Kent Community Safety Partnership
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MEDWAY COMMUNITY SAFETY PARTNERSHIP

Multi-Agency Review (MAR)

Simran Kaur

June 2019

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 15th March 2021

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1. The Review Process

1.1. This summary outlines the process undertaken by the Multi-Agency Review panel in reviewing the death of Simran Kaur, who lived in Kent.

1.2. Simran was not a victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if the suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

1.3. To protect the identities of the deceased and her family members, the deceased is referred to in this MAR as Simran Kaur.

1.4. Simran was a pension age woman, of Indian origin; her husband Ranjit Singh is a pension aged, Indian male.

1.5. Simran took her life in June 2019. The Kent Coroner returned a verdict of suicide in September 2019.

1.6. The MAR Core Panel met on 25th July 2019 and agreed that the criteria for a MAR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a MAR would be conducted. Agencies that potentially had contact with Simran and/or Ranjit prior to Simran's death were contacted and asked to confirm whether they had contact with them.

1.7. Those agencies that confirmed contact with Simran and/or Ranjit were asked to secure their files.

2. Contributors to the Review

2.1. Each of the following organisations were subject of an IMR:

- Kent Police
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- Kent and Medway Clinical Commissioning Group[1]

2.2. In addition to the IMRs, Victim Support provided a short report.

2.3. Information provided by the South East Coast Ambulance Service and the local NHS Trust at the Terms of Reference setting stage did not identify any significant incidents relating to the circumstances of this review and, therefore, IMRs were not commissioned.

3. Review Panel Members

3.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Simran Kaur and/or Ranjit Singh. It also included a senior member of the Kent County Council's (KCC) Community Safety Unit, an independent advisor from a Kent-based domestic abuse service and the KCC Suicide Prevention Programme Manager to provide additional advice and input to the review.

3.2. The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
NHS Clinical Commissioning Group	Caroline Peters	Designated Professional for Safeguarding Adults
Kent Police	Ian Wadey	Detective Inspector
KCC Community Safety	Shafick Peerbux	Head of Community Safety

[1] From 1st April 2020 the eight clinical commissioning groups (CCGs) in Kent and Medway merged to form a single CCG. At the time of Simran's death the CCGs were localised.

Agency	Name	Job Title
KMPT	Tanya Neame	Specialist Advisor Safeguarding Children
DAVSS	Henu Cummins	Chief Executive Officer
Local NHS Trust	Gina Tomlin	Safeguarding Adults Lead
South East Coast Ambulance Service	Jenny Churchyard	Safeguarding Practitioner
Public Health, Kent County Council	Tim Woodhouse	Suicide Prevention Programme Manager

3.3. Unfortunately, it was not possible to identify representation from a Kent based service that had expertise in issues faced by Sikh women and/or women from South Asian communities. This gap in terms of specialist provision also led to a recommendation discussed at sections 18 and 19.

3.4. In lieu of a Sikh or South Asian DA specialist from a Kent based organisation, consideration was given to utilising the expertise of specialist Black, Asian and African-Caribbean women's service Southall Black Sisters (see Glossary). However, following consultation with them, the Chair discovered it would be difficult to include them on the panel due to logistics and financial restrictions. The panel utilised the support of Kent Police's Community Engagement and Hate Crime Manager, who advised the IMR writers regarding harmful practices, honour and shame, and introduced a prominent member of the Sikh community to the Chair to assist in obtaining some insight into Simran's experiences. This was particularly important in the absence of family member involvement within the review.

3.4. Members of the panel hold senior positions in their organisations and have not had contact or involvement with Simran Kaur or Ranjit Singh. The panel met on four occasions during the MAR. Later drafts of the report were agreed by panel members via email.

4. Author of the Overview Report

4.1. The Independent Chair, and the Author of this Overview Report, is Dr Liza Thompson.

4.2. The Independent Chair has worked within the field of domestic abuse for over twelve years and was Chief Executive Officer of domestic abuse charity, SATEDA, from 2013 to 2021. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary sector and private sector agencies. Her doctoral thesis examines the experiences of abused mothers within the child protection system, and she currently lectures within university faculties of Law, Social Care, Policing and Criminology. She has independently accessed specialist DHR/MAR training and has also completed all Kent County Council training required to undertake the role of Independent Chair.

4.3. The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than previously being involved in review panels as an independent domestic abuse specialist and currently being commissioned to undertake Domestic Homicide Reviews and Multi-Agency Reviews. Although SATEDA is situated within the County of Kent, the services provided by SATEDA did not cover the district where Simran lived.

5. Terms of reference for the review

These terms of reference were agreed by the MAR panel following their meeting on 23rd September 2019.

