Sheffield First

SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

Domestic Homicide Review
Overview Report

REPORT INTO THE DEATH OF ADULT G ON 4th March 2014

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THIS REPORT HAS BEEN REDACTED FOR PUBLICATION IN ACCORDANCE WITH THE SHEFFIELD CITY COUNCIL REDACTION FRAMEWORK FOR DHR: 10th September 2015

SECTION ONE – INTRODUCTION AND BACKGROUND

1.1. Introduction

This is the Report of a Domestic Homicide Review (DHR) following the death of G[1] on 4th March 2014. It provides an independent overview of the service provided to G by agencies which had contact with her, by analysing the services provided, discussing lessons learned, and making recommendations with the aim of improving the service provided to victims of domestic abuse in Sheffield.

The incident occurred at the family home in Sheffield. Information received by the police led to the discovery of G's body and her husband was subsequently charged with murder. Following a trial, G's husband was sentenced on 9th February 2015 to life imprisonment with a tariff of 23 years.

Agencies completed Individual Management Reviews (IMRs) during the summer of 2014 and the Overview Report was drafted and put on hold in October 2014 pending the outcome of the criminal justice process. It has been updated and completed during February 2015.

1.2. The purpose of this Domestic Homicide Review

A Domestic Homicide Review (DHRs) is a statutory process under Section 9 of the Domestic Violence, Crime and Adults Act (2004) which came into force on 13th April 2011. The Act states that a DHR should be 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'.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;

[1] Parties are anonymised in the Review as described in paras 1.6 and 1.8.1.4 below. Throughout the Report, the victim is identified as 'G' and 'Adult G' interchangeably.

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future;
- Overall, to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

The guiding principles which underpin this review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible
- **Impartiality** – those conducting the review should not have been directly involved with the victim or the family
- **Thoroughness** – all important factors should be considered
- **Openness** – there should be no suspicion of concealment
- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest
- **Co-operation** – the agreed procedure and statutory guidance published both nationally and locally should be followed.
- **Resolution** – action should be taken to implement any recommendations that arise.

1.3. Process of the review

1.3.1 This DHR was commissioned by the Sheffield Safer and Sustainable Communities Partnership (SSSCP) in line with the expectations of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2011.

1.3.2 A Consideration Report was sent to the Decision Panel and subsequently the Home Office was informed on 2nd April 2014 of the decision to conduct a Domestic Homicide Review.

1.3.3 The Review Panel comprises the following agency representatives:

Organisation	Post
SY Police	Head of Public Protection – Peter Horner
Sheffield City Council	Head of Drug and Alcohol / Domestic Abuse Coordination Team (DACT) – Jo Daykin-Goodall
	Head of Safeguarding and Quality, Communities – Simon Richards
	Sheffield Safeguarding Children Board Manager – Victoria Horsefield

Organisation	Post
	Assistant Director Legal Services – Steve Ecclestone
South Yorkshire Community Rehabilitation Company	Deputy Director of Probation – Dave Pidwell
Sheffield Clinical Commissioning Group	Chief Nurse – Kevin Clifford

The Review Panel first met on 3rd April 2014 and subsequently commissioned Kate Mitchell as independent chair and overview author. Kate Mitchell has previously been independent chair of a DHR and author of an Overview Report which was commended by the Home Office. The Review Panel considered that Kate Mitchell brought a wide range of relevant experience to this role, following thirty years' experience as a practitioner, senior manager and commissioner in the Probation Service, in drug and alcohol services, in local authority children's and learning disability services, as an independent consultant and trainer in health and criminal justice sectors, as trustee in the voluntary sector, and as Lay Member of a NHS CCG responsible for patient involvement. Of specific relevance to this role, her career has included completing a significant number of reviews of further serious offending for the Home Office; serious incident reviews for the Local Safeguarding Board; independent reviews and improvement plans for services including the management of domestic violence offenders, user and carer involvement, and setting up a victim unit; has specialised in working with high risk offenders; developed services and practice guidance in working with lifers, domestic violence, risk assessment and management, and victims; was chair of MAPPPA; and has been commissioned by another area to undertake independent Serious Case Reviews. Although previously employed by the Probation Service in the Sheffield area, and having worked freelance with Sheffield City Council, Kate Mitchell has had no prior working relationship with any of the personnel or departments involved at any point in this Review and is therefore independent of any of the services described in this Report.

The Review Panel met on 4th September 2014 to consider the draft Overview Report which was then put on hold pending the outcome of the trial; and on 12th February 2015 to consider lessons learned and recommendations prior to the final report being prepared. The final report was then signed off by agencies electronically.

1.3.4 A Review Team was established, consisting of the independent chair and members of the Sheffield City Council Domestic Abuse Co-ordination Team (DACT). This Team commissioned Individual Management Reviews (IMRs) in accordance with the Sheffield Safer and Sustainable Communities Partnership Domestic

Homicide Review procedures (2014), and provided oversight, support and quality assurance to agency representatives completing those reviews. The Team analysed the final IMRs for themes and issues, which were further discussed with the authors.

The Review Team consisted of:

Kate Mitchell	Independent Chair
Alison Higgins	Domestic Abuse Strategy Manager - DACT
Simon Finney	Criminal Justice Services Manager - DACT
Alison Howard	Team Support Officer

1.3.5 There was a meeting on 4th June 2014 for the purpose of briefing the IMR authors in accordance with the Guidance. Chronologies were received from the authors by 7th July and the IMRs were received by 18th July. There was a further meeting with IMR authors on 21st July when feedback was given and issues and themes arising were discussed and clarified. A number of IMR authors were then asked to consider queries and provide clarification in discussions which were ongoing during the drafting of the Overview Report from August - October. During this time there were separate meetings and correspondence with some agencies, as reflected in this report, in order to discuss specific issues and queries, and agree actions.

1.3.6 As a result of information received during this process, the Review Team became aware that other agencies had been engaged with G and her family. Contact was made with Northern Refugee Council, SAVTE, the Immigration Service, the Department for Work and Pensions, requesting information. With the exception of DWP, this was received within the timescale of the drafting of the Report.

1.3.7 As the Report was on hold for several months, the Review Team had the opportunity to work with individual agencies to implement an action plan arising from early discussions, with the outcome that actions have been completed and this Report will identify where there is evidence that lessons have been learned.

1.3.8 There are specific aspects in this case arising from the refugee status of the family; and there have been discussions about the impact of faith and culture on G's experience in the UK. During the holding period, the Review Team met with a Focus Group, consisting representatives of the faith and ethnic groups identified during the Review, to discuss the lessons learned and invite their perspective on how services could improve. The outcome of the Focus Group is included in this Report and reflected in the Recommendations.

