous female victim.

17.8 It is outside the scope and influence of this Review to challenge this sequence of events although the Panel feels strongly that this should be addressed in accordance with the relevant recommendation included in this report.

17.9 P has been identified as a serial offender for domestic violence. He entered the UK on numerous occasions and reoffended. He then deliberately left the UK to travel to another country to escape justice.

17.10 These exceptional circumstances placed South Wales Police in unfamiliar territory in terms of managing the investigation. Different criminal justice systems and business processes were difficult to negotiate. To date, P has never been formally interviewed by local detectives. Only accounts provided at the Crown Court can provide us with an insight into his character, antecedents and motivation to offend.

17.11 This can be evidenced by local media reports made during the trial that portrayed P as a millionaire and wealthy property developer, when in fact the local intelligence from the NYPD describe him as a grocery store worker and taxi driver.

17.12 Dating websites are a modern social personal introductory system where individuals can find and contact each other over the Internet to arrange a date, usually with the objective of developing a personal or romantic relationship. Some of these websites offer bespoke facilities for individuals or those with, for example, specific cultural beliefs. Nadine used this facility to find a suitable partner.

17.13 The dating website industry no doubt has difficulty in identity management. Perpetrators of domestic violence can infiltrate a network and prey on other victims. The Panel accepts the legitimacy of such a service but not at the expense of failing in a duty of care to protect. There is no information available to suggest that in this circumstance anyone was aware of P's antecedent history of abuse. However, raising awareness of flawed identities within the public domain may well mitigate risk.

17.14 At Crown Court in April 2016, P was convicted of murder.

17.15 In evidence, P claimed the "voice of god" had led him. His defence argued that P had a dis-social personality disorder which meant he had low tolerance to frustration and a discharge of aggression including violence.

17.16 The Crown Prosecution Service argued that P "deliberately strangled her, (Nadine) then fled the scene and left the country to avoid the consequences of his own actions".

17.17 Extensive family consultation has taken place. Family members were encouraged to actively participate. They were provided with the opportunity to review the report in private. They subsequently offered comment and suggested amendments where appropriate. In one such meeting with the review author, seven family members were present and all took part in the discussion.

17.18 The family were keen to explore the following two issues:

Q. What did the authorities know about P?

The family are satisfied that UK based authorities had very little information regarding P's antecedent or offender history. It was only during the criminal trial that it emerged P may have had a criminal background. This trial was cut short after a guilty plea was offered by P on day two of the proceedings. It was only after the criminal justice process had been completed that Panel members and the family became aware of P's current situation within the US criminal justice system, and his potential arrest for a domestic violence complaint with a previous partner. This issue is contained in recommendation four.

Q. Is there anything that could be done to alert users of web-based sites of potential serial abusers?

This is a particularly sensitive subject matter. Nadine's mother will explain that she encouraged Nadine to use this dating site to find a suitable partner. There was never any indication that P was unsuitable although during the latter period of the relationship, the family became aware that P was influencing, controlling and threatening to circulate through social media intimate and private photographs of Nadine.

Furthermore, the family believe that gifts of a mobile phone and iPad to Nadine were simply a means of monitoring Nadine's movements - an intrusion into her private life.

Recommendation five outlines the family's views on this matter. Other reviews conducted across the UK have also identified this issue, although there is no information available to suggest a collaborative approach has been considered by either the Home Office or the dating website industry to mitigate and inform users of potential risk.

17.19 It is the family's wishes that Nadine is identified personally within the DHR and all other relevant documentation. They do not wish her to be identified by way of a pseudonym.

17.20 This report has purposely set out not to express a conclusion on predictability or preventability but to outline a documented sequence of events that led to the tragic death of Nadine.

17.21 These events are summarised into a series of recommendations that aim to raise knowledge and understanding of individual statutory responsibilities and to improve and develop public protection based policies. Uniquely this review has identified local, national and international issues suitable for review.

List of Recommendations

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. Acceptance, and focus should be placed on victims who may display post-traumatic stress as a reason for non-engagement.

Recommendation 2

- The Public Services Board considers the 'Between the Lines' research document as a means, to improve engagement with BME victims.

Recommendation 3

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

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.

Recommendation 5

- The Home Office works with the US Authorities and conducts 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.

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.

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.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews
2011, Home Office

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
Revised August 2013, Home Office

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
December 2016, Home Office

Independent Police Complaints Commission Report into the actions of South Wales Police following a complaint of domestic abuse made by Nadine Aburas (deceased) in September 2014

National Guidance on Investigating Domestic Abuse 2008

Between the Lines - Research Briefing document into service responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence. May 2015. Dr Ravi K Thiara, Samantha Roy and Dr Patricia Ng.

Correspondence

1: April 2015 – Correspondence to Home Office

2: August 2015 – Letter of introduction to family

3: August 2015 – Letter to P

4: August 2015 – Letter to Governor HMP

5: August 2015 – Letter to solicitor representing P

6: August 2015 – Letter to Coroner

7: January 2016 – Additional correspondence to family (Update on status of review)

8: January 2016 – Additional information to Home Office (Update on status of review)

9: September 2016 – Additional correspondence to Home Office (further update)

10: September 2016 – Response from Home Office acceptance of status of review.

11: July 2017 – Family invited to meet with Panel

12: August 2017 – Border Force approve report and Action Plan