5.1 Background

In June 2019, following a call from SECAmb, police officers attended a property in Kent, where they found Simran deceased. At the time of her death, Simran's husband Ranjit was on remand for assaults upon Simran and their son.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 25th July 2019. It was confirmed that the criteria for a DHR had been met.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct MARs jointly) and the Home Office has been informed. In accordance with established procedure, and due to the nature of the death, this review will be referred to as a Multi-Agency Review (MAR).

5.2 The Purpose of the MAR

The purpose of the MAR is to:

a) establish what lessons are to be learned from the suicide of Simran Kaur, 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 related deaths 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.

5.3. The Focus of MAR 34

This review established whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Simran Kaur.

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

This review also focused on whether each agency's response to the identification of domestic abuse was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. The review examined which methods were used to identify risk and any action plans which were put in place to reduce that risk.

5.4. MAR Methodology

Independent Management Reviews (IMRs) were submitted using the templates current at the time of completion.

This review is based upon the IMRs provided by the agencies that were notified of, or had contact with, Simran Kaur and Ranjit Singh in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse. IMR was prepared by an appropriately skilled person who did not have any direct involvement with Simran Kaur and Ranjit Singh, and who is not an immediate line manager of any staff whose actions were subject to review within the IMR.

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 made recommendations for the individual agency and, where relevant, for multi-agency working. The IMRs included issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

Each IMR included all information held about Simran Kaur and Ranjit Singh from 1st January 2005 to 31st December 2005 and from 1st January 2018 to 20th June 2019. Any information relating to Simran as the victim(s), or Ranjit being a perpetrator of domestic abuse before January 2005 was also included in the IMR.

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.

IMRs received were considered by the MAR panel on 5th February 2020. The review report was then drafted by the Independent Chair, sent to the panel on 7th July 2020, and discussed at a panel meeting on 31st July 2020.

5.5. Specific Issues Addressed

The following specific issues were considered within each agency IMR, and subsequently by the panel:

i. Practitioners' sensitivity to, and knowledge about, Simran and Ranjit's needs as either a victim or perpetrator of domestic abuse, including indicators of domestic abuse and how to respond if they had concerns.

ii. Policies and procedures in place for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators. Were these assessments correctly used in the case of Simran and/or Ranjit?

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

iv. The key points or opportunities for assessment and decision making in this case. Whether actions or risk management plans, including services offered/provided, fit with assessments – including whether accessible services were available for Simran and/or Ranjit.

v. When, and in what way, were Simran's wishes, and feelings ascertained and considered – including the response provided to Simran if she had disclosed domestic abuse to any professionals.

vi. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of Simran, Ranjit and/or their family?

vii. Any lessons which were to be learned from this case – relating to the above.

6. Summary Chronology

6.1. Simran and Ranjit were married for around 40 years.

6.2. In March 2019, during a holiday in India, Ranjit assaulted Simran.

6.3. Upon return to the UK, Ranjit assaulted his adult son, and made threats to kill Simran and other members of the family.

6.4. Ranjit was arrested and remanded in custody awaiting a trial set for July 2019.

6.5. During this time, Simran approached her GP on a number of occasions complaining of insomnia and anxiety, citing her husband's arrest and their subsequent estrangement as a stress factor. She was not offered domestic abuse support or referred for support with her mental health.

6.6. In early June, Simran contacted police to request a retraction of her statement supporting prosecution of her husband.

6.7. Before Simran's request could be actioned, Simran was found deceased at home, having taken her own life.

7. Conclusions

7.1. Simran Kaur did not receive any specialist support beyond her interactions with police and appointments with her GP.

7.2. There did not appear to have been any consideration given by any professionals who came into contact with the family, to the impact of honour and/or shame on Simran or her children.

7.3. The police responded to Simran as a victim of domestic abuse and followed a standardised process – however, Simran's specific needs were not provided for, and this led to a lack of ongoing support for Simran from specialist domestic abuse providers.

7.4. The GP failed to identify Simran as a victim of domestic abuse, and therefore did not make any referrals into specialist domestic abuse services.

7.5. Specialist domestic abuse support may have helped Simran to navigate the criminal justice system, the separation from Ranjit and any shame that may have come from this. Support services could also have helped with Simran's finances and housing concerns which she raised with police and the GP. This may have prevented her from requesting to retract her police statement, but more importantly, may have helped her emotional wellbeing and stopped her turning to suicide.

7.6. For Simran, access to domestic abuse services hinged on her engagement with Victim Support: this was reliant upon her answering one of three calls they made to her. No messages were left for her to return their call and the Victim Support case was closed following three failed attempts.