1.4 Time period

G's husband arrived in the UK alone on 19th October 2010, and claimed asylum. He was granted limited leave to remain as a refugee, as a lone male, until 18th January

2016. The National Asylum Service placed him in supported housing in Leeds. His brother and sister were living in that area. He was not known to agencies in Leeds at that time and it is not known on what date he moved to Sheffield; however on 1st February 2011 he presented at Sheffield City Council Housing Service, indicating that he lived in Sheffield. The agency records start on that date.

G applied for Family Reunion visas for herself and 4 children, to join her husband, on 6th July 2011. The visas were issued with entry clearance valid until 18th January 2016. They arrived in the UK on 17/07/2011. It is understood that one child was not granted leave to remain as it was deemed not to be a relative of G; 3 children therefore accompanied G to join her husband. G resided in Sheffield from the point of her arrival in the UK until her death on 4th March 2014.

The timescale for this DHR is therefore the period from the arrival of G's husband in the UK on 19th October 2010 until the date of G's death on 4th March 2014. For context, information received regarding the family's earlier life in Kuwait and other countries will be included.

1.5 Terms of reference

The Domestic Homicide Review will be conducted according to best practice, with effective analysis of the information related to the case.

1.5.1 The Terms of Reference set out the purpose and process of the DHR as required by local and national guidance. The following areas, specific to what was then known of the homicide of G, were to be addressed in the IMRs and this Overview Report:

- How agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on interventions.

- The family does not speak English as a first language. The review will consider whether agency processes for the facilitation of communication were sufficient for identifying or meeting their needs.

- Neighbours and family members appear to have been aware of domestic abuse in the family – consideration will be given as to whether appropriate information is readily available to members of the public, including hard-to-reach communities, regarding the unacceptability of domestic abuse and how to seek help for someone they know who is affected.

- Concerns were expressed by agencies in contact with the children in relation to neglect and attendance. There also appears to have been little contact with their

mother. The review will consider whether agencies worked together effectively to safeguard the children in the family.

1.5.2 In addition, IMR authors were asked to reflect and comment upon important issues that may lead to lessons to be learnt in this case:

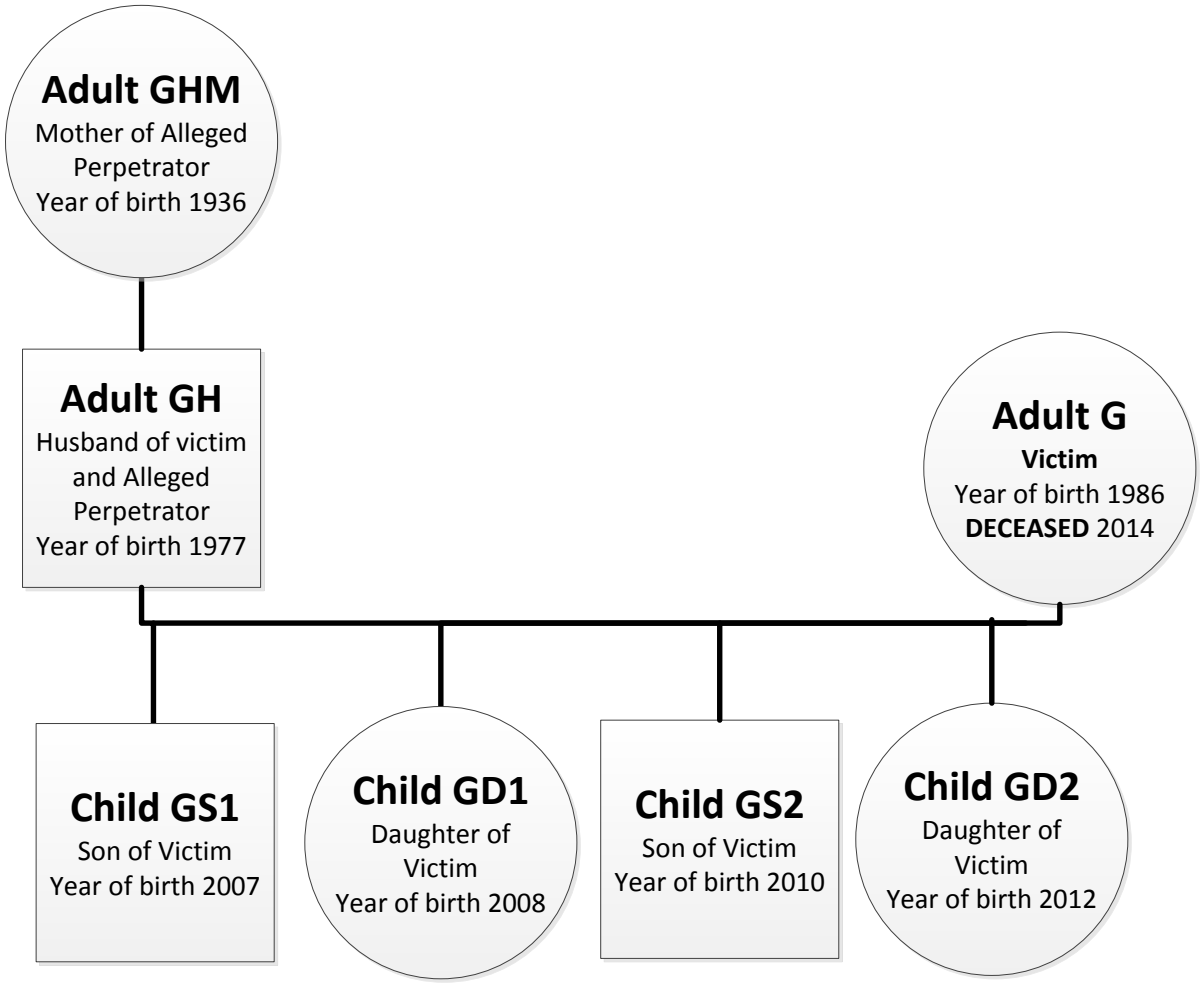
- Was there appropriate information sharing between agencies?
- There are similarities with other domestic homicides in Sheffield: two previous DHRs and one Serious Incident Review involved people from black or minority ethnic backgrounds and two of these previous DHRs involved recent migrants.

