Domestic Homicide Review

Salome

January 2021

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 7th November 2023

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Salome, a resident Kent, prior to her death in January 2021. On that day, police officers attended the property and found that the victim had sustained fatal injuries. Her ex-husband, Ahmed was arrested for murder and was subsequently charged and remanded in custody.

1.2 This DHR examines the involvement that organisations had with Salome who were both of North African heritage. Salome had been brought up in Britain and viewed herself as British.

1.3 This review began in June 2021, following a decision by Kent Community Safety Partnership after discussions and research received from the core group panel it was confirmed that the case met the criteria for conducting a DHR. That agreement had been ratified by the Chair of the Kent Community Safety Partnership.

1.4 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members.

1.5 In order to respect the wishes of the family, the ethnicity of the individuals who are subjects of the review is not specified within the report but explained as North African and British. The cultural background of the two individuals has not been made specific to protect the family.

2. Methodology

2.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Salome and/or Ahmed.

2.2 In addition to IMRs, one organisation provided a Supplementary Report in relation to questions about their contact with Ahmed.

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2.3 Each IMR included a chronology and analysis of the service provided by the agency submitting it. The IMRs highlighted both good and poor practice and identified areas for improvement for the individual agency.

2.4 Any issues relevant to equality, i.e., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation were identified within the IMRs.

3. Terms of Reference

3.1 The Review Panel first met on 11 June 2021 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined.

3.2 The Purpose of a DHR

a) 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;
b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

3.3 The Focus of the DHR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Salome.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The full subjects of this review will be the victim, Salome, and the alleged perpetrator, Ahmed.

3.4 Specific Issues to be Addressed.

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Salome and Ahmed knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Salome and Ahmed? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Salome and/or Ahmed subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries

made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

viii. Was this information recorded and shared, where appropriate?

ix. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

x. Were senior managers or other agencies and professionals involved at the appropriate points?

xi. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiii. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Salome and Ahmed and promote their welfare, or the way it identified, assessed, and managed the risks posed by Ahmed? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

xiv. Did any staff make use of available training?

xv. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvi. How accessible were the services to Salome and Ahmed?

xvii. How did agencies seek to offer Salome an ongoing carer's assessment and support as Ahmed's condition deteriorated?

xviii. When Ahmed sought help from services between 23 and 26 January 2021, what risk assessment was undertaken to support both him and Salome?

xix. What impact did the Covid-19 Pandemic have on the provision of services to Salome and Ahmed?

4. Contributing Organisations

4.1 Each of the following organisations contributed to the review…

Agency/ Contributor	**Nature of Contribution**
Kent Police	*IMR, panel member for Domestic Abuse Family Liaison contact*
Kent and Medway Partnership NHS Trust	IMR and panel member
Kent and Medway Clinical Commissioning Group	Facilitated GP IMR and supplementary report, panel member
Thanet Housing Department	IMR and panel member
Kent County Council	Panel member for safeguarding advice
Oasis	Specialist Advice for Domestic Abuse and panel member
NHS England and Improvement South East Mental Health Homicide Lead	Mental health and dementia advice

5. Review Panel Members

5.1 The Review Panel was made up of an Independent Chairperson and senior representatives of organisations that had relevant contact with Salome and/or Ahmed. It also included a senior member of the Kent Community Safety Team and an independent advisor from a Kent-based domestic abuse service.

5.2 The members of the panel were:

Agency	**Name**	**Job Title**
Independent	Nicola Brownjohn	Chair and Overview author
KCC Community Safety	Kathleen Dardry	Community Safety Practice Development Officer
Kent & Medway Integrated Care Board	Zoe Baird /Lisa Lane	Designated Safeguarding Nurses

Agency	Name	Job Title
(Formerly the Clinical Commissioning Group)		
Kent Police	Ian Wadey/Mike Brown	Detective Inspector
Thanet Council	Jo-Anna Taylor	Community Services Manager
Kent County Council Adult Safeguarding	Catherine Collins	Adult Strategic Safeguarding Service Manager
Kent & Medway NHS and Social Care Partnership Trust	Alison Deakin	Head of Safeguarding
Oasis	Deborah Cartwright	Independent Domestic Abuse Specialist

5.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Salome or Ahmed. The panel met on five occasions during the DHR.