7.7. Simran's specific needs as an elderly Asian woman, who expressed feelings of anxiety to her GP, should have been referred into specialist mental health services. In the area where Simran lived there is a mental health charity specifically supporting people from the Asian community. Her GP failed, or

refused, to identify Simran's needs due to his unconscious bias regarding her religion, race, sex, marital status and age.

7.8. Ranjit was afforded this support when the GP referred him into KMPT SPoA, and again when he was referred into the CJLDS. It would appear that Ranjit - as a perpetrator - was seen, heard and supported to a far greater extent than Simran was as a victim.

8. Lessons to be Learnt

8.1. It is the duty of all agencies to identify and respond to possible risky and harmful practices within families. The dishonour and shame that involvement with the criminal justice system may bring to Simran and her family does not appear to have been addressed, or even identified by anyone – from the time the family approached the GP, and reported Ranjit to police, through to Simran's tragic death. There is a need for refresher training around harmful practices for all agencies, including GP practices. This training would increase awareness of practices within specific cultures, which may carry a high risk of harm, especially for those who may already be vulnerable in those communities, such as women and children. (**Recommendation One)**

8.2. Pathways into the Kent Integrated Domestic Abuse Service (KIDAS) should be reviewed to ensure that there is greater access to specialist services for all domestic abuse victims. **(Recommendations Two and Three)**

8.3. It is feasible that Simran and her family may have been either reluctant to contact agencies to seek help with marital/domestic concerns prior to April 2019 or may have been unaware of the availability of services.

8.4. BAME women and girls experience disproportionately high rates of violence and abuse, are less likely to disclose their abuse,[2] and experience barriers to

[2] Walby, S and Allen J *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey* Home Office (2004)

support due to intersectional discrimination,[3] which sees the relevant protected characteristics identified in section 12, alongside class, poverty and caste, overlap and hinder BAME victims' ability to access services.

8.5. Leicestershire DHR Rabia (2014)[4] and Stockport DHR Sarah (2018)[5] called for improved understanding and awareness of domestic abuse for women who do not have English as their first language.

8.6. A case study of the Angelou Centre in Newcastle (see Overview Report Glossary) reports on their provision of a range of services for BAME women which has increased accessibility and offers a culturally appropriate response to the women who attend.[6] In 2015, Imkaan reported on a lack of specialist services, such as the Angelou Centre, for BAME women across the United Kingdom.[7] This appears to be reflected in Kent and Medway where there are limited domestic abuse services available who offer a specialist understanding of the experiences of victims of domestic abuse from culturally diverse backgrounds. This is especially stark for areas of Kent and Medway with culturally diverse communities. (**Recommendation Four)**

8.7. There are wider lessons to be learnt about the barriers to engagement with police and domestic abuse services from victims within BAME communities, along with the reasons for disengagement with police following initial reports/arrests. This learning would allow the development of processes and services aimed at increasing opportunities for reporting and ongoing engagement of victims with police and specialist DA services. (**Recommendation Five)**

8.8. There is a need for all professionals to act quickly and effectively, offering support and the opportunity for referral to specialist services as soon as

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[3] Crenshaw, K "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" *University of Chicago Legal Forum* 1 (1989)
[4] Available <https://www.leicester.gov.uk/media/185942/rabia-overview-report-dhr-2019.pdf>
[5] Available <http://www.stockportdaf.org.uk/wp-content/uploads/2019/04/DHR-7-Overview-Report.pdf>
[6] Available <https://www.vonne.org.uk/resources/case-study-angelou-centre-supporting-bame_victims-domestic-abuse-and-sexual-violence>
[7] Available < https://drive.google.com/file/d/0B_MKSoEcCvQweWY4cDJMeG1QTkk/view>

possible after domestic abuse has been disclosed. The pathway into Kent County Council's domestic abuse services is potentially prohibitive as it relies upon a victim answering one of three calls from Victim Support. This may pose a problem for someone who is reluctant to answer telephone calls, especially from an unknown number, for those victims who may be fearful of speaking about such a sensitive matter, or victims with English as a second language - or indeed other communication barriers. Simran's age, race and mental health challenges may have created barriers to her answering her phone, and therefore gaining access to specialist services. **(Recommendation Two)**

8.9. Cultural sensitivities are important when assessing a case of domestic abuse but must not act as a barrier when discussing potential domestic abuse with a victim. Research has indicated that there is a need for improved cultural awareness amongst healthcare professionals responding to South Asian women when assessing suicide risk factors.[8] (**Recommendation Six)**

8.10. The term "Cultural Competence" refers to the ability of practitioners to respond sensitively to the operations in human behaviour, including suicidal behaviour. Responding with cultural competence includes the following:

- Empathy to the emotional issues posed by cultural factors
- A willingness to view the clinician-patient interaction in a cultural context
- A willingness to use cultural factors when developing a care plan.[9]