1.5.3 The review will consider any other information that is found to be relevant.

1.6 Subjects of the Review

1.6.1 Family Structure:

The following diagram describes the structure of the family living in the household at the time of the incident:



1.6.2 Subjects of the review

The Review was concerned with G and her immediate family: her husband (the perpetrator), four children, and her mother-in-law, who were resident in the household at the time of the incident. G's sister lives nearby and is included in this Report. The perpetrator's sister and 9 brothers are referenced but not included except one brother, who is married to G's sister and whom we met during the Review. Information from the trial indicated that G's husband had three other wives at various times, none of whom are resident in the UK and as such they are noted, and referenced where relevant, but are not subjects of this Review.

G and her family came to the UK from Kuwait although various members of the family have lived in other Arabic countries, and extended family members continue to

reside in Jordan, Iraq and Syria. The husband's family is known as 'bidoon', an Arabic word meaning 'without', or in this context, 'stateless'. It is not clear whether G was also 'bidoon'; however once married to her husband she would have become 'bidoon', whatever her status previously. As little is known about this group of refugees, I have included information for the purpose of context, later in this Report.

G's husband came to the UK on 19th October 2010 seeking asylum, and was granted refugee status with leave to remain until 18th January 2016. G was granted entry under a Family Reunion Visa and arrived in the UK on 17th July 2011. She was accompanied by 3 children: two sons and a daughter. A fourth child was refused entry as having no DNA relationship with G. I was informed that this was a child of G's husband's previous wife who was being cared for by G. A second daughter was born in the UK. I am advised by UKBA that all four children have the same legal status as the parents, i.e. they also have refugee status.

The extended family in the UK, which consists of G's younger sister who is married to a brother of her husband, and his other 8 brothers, reside in either Sheffield or Leeds, as refugees. G's mother-in-law arrived in the UK on 27th March 2012, and was granted limited leave to remain. She stayed with G and her family and on occasions with other relatives. At the time of G's death, her mother-in-law was residing in the home.

1.7 Development of the Individual Management reviews

1.7.1 Authors:

In order to ensure professional objectivity, which is an important principle of the IMR process, IMR authors are professionals who are independent from any involvement with the victim, her family or the perpetrator.

The following authors prepared Individual Management Review Reports (IMRs):

Organisation	Author	Role
South Yorkshire Police	Louise Houghton	Sergeant, Public Protection
NHS England	Dr Helen McDonough	General Practitioner
Sheffield Teaching Hospitals NHS Foundation Trust	Sharon Clarke	Named Professional Safeguarding
Sheffield Children's NHS Foundation Trust - Community Wellbeing and Mental Health Services Division	Caroline Spencer	Safeguarding Children Trainer/ Advisor
Sheffield City Council Housing	Penny Hicks	Assistant Manager

Service		
Sheffield City Council - Housing Solutions Service	Jayne Stacey	Team Manager
Metropolitan Housing Care and Support	Sarah Cox	Team Manager
Sheffield City Council -Children, Young People and Families Service	Catherine Sikakana	Assistant Service Manager
Sheffield City Council – Prevention and Early Intervention Service in Children & Young People's Service, including Education and Multi-Agency Support Teams	Victoria Stringer	Assistant Service Manager

1.7.2 Development of the reviews

The Review Team issued guidance by email to nominated authors to assist in the preparation of chronologies. IMR authors were then briefed at a meeting on 4th June 2014 by the Review Team. The guidance used was the Sheffield Safer and Sustainable Communities Partnership's 'Domestic Homicide Review Guidance, page 21 and Appendix 21 – Individual Management Reviews', which comprehensively guides authors through the process for the development of the IMR.

Guidance included advice on conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters. There was guidance specifically about preparing an IMR during a parallel criminal justice process, given that a number of key staff members were potential witnesses; in this the Review Team was supported and advised by the Senior Investigating Officer. Guidance also covered providing feedback and debriefing to relevant staff; and implementing the recommendations from the DHR within the Agency.

IMR authors are asked to work with the spirit of the DHR process, to enable lessons to be learned, by giving as accurate as possible an account of what originally transpired in the Agency's response to G and her family, to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors are encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. Where changes have taken place within agencies during the timescale of this Review, as a result of lessons learned or other factors, authors assessed these changes and considered the impact in terms of meeting the needs of individuals at risk of, or experiencing, domestic abuse.

IMR authors each prepared a chronology of their agency involvement and significant events during the specified time period. This was merged into a comprehensive,

integrated chronology which was compiled and analysed by the Review Team and discussed and issues clarified with the authors at a meeting on the 21st July 2014. Subsequently further organisations were identified and following liaison were included in the merged chronology. The final document appears at *Appendix 1*.

The first draft IMRs were quality assured within agencies through the signing-off process, then forwarded to the Review Team where they were analysed. Queries, issues, emerging themes and initial ideas for solutions were discussed with authors and senior managers at the meeting on 21st July. Amendments were made where required, and copies of final draft IMRs were subsequently circulated to all authors in order that they could cross-reference significant events and highlight missing information. During August, while the Report was being drafted, there was continuous development of emerging themes and recommendations, through discussions with IMR authors and senior managers. The Overview Report reflects the outcome of the preparation of IMRs, the further discussions and clarifications.

1.7.3 Other information received by the Review Panel

As a result of information provided during the development of the IMRs, the Review Team contacted other agencies and received information from:

- The Family Development Project
- Arches Housing
- Immigration Service
- Sheffield Association for the Voluntary Teaching of English (SAVTE)

The Department for Work and Pensions was contacted by the Review Team and whilst there was lengthy and detailed correspondence confirming that the Department could share information, none has to date been received. I have concluded that whilst this would be of interest, in that it may provide context in relation to G's husband, including learning lessons about English classes (referenced later in this Report), the absence of information does not inhibit the findings of this Review, and that any opportunity lost is for the DWP, in not working jointly with local agencies to learn lessons, and not for local agencies.

1.8 Development of the Overview Report

1.8.1 Confidentiality

1.8.1.1 Access to confidential records in relation to members of the family

The Review Panel applied legal opinion and the guidance of the General Medical Council in order to request access to the medical records of G and her husband, as well as the records of the children of the family without parental consent[2].

[2] The General Medical Council stated that: 'We… feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "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

1.8.1.2 Access to children's records

The children have been looked after by the Local Authority following the death of G and the arrest of the perpetrator. The Local Authority was therefore able to consent to access to information about the children by IMR authors.

1.8.1.3 The DHR and confidentiality

The findings of each IMR are confidential. At each meeting of the Panel and of the IMR authors, attenders were asked to sign a confidentiality agreement. Whilst IMRs from all agencies were made available to IMR authors, this was for the purpose of cross-reference and information to inform their own IMR. The reports of other agencies will not be circulated outside of their own agency without their express permission.