6. Independent Chair and Author

6.1 The Independent Chair, who is also the Author of this Overview Report, is Nicola Brownjohn. Nicola is a registered nurse who has worked in safeguarding for 20 years. She has extensive experience of strategic multi-agency partnership work which has enhanced domestic abuse knowledge which has included commissioning of domestic abuse prevention programmes and leading on domestic homicide reviews, on behalf of the NHS. Since November 2019, Nicola has worked independently advising strategic safeguarding partnerships and undertaking audits and learning reviews in relation to domestic abuse and safeguarding. She has completed the Home Office DHR training and has completed all Kent County Council training required to undertake the role of Independent Chair.

6.2 The Independent Chair role is to provide assurance that the approach into undertaking the review has been transparent to allow the family to be confident that their questions have been fully explored and that the agencies involved

commit to taking forward their learning from the review to prevent future deaths from domestic homicide.

6.3 The Independent Chair has no connection with eh Community Safety Partnership and agencies involved in this review, other than in relation to Safeguarding Adult Reviews she has chaired since 2020.

7. Summary Chronology

7.1 Salome was living in her property, owned for several years, when she was killed.

7.2 On a mid-morning in January 2021, police were called to the home by members of the public.

7.3 When police arrived, they found Salome in the house, having sustained fatal injuries.

7.4 Following Salome's death, Ahmed was charged with her homicide. A trial of fact took place in 2022 where the jury agreed that Ahmed was responsible for Salome's death. Ahmed is currently in a mental health unit.

7.5 Salome owned the property and Ahmed lived in the house as well, although they had not lived as a married couple for several years.

7.6 Around the time of the breakdown of their marriage, Ahmed had been diagnosed with dementia. According to Salome's family, she felt responsible for him and so he remained in the home, with Salome as his carer.

7.7 Over a number of years, Ahmed's condition gradually deteriorated. His behaviour changed and Salome described him as having multiple personalities.

7.8 Services worked with both Ahmed and Salome to offer support. Salome expressed frustrations at times, due to Ahmed not listening to her and not respecting her wishes in relation to the management of the home. Salome stated that she was 'taking on more and more' and that it was increasingly impacting her life.

7.9 Mental Health and GP services interacted with both Ahmed and Salome. There were offers of referrals to social care to provide support for Salome in her caring for Ahmed. However, it was reported that Salome repeatedly refused the referrals to social care as she did not want to see Ahmed placed in a home.

7.10 In January 2019 Salome telephoned the mental health team to inform them that she could not cope with being Ahmed's carer anymore as he did not listen, he was rude, disrespectful and she wanted him out.

7.11 In March 2019 Ahmed was seen for an outpatient appointment with the consultant psychiatrist with Salome in attendance. It was noted that Ahmed's presentation was more changeable, he was more labile in his mood. It was thought this change was the main factor causing the breakdown of his relationship with Salome. Salome was still supporting him but found it difficult at times. There was no reported suicidal ideation and thoughts of harming others by Ahmed. The main risk was noted as self-neglect and no support due to the risk of carer breakdown.

7.12 In September 2020, a mental health risk assessment for Ahmed was reviewed. In relation to any risk to himself, to others or from others Ahmed denied any thoughts or risk of harm. The possible risk noted for him was potential self-neglect due to his difficulties managing his day-to-day activities and his reliance on Salome who supported him. Salome was recorded as a protective factor for Ahmed, and it was noted that she was supportive.

7.13 In January 2021 Ahmed attended the local police station front counter reporting he wanted to leave his wife (Salome) and seek alternative accommodation. He disclosed that whilst arguing with Salome in relation to finding other housing, she had pushed him in the face. It was reported that he had no visible injuries and would not discuss this issue with the officer further, he did not want anything done in relation to this incident.

7.14 Whilst at the Police Station Salome reportedly rang Ahmed and they spoke in the officer's presence. Salome expressed concerns for Ahmed's mental health and vulnerability and agreed to attend the Police Station to collect him. Ahmed stated he did not want to return to the home and left the Police Station stating he would stay at the beach for the night.