8.11. The apparent lack of incidents of suicide within a specific community should not equate to a lack of risk of suicide occurring within that community. Research has shown that rates of suicide amongst South Asian women are

[8] Baldwin, S and Griffiths, P "Do specialist Community Public Health Nurses Assess for Risk Factors for Depression, Suicide and Self Harm among South Asian Mothers Living in London?" Public Health Nursing 26 (3) pp. 277–289 (2009)

[9] Wendler, S, Matthews, D and Morelli, P "Cultural Competence in Suicide Risk Assessment" in *The American Psychiatric Publishing textbook of Suicide Assessment and Management* (2nd eds) p.75 (2012)

disproportionately high.[10] However, Simran's GP reported during the IMR interview that he did not know of any Sikh women who had died by suicide, and this led to him ruling out a risk of Simran taking her own life. In fact, Southall Black Sisters argue that domestic abuse is either a causal or contributing factor in the majority of deaths by suicide in South Asian women.[11] (**Recommendation Seven)**

8.12. There is a benefit of continuity within a small single handed GP practice, however, there may also be issues with collusion and/or over familiarity as the GP had known the family for many years.

8.13. Health professionals should "Think Family" with each consultation. However, Simran appears to have been forgotten about during the initial GP appointments with Ranjit and other members of the family. There was no curiosity around Simran's whereabouts or her welfare, in fact, throughout the family's involvement with the GP, Ranjit appeared to receive more care and concern than Simran. (**Recommendation Eight)**

8.14. Multi-agency training should include sessions on behaviours of domestic abuse perpetrators, the identification of abusers and recommended responses to addressing abusive behaviours. (**Recommendation Nine)**

8.15. Had Ranjit been identified as a perpetrator of domestic abuse, there would have been no suitable community-based perpetrator programmes to refer him to within his area of residence. There is a need for perpetrator programmes for abusers to access outside of the offender management courses which are reliant upon the perpetrator being involved in the criminal justice system (see Overview Report glossary).

[10] Crawford, M, Nur, U, McKenzie, K and Tyrer, P "Suicidal ideation and suicide attempts among ethnic minority groups in England: Results of a national household survey" *Psychological Medicine* 35 pp.1369-77; McKenzie, M, Serfaty, M and Crawford, M "Suicide in Ethnic Minority Groups" *British Journal of Psychiatry* 183 pp.100-101 (2003); Hunt, I et al "Suicide in Ethnic Minorities Within 12 Months of Contact with Mental Health Services" *British Journal of Psychiatry* (103) pp.155-160

[11] Siddiqui, H and Patel, M *Safe and Sane* (2010)

8.16 When Lakhveer reported her father's behaviour to police and disclosed how his behaviour had also been aimed at her – there was a missed opportunity to better understand the family dynamics, by completing a risk assessment with her. **(Recommendation Ten)**

9. Recommendations

The Review Panel makes the following recommendations from this MAR:

	Paragraph	Recommendation	Organisation
1.	8.1	Harmful Practices training made available for all agencies.	Kent Police All Agencies
2.	8.2	Commissioned domestic abuse services to explore and implement methods to strengthen engagement with victims from a diverse range of cultures.	KCC DA Commissioning
3.	8.2	The offer of DA safe enquiry and referral training for GPs – and the availability of an enhanced pathway into support services when domestic abuse is suspected or disclosed. With assurance sought from GPs, by CCG, that this is in place.	Kent & Medway CCG
4.	8.6	Commissioned domestic abuse services should include those that are equipped with the knowledge and ability to respond to victims from a diverse range of cultures.	KCC DA Commissioning
5.	8.7	Research into barriers to engagement with - and reasons for disengagement from - police and domestic abuse services, from victims within Black and Asian communities to be undertaken.	Home Office/Designate Domestic Abuse Commissioner

	Paragraph	Recommendation	Organisation
6.	8.9	The offer of culturally specific training around the impacts of domestic abuse on mental health to all GP Practices. CCG should seek assurance that this has been undertaken.	Kent & Medway CCG
7.	8.11	The Kent and Medway Suicide Prevention Programme to consider and highlight culturally specific issues relating to suicidal behaviour within different religious and ethnically diverse communities (including the Sikh community).	KCC – Public Health Team
8.	8.13	An update on the definition of domestic abuse and how to respond within the Think Family agenda should be provided to Primary Care.	Kent & Medway CCG
9.	8.14	DA providers to make a consistent level of domestic abuse training widely available - which will include identifying abusive behaviours.	KIDAS and MDAS
10.	8.16	Kent Police - through new recruit and ongoing training - will raise awareness of the need for secondary risk assessments, involving parties who may not be direct victims of domestic abuse.	Kent Police