1.8.1.4 This Overview Report and the Executive Summary are anonymised in order to protect the identity of the victim, perpetrator, family members, staff and others, and to comply with the Data Protection Act, 1998. Within the Review, parties have been anonymised as described in para. 1.6. Within this Report, the victim will be identified as 'G' or 'Adult G', and other parties in relation to her, e.g. 'Adult GH' or 'G's husband', etc.

1.8.1.5 Once the Report has been quality assured by the Home Office, it will be redacted as set out in the Redaction Framework at *Appendix 3* to prepare it for publication.

1.8.2 Dissemination

1.8.2.1 Whilst key issues have been shared with organisations during the DHR process, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were seen by the membership of the Review Panel, IMR authors, and the membership of Safer and Sustainable Communities Partnership Board and its sub-committee, the Performance, Planning and Resources Group. The IMRs will not be published. The redacted Report, which includes the relevant content of IMRs, will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the Review are learned.

1.8.2.2 We will meet with G's family prior to the date of publication to explain the findings, with Arabic interpretation; and will provide the family with a Summary of the Overview Report, translated into Arabic, upon publication.

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parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHRs as well.'

1.8.3 Parallel processes

1.8.3.1 This Report was drafted in parallel with the criminal justice process and completed following the conclusion of the trial in February 2015. In order to ensure there was no conflict between the processes, there was liaison with the Senior Investigating Officer and his team throughout. The SIO attended the meetings and had sight of the chronology and IMRs.

1.8.3.2 Children's proceedings have been ongoing during the timescale. Any liaison between the children's legal team and the Review Team has been through the City Council Legal Department only for the purpose of cross-referencing information.

1.8.4 Expert Information and Advice

This Review has been undertaken within a specific context of faith and culture and in order to understand the issues that were raised during the process, the Overview Author with the Review Team undertook a literature search; liaised with refugee organisations which provided information and references; and immigration and police services, where officers had previously prepared briefing notes; held a Focus Group to discuss emerging themes; and took advice from specialist voluntary, community and faith organisations. A specialist from City of Sanctuary was included in the Review Panel meetings. The Overview Author considered these steps fulfilled the need for expert information and advice.

1.8.5 Other names

The subjects are not known by other names to the knowledge of the Review Team. However, there are various forms of spelling of names within the documentation, which reflects that the first language of the subjects is Arabic and the names often recorded phonetically at the point of translation. There having been several points of translation, spellings differ. The Review Team has cross-referenced names to ensure that the correct subject is identified within this Report.

1.8.6 Involvement of the family

G's extended family, but for her sister, remains in the Middle East. There has been no contact between the Review Team and G's father or brother, though there was contact by the Police Service who advised the Review Team and shared information provided by the family to the Police Service in the course of their investigation. Following the trial, the Independent Author and the DACT manager met with G's sister and her husband (the perpetrator's brother) with interpretation and the outcome of this meeting is included in this Report. Prior to publication, the Independent Author and the DACT manager visited G's sister and her husband to discuss the findings; provided copies of the Executive Summary in Arabic, and provided an interpreter who had known the family throughout, to work through the Report's findings with the family and take feedback to the Independent Author. The

Arabic version of the Executive Summary will be published alongside the English version.

1.8.7 The Overview Report and Conclusions

This Report is authored by the Independent Chair who is responsible for ensuring that the principles of the DHR system as described above are implemented. The Chair's analysis and conclusions have been subject to full and frank discussion within meetings and correspondence with individual agencies; within the Domestic Homicide Review Panel; and a final set of recommendations was prepared and agreed following these discussions. The recommendations represent the view of the Domestic Homicide Review Panel which has the responsibility, through its representative agencies, for fully implementing the findings. Following acceptance of this report by the SSCP, the Action Plan at will be disseminated amongst the agencies, and progress in implementing the recommendations will be monitored by a sub-group of the Domestic Abuse Strategic Board.

SECTION TWO – DOMESTIC HOMICIDE REVIEW PANEL REPORT

2.1 Summary of the case

On the afternoon of Tuesday 4th March 2014, South Yorkshire Police Service received a call from a man with limited English language who stated that G's husband had killed her at an address in North Sheffield. Uniformed police officers attended the address. G's husband admitted the officers to the house. Three men, speaking rapid Arabic, approached the officers and as the officers were unable to establish the circumstances, all four men were arrested. Acting on information received from one of the males who spoke English and stated it was he who had called the police, the officers conducted a search of the property and located the body of a female in an under stairs cupboard. The body, later identified as G, had no signs of life and had evidently suffered multiple injuries including defence wounds. The cause of death was given as neck and head injuries.

Police investigations subsequently established that the other males in attendance were the perpetrator's brother and nephew, who lived nearby, and a friend of the family. The nephew's testimony, accepted by the police, indicated that he was called by G's husband, and on arrival at the house was asked to assist him in moving G's body from the kitchen where the murder had taken place, into the under stairs cupboard. The nephew was able to leave the property and alerted his father, who in turn contacted a friend of the family who was able to speak English and telephone the police on their behalf. G's husband was charged with murder and the three other males assisted the police with their inquiries as witnesses.

Evidence presented at the trial indicated that G had suffered 270 wounds inflicted with various household and DIY implements; and was found with a screwdriver in her eye. It became clear from the investigation, forensic evidence and neighbour statements, that the assault leading to G's death had been ongoing for up to three hours, having started when the older children had been taken to school, and ended at midday when the perpetrator telephoned his nephew and asked for his help. Two neighbours living next door told police they had heard violent incidents occurring in the property on Monday 3rd March and Tuesday 4th March, when they heard the deceased screaming on several occasions before eventually becoming silent. They formed the opinion that she had become unconscious due to an assault. A male and female neighbour living on the other side of the property told police they heard sounds of a protracted violent assault.

Also present at the property at the time was G's mother-in-law, and the two youngest children, who are believed to have been in her care in another room at the time of the murder. The mother-in-law stated she was not aware of the incident.

The perpetrator pleaded not guilty to murder but guilty to manslaughter on grounds of diminished responsibility. This plea was not accepted by the prosecution and the case was tried in January 2015. Meantime, the perpetrator was first held on remand at Doncaster Prison, and then transferred to Rampton Hospital for assessment. Following a three week trial in which the defence presented psychiatric assessments which supported a diagnosis of psychosis, which was contested by the prosecution, the jury found the perpetrator guilty of murder. He was convicted and sentenced on 9th February 2015, to life imprisonment with a tariff of 23 years.