7.15 Ahmed was reported to leave the police station abruptly and officers were concerned about his welfare, as Salome had told them about the dementia. Ahmed was recorded as a missing person and located some two hours later.

7.16 The officers who located him spent some time speaking with him. They had been made aware that he had dementia and was considered vulnerable. They noted that Ahmed had food, drink, a sleeping bag, and a bag of clothing. He was negative in some respects when speaking of Salome describing her as narcissistic and alternatively explaining how she had helped and supported him.

7.17 Two days later Ahmed telephoned the Single Point of Access (SPoA) to request support and requested to see the consultant psychiatrist. During the call, Ahmed expressed that Salome was manipulative. He referred to her as a psychopath and a narcissist. He stated that he was 'broken physically, mentally, morally and spiritually.' He lost everything he had, and she gained.

7.18 Ahmed stated he had not been able to sleep for the last three days due to the trauma he had suffered and had just been crying. He feared that his wife wanted to have him admitted to a mental health hospital because he was 'crazy', but he said he was not.

7.19 The SPoA call handler advised Ahmed to contact SPoA again if needed or if his mood declined and that the issues expressed were not mental health problems.

7.20 The following day, Ahmed contacted the local housing team, and reported that he had been abused by his landlord and asked to be housed. The call handler advised that he needed a police reference number and so Ahmed was reported to say that he would go back to the police station the next day. There was no further contact.

7.21 Three days later police gained entry to the home following calls of an incident, to find Ahmed downstairs and Salome in a nearby room with fatal injuries. Ahmed was arrested and subsequently charged with the murder.

8. Conclusions

8.1 Salome's death could not have been predicted. There were no indications that she had been victim of domestic abuse prior to the day of her death. Certainly,

her sister informed the reviewer that Salome had not been a victim of domestic abuse. However, there were significant indicators of the stress she was under in caring for Ahmed. The reason for her refusal of a referral to social services was not questioned. This could have provided her with support and the opportunity to stop being Ahmed's carer. Yet, there was no recognition that Salome might have been minimising the challenges she faced in order to avoid Ahmed being taken into residential care, rather than being able to see that a home care package might be possible.

8.2 Salome's misunderstanding of the extent of Ahmed's condition on his capacity to function was recognised but not explored with her. Had this been done, she might have been able to accept support in his care.

8.3 Ahmed reported that he was being abused, yet the possibility of him being a victim was hidden due to the focus on his dementia and gender. Had this been explored then there would have been the opportunity to fully assess Ahmed's needs and safeguard him, whilst also assessing Salome's needs as his carer.

8.4 The potential for domestic abuse to be occurring in a household of with older adults did not appear to have been part of the assessments and contacts undertaken by practitioners. Bows (2018) suggests that, nationally, older people are traditionally seen as a low risk for violent crime. Yet, 1 in 4 domestic homicides involves an older victim.

8.5 The DHR panel has had considerable debates about the needs of both Salome and Ahmed. The victim in this DHR is Salome and the panel has fully acknowledged the harrowing circumstances of her death. However, the panel has also discussed the situations in which Ahmed either reported he was a victim or that there were indicators that he could have been someone with care and support needs, with the carer making decisions about the support he received.

8.6 It is acknowledged that the DHR panel has had the benefit of hindsight and seeing the information of all agencies together. However, the approach the panel has taken has been to consider what was known at each critical point in the chronology. This demonstrates that, although the traumatic outcome could not have been predicted, there could have been more professional assessment and

reflection on the circumstances in which the two individuals functioned. Salome's sister affirmed the panel's approach.

8.7 What this review has shown is that this case is not unique within DHRs and the learning from this case could have the impact of preventing future homicides involving individuals with dementia.

8.8 The DHR panel were aware of another DHR involving an individual diagnosed with dementia and their carer. It is crucial that the learning from these DHRs is taken forward to establish a system in which there are assessments of both the individual with dementia and their carer to ensure that they are able to express their wishes, fears, and concerns for their future.

8.9 This DHR demonstrates the risks of services with pathways that do not promote a personalised approach to the individual with care and support needs. This leads to transactional contacts between the professional and the individual, or carer. This leads to the missed opportunities to undertake thorough assessments and work collaboratively to develop a plan of care for the individual.