2.2 A Profile of Adult G

We learned from the statements and the family that G was born and grew up in a large family which moved between Jordan, Syria, Iraq and Kuwait. The family is of the Shia Muslim faith. G was educated in Kuwait. She was particularly close to her sister who is just a year younger, especially after the two women came to the UK and knew only one another. Her sister says: 'My sister was a happy child… popular, kind, always smiling... She spent her life smiling. That was before she got married.' She married at age 17.

Following G's death, the Family Liaison Officer completing a victim-focussed report noted that little was known about G's lifestyle in the UK. A search of G's property revealed that she owned very little, having no toiletries, handbag or personal belongings that would be expected, and few clothes other than soiled and stained items.

The lack of information about G is indicative of one of the significant factors of this case - which will be reflected in this Report - and that is G's isolation. Very few people met her and fewer people knew her as an individual personality. Only professionals who came into the home, i.e. midwives, health visitors, a refugee support worker, and a volunteer English tutor, met G and it was rare for these contacts to be with G alone, unaccompanied by either her husband or her mother-in-law. At GP appointments she was invariably accompanied, and following discussion with her sister it is thought that this may have been one reason she missed her own appointments and used the children's appointments to seek treatment for herself. She was not known to neighbours who reported only that they occasionally saw a figure in the garden, always fully covered. When discussing this homicide with the Police, we were struck by G's lack of visibility to the world outside her home, and reflected that, had her husband's nephew done as he asked and helped to conceal the body, her death could have gone unremarked outside the family.

2.3 Information from Adult G's Family and Friends

The Family Liaison Officer contacted G's brother in Iraq, who informed the investigation that G had been married to her husband for ten years and that the family knew he was violent and would beat her. In Kuwait, G had the support of her brothers, which the family believes was to her advantage in deterring her husband from violence, but once in the UK her family worried for her safety. G told her brother on the telephone, in September or October 2013, that her husband was mistreating her and threatening to take the children away from her, and have her deported to Kuwait, if she reported him. G told her brother that her husband was upset about failed business deals and had money worries. Her brother believed G's husband knew she was telling her family about the abuse because he took the telephone away from her and did not allow further contact after October 2013. Two days before her death, G contacted her father using her husband's mobile phone and although she told him she was okay, he felt this was because her husband was present, and even though her husband came on the telephone and told her father he loved her, he had the impression throughout the call that she was 'under threat', especially when she asked him to pray for her. The family was in the process of requesting a divorce for G, with the aim of bringing her home.

We met G's sister both separately and together with her husband who is G's brother-in-law (i.e. the two sisters married the two brothers), accompanied by the Arabic interpreter who had been with them throughout the trial and as such had a good relationship with the couple. We were able to discuss G's experience as perceived by her sister; their opinion of the services that had been provided to G by the local agencies; the themes of faith and culture that had emerged during the Review; and their ideas for how services could be improved to help women in similar circumstances to stay safe.

2.3.1 Information about G and her experience:

G told her sister that she was assaulted on a daily basis, both in their own country and in the UK. Her sister related how G was protected in Kuwait, by her family, and whilst she knew, and observed, that G's husband beat her, she believed there were controls on his violence due to the presence of G's brothers. However, once they came to the UK, his violence escalated. She related incidents when she believed he had kicked G and hurt her leg as she was limping; when he pulled out her hair and G told her sister that she was hiding the hair (and this was subsequently found by the police investigation and established to have belonged to G). G told her sister that her husband had threatened to kill her, then the children, then himself, and she believed he would do this, that he was 'all-powerful', if she tried to divorce him or to resist his abuse. The sister related that he had taken away the child of his previous wife, the day after he was born, and that G had been required to bring this child up (this was believed to be the child that had been refused entry when G entered the UK on a Family Reunion Visa). We were told that in their culture, the husband would take the

children when a couple divorced. G knew this, and therefore believed his threats to take the children.

As his behaviour escalated, during the autumn and winter of 2013/14, the perpetrator refused to allow G to have contact with her sister, and took away her mobile phone. [*Redacted*.] She thought if she complied with this, G might be safer. However, she continued to telephone the home, and spoke to the perpetrator who told her G did not wish to speak to her. The sisters last had contact around the end of the year, 2013.

Her sister believes that G was aware of the law and that she could have got help, but would not have asked for help, because of the shame. The shame would have affected her family here in the UK, and also in their home country, where her family would have felt the shame; and it would also affect the children's generation as they grew up. The sisters used to speak on the mobile phone daily: they did not know where one another lived, did not know their address; the children were taken to school by their husbands and they were taken to visit one another by their husbands, and therefore neither could have found their way to the other's home independently. G asked her sister not to tell anyone about the abuse. The sister did tell her husband (the perpetrator's brother) about the abuse [*redacted]* but as a family member, he could do nothing. She was confident that, had she told anyone outside the family about the abuse, G would have denied it for all these reasons.

The sister felt that G was always tired, that she was worn down from looking after four children, her husband, his mother, and from doing everything around the house. She was never alone; whilst her husband was afraid of people visiting the house, G would always be accompanied in the house either by her husband or by her mother-in-law. [*Redacted*.]

The sister's husband told us he last saw G a month before her death; he stated that it would not be acceptable for a man to speak to his brother's wife and therefore he would not know how she was.

2.3.2 Services that were involved with the family:

Neither sister nor brother-in-law had any awareness that the family had been provided with food parcels by professional staff, though pointed out that asylum seekers would struggle to feed their family and keep them warm as there would be difficulties with benefits and finding work. The sister expressed concern that there were no services specifically understanding and working with refugee families to monitor how they were, and this meant many could be living in hardship and isolation.

G's brother-in-law took her eldest children to school usually, and explained that this was because the schools were distant from the house, that G's husband and he

would share the school run. Notwithstanding that G was not allowed to go out of the house, they stated this would have been impractical as G needed to care for the two children, including one baby, at home. G's brother-in-law was not aware that there had been concerns about the eldest daughter at school. G's sister queried why the school staff did not visit the home to discuss these concerns with the child's mother. She felt the school had not been sympathetic with the children's experience as refugees, and had not attempted to make a relationship with them prior to the murder of their mother. She believed that as children in refugee families, they were likely to be under stress, and schools should make more effort to get to know them. Her point was that, following the murder, the school staff gave good care and support to the children, and she believed that at that point, the children disclosed abuse; had school staff got to know the children before the incident, the children would have disclosed abuse and something might have been done. Her concern was that this could be happening in other refugee families, and she thought schools could do more.

The sister believed G would never have gone to the GP unaccompanied by her husband or her mother-in-law, and this would be a reason why she did not keep her appointments, and used the children's appointments to seek treatment for herself. She felt there had been insufficient follow-up by the practice when G failed to attend appointments, although we discussed the attempts the practice had made to encourage G to keep appointments, and her sister agreed that she might have made a decision not to attend for the reasons given above. By her sister's account G did not attend the dentist despite having dental problems, and she queried who would follow this up; in reality, this is no one's responsibility.

G's brother-in-law was very concerned about his brother's mental health and continues to believe that this caused his behaviour and ultimately the homicide. He believed there had not been sufficient follow-up of his brother's episode of depression, and that health services could have done more to recognise and treat his condition. He said that when GH's mental health had worsened prior to the incident, GH had not gone to the GP but had sought support from the Mosque where he believed GH was encouraged to address the issue through prayer.

We discussed the routine inquiries that midwives and health visitors make of all women regarding domestic abuse. G's sister told us she had never been asked these questions. With the interpreter, we discussed how questions could be phrased in Arabic, and were told that violence in the home was a concept that was understood. She was very clear that even had she been asked, no woman in her culture would disclose domestic abuse to a man, whether this was a GP, or a member of the family, and that they would never disclose via an interpreter who was male. She felt it would be possible to disclose to a health visitor or midwife, who she considered would be aware and sympathetic.

G's sister told us that G's relationship with her volunteer English tutor was important to her. G looked forward to the visits and welcomed the gifts of sweets and flowers that the tutor brought. She believed it was very significant that it was to this worker that G chose to show her bruise; that she would never have admitted abuse to the worker, but did want her to know that she was hurt. She felt let down by the tutor's organisation which the family believed could have done more to act on the information the tutor passed on.

2.3.3 Domestic abuse, faith, culture and family values:

G's sister told us that whilst it would be 'normal in our culture to see a bruise' and that there is tolerance of domestic abuse, this does not mean it is permitted. On the contrary, she was clear that the Qu'ran does not permit assault but explained that there is often a difference in interpretation by individuals and families, and this is why it is so widely tolerated. Following a lengthy discussion on this point, we established that G's sister believed violence to be unacceptable, but that this would depend on the family; that tolerance of abuse is a matter of family values in her Kuwaiti culture, and not a matter of faith: 'If [my husband] thought I expected to be assaulted, he might do that. But in my family this does not happen, so he does not… [*Redacted*]. In families that believe abuse is acceptable, 'it has to be for a reason'.

We discussed reporting to the police and whilst G's sister stated that she now knows and would do this if she was assaulted, she only knows because of what has happened. Generally, within her culture, it would not be acceptable to report abuse; the shame would be attached to the woman who was being abused - the community would assume she was only reporting her husband in order to get more freedom for herself; and this would shame her and the family.

G's sister felt strongly that the one thing that could be done would be to reduce the isolation of women in refugee households. Her suggestion was that English classes should be compulsory for refugees; she believed this would take women out of the home, educate and inform them about the law and what they can do to get help; give them confidence in speaking to people outside the family; help them to build social networks. Overall this would help women to integrate with local communities. We discussed the resources currently existing to support families with children, and G's sister was very clear that women in her culture would not be able to go out unaccompanied to attend these. Further, that it would never be acceptable within her faith to attend an event held at a church or church-owned premises.

We were told there has been a significant change in this family since the incident. Whereas she was never previously alone, G's sister has been allowed to join a local English class and to use the crèche for her children while she does so; and to go to the GP on her own; though it would also be true to say that she expressed how, since the incident, she has been more determined to do something, and to assert her

right to go to English classes. She therefore expects to make a social and support network and model her own ideas.

2.3.5 Conclusions from information provided by family:

This is a family grieving for the loss of a sister through homicide and a brother through imprisonment, and their participation in the Review was remarkable for their honesty and willingness to discuss difficult matters. Each clearly had a very different perspective on the character of the perpetrator and the outcome of the trial. We heard that the abuse of G by the perpetrator was historical, having started after her marriage in Kuwait, and became more serious in this country; and how, during the months leading up to the homicide, the perpetrator effectively isolated G from her support network, obscuring the extent of the abuse. We heard how the family, whilst not finding domestic abuse acceptable, had tolerated the abuse of G, believing that agreeing with the perpetrator was the way to keep G safe. We were told of the cultural and family values that impacted on G's circumstances, and the family's suggestions of how services could develop to help women in G's situation to become safer. Understandably some suggestions were an emotional response, but within this there are some concrete ideas that resonate throughout the Review and can be taken forward. These include awareness for schools/ children's agencies working with refugee children, and specifically the need for agencies to ensure they have face to face contact with mothers in refugee households. Whilst the suggestion of compulsory English classes may not be achievable, as a constructive way of reducing isolation, increasing integration, and developing social and support networks for migrant families, the provision of English classes needs careful consideration.

2.4 Analysis of Individual Management Reviews

This section of the Overview Report is an anthology of the IMRs prepared by the 9 agencies, as analysed by the report writers and further information and facts from the other 3 organisations which had contact with G and her husband and their children during the relevant time period is included in this section. It includes points from discussions between the independent Chair, the Review Team, and the agencies, at meetings and Panel sessions, in order to clarify, scrutinise, analyse, and cross reference information, to try to ensure there are no gaps and no conflicting information between IMRs, to discuss the internal organisational or legal contexts that applied to this case, and to validate and triangulate the information presented by agencies.

Throughout this process I have appreciated the commitment of the IMR authors to producing frank accounts of their involvement within detailed reports, in keeping with timescales; and to making themselves available for ongoing discussions, further investigations and amendment of their findings in order to resolve conflicting information, to complete gaps, learn lessons and to respond to challenges, all of which are an important part of an independent process.

Each agency's involvement is described and analysed separately, and there then follows an overall synthesis of the IMRs taken together.

Health Services

2.4.1 General Practitioners

The organisation:

The General Practitioner service is commissioned by NHS England; GPs are independent contractors responsible for providing personal, primary and continuing care to individuals and families both at the practice at which they are registered and through the Out of Hours service.

Two practices were engaged with this family: Adult GH registered with Practice 1 on arrival in Sheffield (there is no record of contact with the health services in other cities whilst Adult GH was an asylum seeker). Practice 1 is a small practice with one GP and locum GPs on occasions. Here, Adult GH saw the GP and a locum. Practice 2 is a large practice based in the north of the city; Adult G and the children all registered here and were seen by a number of GPs, male and female, and by practice nurses. Practice 2 is based in a multi-ethnic community and its workforce reflects the profile of that community; reception staff routinely translate during consultations and support newly migrant patients to access the health system, for example by explaining appointment systems. Adult GH moved from Practice 1 to Practice 2 after the arrival of Adult G; he later consulted Practice 1, whether because he had a preference, wished to transfer back or because he did not understand the

system, is not known. Adult GHM on arrival in the UK registered at Practice 1, remained with that practice, and was accompanied to appointments by Adult GH. Adult G had no contact with Practice 1.