9. Lessons to be Learnt

9.1. Professionals working with those taking on 'informal' caring responsibilities for another person, must be able to consider the needs of the carer without bias in relation to gender and ethnicity.

9.3.1. It is vital that assumptions are not made about women caring for 'husbands', especially if it is reported that the marriage or partnership has ceased.

9.3.2. Agencies should promote, with their staff, the use of the frameworks of the Care Act 2014[1] and NICE guidance for dementia[2], to support them in working with carers effectively.

9.3.3. The recommendations from the Sylvie DHR should be reiterated to all agencies working with individuals who are receiving support from informal carers. These

[1] HM Govt. Care Act 2014. c23.s1(2)
[2] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#supporting-carers

recommendations should be shared with the Kent and Medway Safeguarding Adult Board to link with their work on carers' assessments.

9.2. Those who work in public services must have knowledge and skills in recognising potential victims of domestic abuse, without bias in relation to gender, religion, ethnicity, age, mental health or disability.

9.3.1. This is important to ensure that assumptions are not made about who a person is and the circumstances that can place them at risk of harm.

9.3.2. Agencies should promote the understanding of intersectionality, to support staff in avoiding the labelling of individuals and ensure that assessments are person-centred.[3]

9.2.3 The categories and systems can be described as[4]:

- Social identities- woman, ethnicity
- Sociodemographic categories of gender, ethnocultural
- Social processes (e.g., gendering and racializing)
- Social systems (patriarchy and racism)

9.2.4 In addition, the age of an individual should not make the difference between whether they are asked about domestic abuse as a routine enquiry. Agencies should emphasise, within domestic abuse training, the need to consider the risks of domestic abuse in households where there is someone whose behaviour is changing due to dementia or other health conditions.

9.3. Those working with individuals with care and support needs, and their carers, must be able to recognise, and respond appropriately, to indicators of domestic abuse such as disclosures of a carer not being able to cope.

9.3.1. It is important that professionals undertake holistic assessments for those individuals who have complex care and support needs. This will enable the

[3] UN Gender and racial discrimination: Report of the Expert Group Meeting) https://www.un.org/womenwatch/daw/csw/genrac/report.htm

[4] Dhamoon, R. K. (2011). Considerations on mainstreaming intersectionality. *Political Research Quarterly*, *64*(1), 230–243.

inclusion of the carer views, needs, and any risks to either the carer or the individual to whom they are providing care.

9.3.2 Situational couple violence (SCV) can be described as escalating violence due to the dynamics of the relationship and wider issues in which a couple find themselves. Johnson states that this type of domestic abuse is not caused by any coercive control by either partner.[5] Violence does not always appear as a routine part of a couple's relationship in situational couple violence. Johnson recognises that all couples can experience conflict rather than one controlling partner.[6] Johnson[7], states that SCV is the most common type of partner violence which does not involve one controlling the other but there may be more '*gender symmetry'* that is not seen within intimate partner violence, with coercive control.

> '*The violence is situationally provoked, as tensions or emotions of a particular encounter lead one or both of the partners to resort to violence.'*[8]

9.3.3 This type of domestic abuse relates well to Ahmed and Salome's situation, as far as the information available to the panel would suggest. There had been no report of domestic abuse until just a few days before the incident. However, the couple were in a situation not within their control and so was known to have its challenges. Johnson suggests that

> *'Sometimes the root cause lies in chronic sources of stress and conflict in the couple's life that are no fault of their own; sometimes it lies in the psychological problems of one member of the couple'*[9]

9.4. Those working with individuals with care and support needs, due to dementia, must be able to recognise, and respond appropriately, to indicators of safeguarding risks.

9.4.1. It is crucial that professionals recognise the impact dementia can have on relationship between the individual and those who care for them.

[5] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press. pp60-62.
[6] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press. p63.
[7] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p108
[8] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p108
[9] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p70.

9.4.2. The frequency of reviews should be responsive to the needs of all individuals diagnosed with dementia. It is important that a review date is set when the initial care plan is agreed. As a minimum, the plan should be reviewed annually (any reviews should always be with the person living with dementia and their family/ carers to reflect changes in needs and wishes, although this should be separately to promote an openness from all parties.[10]

9.4.3. Professionals should be able to have the time, and skill, to explore with the individual and their carers how they manage their life, on a day-to-day basis, and their plans for the future. For an individual who has been diagnosed with dementia, there needs to be professional understanding of what they want from their life in the long term. For the carer, there needs to be ongoing clarification that they are willing to continue to provide the care, are able to do so, and that they comprehend how the individual's condition will progress. The NICE guidance 97 (2018) sets out the need to involve people living with dementia in their care, using modified ways of communication and a structured tool to assess the likes, dislikes, routines and personal history of a person living with dementia.[11] This provides a platform from which a professional can undertake their exploration to ensure that the individual and carer are united in their situation.

9.4.4. Good practice when assessing the needs of an individual who has been diagnosed with dementia is to find out about their personality and their history.[12] This can help practitioners to use as a benchmark for any behavioural or mood changes noted at a later stage. It can also help the practitioner to ask the question about any previous domestic abuse.

9.5 National action is required to address the evidence that dementia is featuring increasingly in DHRs and Safeguarding Adult Reviews (SARs)

9.5.1 There is research in the United States of America looking at fatality reviews which includes those cases where dementia is a feature.[13]

[10] https://www.england.nhs.uk/publication/dementia-good-care-planning-information-for-primary-care-and-commissioners/ 2020 (update)

[11] NICE (2018) Dementia: assessment, management and support for people living with dementia and their carers

[12] Dementia Action Alliance Gloucester et al. *Dementia and Domestic Abuse.* https://www.fdean.gov.uk/media/lg4d0mg0/dementia-and-domestic-abuse.pdf

[13] Meet the Director - National Domestic Violence Fatality Review Initiative (ndvfri.org)

9.5.2 In Kent and Medway, as nationally, there continue to be learning reviews featuring dementia.[14] [15]These reflect the behavioural changes that can occur for some individuals with dementia or the impact on the informal carers. This suggests that there needs a change of approach to the care of someone with dementia to promote their safety.

9.5.3 The Department of Health and Social Care (DHSC) to consider the extent to which DHRs reflect issues with dementia and to develop a response.

10. Recommendations

10.1 The Review Panel makes the following recommendations from this DHR:

	Paragraph	Recommendation	Organisation
1.	9.1.2	Agencies should promote the use of the frameworks of the Care Act 2014 and NICE guidance for dementia , to support them in working with carers effectively.	KMPT, Primary Care
2.	9.1.3	Revisit the following recommendations from the DHR Sylvie and report to the KMSAB and KCSP on progress with changing practice: A) *That someone diagnosed with dementia should be offered a one-to-one discussion shortly after diagnosis so that their hopes, wishes, fears and concerns can be recorded in an assessment that can be referred to throughout the duration of their illness. This can be updated as circumstances change.* B) *That provision is made for carers to be spoken to on*	KMICB,

[14] https://nationalnetwork.org.uk/search.html

[15] Kent and Medway Community Safety partnership. 2018. DHR: Sylvie.

	Paragraph	Recommendation	Organisation
		their own about how they are managing/coping. This should be a structured conversation where a realistic assessment of capability is made according to the pressures that the individual carer is subject to and include the offer of a carer's assessment. Any decision to complete the carer's assessment or not should be accurately recorded. The agency most familiar with the carer should offer the session. The suggestion should always be made to a carer that they could work with an advocate if that would be helpful to them.	KCC ASC
3.	9.2.2	Agencies should promote the understanding of intersectionality, to support staff in avoiding the labelling of individuals and ensure that assessments are person-centred.	All agencies
4.	9.3.1	Domestic Abuse training should emphasise the importance of holistic assessments for those individuals who have complex care and support needs. This will enable the inclusion of the carer views, needs, and any risks to either the carer or the individual to whom they are providing care.	All agencies
5.	9.4.2	The frequency of Dementia Annual Reviews should be responsive to the needs	Primary Care

	Paragraph	Recommendation	Organisation
		of all individuals diagnosed with dementia. Reviews should always be with the person living with dementia and their family/ carers to reflect changes in needs and wishes	
6.	9.5.3	Department of Health and Social Care (DHSC) to consider the extent to which DHRs reflect issues with dementia and to develop a response.	Department of Health and Social Care (Via the DA Commissioner)