For clarity, this Report refers to Practice 1 and its staff, and Practice 2 and its staff, as generic terms, rather than listing individual practitioners, as these are numerous. The identity of the individual practitioners is recorded by the IMR author who interviewed those featuring in significant events in the chronology.

Summary of involvement of General Practitioners with the family from 19th October 2010 to 4th March 2014:

Adult G

For the whole of the period under review Adult G was registered with one GP practice (Practice 2). She was first seen for a new patient check on 5.9.11 by the practice nurse together with Adult GH and her 3 children. A further appointment was made [*redacted]*. On 19.9.11 she attended [*redacted*] she was booked in with the midwife. The midwife completed a 'Common Assessment Framework' (CAF) as the family reported being homeless and this was scanned onto the GP system clearly. Adult G was prescribed iron in pregnancy but this script was sent to the wrong property because they had moved but not informed the practice.

After her pregnancy Adult G failed to attend [*redacted]* and this was followed up by the practice administrative staff with letters and text messages.

[Adult G's non-relevant medical information has been redacted for confidentiality reasons.]

Overall there were seven face to face contacts between the practice and Adult G; all the consultations were with an interpreter which is coded in the records. It is not clear from the record if Adult GH attended with her.

Her ethnicity and need for an interpreter is clearly recorded in the computer records.

Adult GH

Adult GH registered Practice 1 from February to September 2011 and then transferred to Practice 2 and remained registered at Practice 2 until July 2012. At this point he re-registered with his original practice, Practice 1, where he remained registered until the date of the incident.

On 9.2.11 when Adult GH registered with Practice 1, he was seen by a GP and described long-term back pain and reported having been told by a previous doctor that he had a slipped disc. His examination was normal and he was given paracetamol.

On 15.4.11 Adult GH was seen by a GP who recorded a chest infection and he requested a letter for the home office for travel documentation relating to depression. It is not clear why he would he need travel documentation about depression and he had not consulted about this or had any medication.

On 5.9.11 when he registered at Practice 2, Adult GH attended with Adult G and the three children for a new patient check with the practice nurse at Practice 2. It was noted he lived with his wife and 3 children and that he had occasional back pain. During this consultation he was issued with a prescription for treatment of thread worms. Also on 5.9.11 a nurse tried to ring him back for a requested telephone consultation but there was no reply.

On 25.10.11 Adult GH saw the Practice 1 GP, reporting feeling low, depressed and angry for 4 months which had been worse for six weeks. He stated he was feeling angry all the time. A social history was taken establishing that he had come to the UK a year before and his wife and children had joined him two months previously. The children's ages were recorded. He stated he had never felt like it before, that he was not in work because he had language difficulties but that he had previously worked in mechanics. He had smoked cannabis for a month but was not using Ghat. He was asked what he thought had triggered his low mood and anger and told the GP that he found living in the UK hard; that he left Kuwait due to political problems; had been in prison for a little while but was never physically abused; and that he was of Muslim faith. A depression score was undertaken and he scored highly. He stated he had thoughts of ending his life on most days but didn't have any plans to do so. He was asked if he had shared with his wife how he felt and said 'no', he didn't feel he could talk to her, but he had a good relationship with her. He was asked if he had ever hit his wife or children and the answer was 'no'; he stated he just wanted to be on his own. He stated he had a few friends but did not want to see anyone. He said he did not hear voices but 'thought a lot'.

The GP states that Adult GH felt this state had been triggered by his arrest by the police six weeks previously when he was accused of smuggling people into the country; had been in a cell for four hours and pictures had been taken and then he had been released; he had not been badly treated. Adult GH stated, when asked by the GP, that he believed that depression was caused by evil spirits but didn't believe this about himself. The GP's impression was that he had a reactive depression and should make a good recovery. He was advised to stop cannabis and prescribed an antidepressant (fluoxetine), given a sick note so he did not need to look for a job and advised to make an appointment for two weeks for review of his mood.

On 8.11.12 Adult GH was reviewed by the GP and said he had been unable to sleep on the medication and so this was changed to mirtazapine. He attended with a friend and was given another sick note. On 17.11.12 he requested a duplicate sick note which was issued. Two weeks later on 22.11.12 he was further reviewed by the GP.

A friend accompanied him and did most of the talking. He stated he had been taking one antidepressant tablet before bed and another in the night to help him sleep. He was advised against taking the medication in this way by the GP. The friend was concerned as he felt Adult GH was very forgetful. The GP advised that this would be secondary to his depression and his memory should improve as his mood lifted. Adult GH also disclosed having urinary incontinence for two weeks. He stated he knew he needed the toilet but was having accidents before he got there. He stated that he passed urine frequently but not at night and there was no pain when he passed urine. He also stated that he had nightmares. He stated he had stopped using cannabis and the GP recorded this. The GP recorded that the new treatment was suiting him but he must take it at the correct dose. He was given a sick note for 4 weeks and told to make a further appointment to see the same GP in four weeks. A urine test was requested but the GP thought the urinary symptoms were due to detruser instability which is a stress related condition. He was advised to check the result in 3 days and if the urine symptoms persisted to rebook a separate consultation. There is no record of a urine test being returned by Adult GH.

On the 5.1.12 Adult GH returned to be seen as requested on 22.11.12 but was seen by a different GP who requested the in house interpreter be used during the consultation. It is recorded that a friend was present and interjecting (in the meeting with family, this was thought to have been his brother). Adult GH stated he felt the depression was only slightly better but he did not have any suicidal ideas. He was unable to sleep and was prescribed sleeping tablets to establish a good sleep cycle. He was given a sick note for 6 weeks and a prescription for another month of anti-depressants. During this consultation Adult GH complained of diarrhoea for three days and urinary dribble. A further urine test was advised and he was advised to see the previous GP for a depression review. However he saw this GP again 4 weeks later and stated he was starting to improve but sleep was still a problem. At this consultation Adult GH complained of back ache radiating down his right leg. The GP agreed he had a prolapsed disc and prescribed painkillers and antidepressants and sleeping tablets.

On 1.3.12, 4 weeks later, he saw the GP again with back pain. He was examined, no serious pathology was detected and he was referred for physiotherapy for sciatica. A further sick note for 6 weeks was given. The GP noted that the depression was responding to treatment and one month's supply of antidepressant treatment was issued.

Adult GH then did not attend appointments with the GP on 29.3.12 or 25.4.12, nor did he attend the physio appointment on 1.5.12, despite reminders. He did not have any more treatment or contact with the practice for himself.

On 18.7.12 adult GH re-registered with Practice 1 and was seen by a locum GP when he attended with a friend; with the receptionist interpreting. He complained of

back pain which he had on and off for three years. He was limping which he said was due to the pain and on examination his back was tender. He stated he did not have any bladder or bowel symptoms but was advised to attend A&E if he developed any. He was referred for an x-ray and for spinal physio. He was prescribed diazepam as a muscle relaxant and diclofenac (pain killers). He was given a 4 week sick note.

On 17.8.12 Adult GH was again seen by this GP and was waiting for back clinic, which is the physiotherapy spinal service. He was reassured that the x-ray result was normal. He was given a sick note for a further 2 months and prescribed medication to protect the stomach from the side-effects of the painkillers. There is no letter from the spinal service to say whether he attended or not.

On 3.9.12 there is an entry which states Adult GH requested a report to support his court appeal against the Department of Social Security (DSS) decision. The GP commented that he must have evidence for an appeal before he issued any further sick notes.

On 10.9.12 there is an entry stating that the Job Centre Plus had declared Adult GH capable of work.

There are entries on 21.9.12, 16.11.12 and 25.1.13 to state that sick notes were issued for back pain. There is an entry to state a duplicate sick note was issued on 1.3.13 as a previously issued one had been lost.

On 1.3.13 Adult GH was seen by GP 1 and given a 3 month sick note for backache subject to appeal outcome.

On 5.5.13 there is an entry regarding a hand injury for which Adult GH was seen at the Northern General Hospital A&E but did not attend an appointment at the hand centre on 8.5.13. He did not see a GP about this injury.

He was not seen by a GP again for himself in the review period.

<u>Adult GHM</u>
[Adult GHM's medical information has been redacted for reasons of confidentiality.]

<u>Child GS1</u>
For the whole of the period of the review Child GS1 was registered with Practice 2. Both parent's names were detailed in Child GS1's medical records and the need for an interpreter was recorded. Child health records including entries from health visitors and GPs were shared on the computer records.

On 5.9.11 Child GS1 saw a practice nurse with both parents (Adult G and Adult GH) and two siblings for a new patient check. [*Redacted*].

On 27.2.12 Child GS1 did not attend a GP appointment which had been requested by the family. It is not known why the appointment was requested or why Child GS1 did not attend.

On 13.8.12 it had been arranged to provide a 'ring back' telephone consultation regarding Child GS1. However when the practice nurse phoned back and spoke with Adult GH, he said he was unable to speak as he 'had to attend another appointment' and subsequently put the phone down on the interpreter. It wasn't clear what was the matter with Child GS1 although the baby, Child GD2, [*redacted]*. They were advised to attend the walk in centre that day but they attended the surgery the next day. The chronology notes that when Child GD2 was brought to the practice the following day, 14.8.12, she was well.

[*Further medical information regarding Child GS1 redacted for confidentiality reasons*.]

Child GD1

For the whole of the period of the review Child GD1 was registered with Practice 2. At her new patient check on 5.9.11 GD2 was accompanied by both parents, Adult G and Adult GH. [*Redacted]*.

Following the practice nurse's incomplete telephone call with Adult GH on 13.8.12 the family attended the walk in centre on 14.8.12. Child GD1 presented with both parents and [*redacted]*. They were advised to make a routine appointment to see the doctor and the code 'advice regarding provision of local health services' was used because they had not phoned to make an appointment but just turned up.

[*Further medical information regarding Child GD1 redacted for confidentiality reasons*.]

Child GS2

For the whole of the period of the review Child GS2 was registered with Practice 2. At the new patient appointment on 5.9.11 [*redacted].*

[*Further medical information regarding Child GS2 redacted for confidentiality reasons*.]

Child GS2's records state that the homeless health visitor team and GP records were shared. There is an entry from the health visitor with information regarding frequent house moves, lack of stimulation in the home and no toys. It is recorded that Adult GS2's mother was 39 weeks pregnant and that a CAF was completed.

Child GD2

Child GD2 is the fourth child of the family, having been born in the UK on *[redacted]*. On 7.8.12 and 9.4.13 it is noted that Child GD2 still needed registering with the GP practice. On 29.5.13 a health visitor entry on the record advised that Child GD2 had been seen and universal services were in place.

[*Further medical information regarding Child GD2 redacted for confidentiality reasons*.]

On 25.7.13 the practice nurse completed a missing child immunisations data request from child health because Child GD2 had not attended for her one year immunisations. (This means that parents are sent a letter from Child Health Services instructing them to make an appointment at their GP surgery for an immunisation). Subsequently Child GD2 was sent an appointment with for 7.8.13 but this was not attended or followed up by the practice.

On 5.2.14 the practice nurse posted another appointment for immunisations for 19.2.14. Again this was not attended.

Analysis of General Practitioner involvement with Adult G and Adult GH:

Analysis of involvement with individuals:

Adult G was seen seven times for herself at the Practice as well as having contact for her children. An interpreter was used for all her appointments. She had a thorough new patient check. She was not seen by the practice during her pregnancy but the involvement of the midwife is clear in the records including the CAF regarding homelessness and financial hardship. It is standard practice to have midwifery-led care. She was prescribed iron but this prescription was returned because the family had moved and not told the practice. This was followed up by practice staff who obtained the new address and sent the prescription to her.

Adult G did not attend for a post natal check or for [*redacted]* and ultimately declined screening. It is not clear if she declined herself or if this was done on her behalf. [*Redacted*.]

On the 29.4.13 [*redacted].* In hindsight it is thought this might have been an opportunity to examine her and find evidence of domestic abuse, but there was nothing to indicate this at the time.

She was examined by the triage nurse who listened to her chest on 14.2.14 when no injuries were noted. It was not noted who she attended with at this appointment but her daughter Child GD2 also attended the same nurse on that day with both parents so it is likely Adult GH was there. This nurse had received domestic abuse training two months before.

Adult G was not asked about domestic abuse because none of the consultations would have suggested any triggers to prompt even screening questions in relation to domestic abuse. It would not have been appropriate in the consultations that are recorded. It is not clear if she attended all the appointments with Adult GH but there is evidence that she was seen without him in her children's appointments.

Adult G was not known by any particular GP and she was seen infrequently and opportunistically in nurse triage and her children's appointments. Her ethnicity and need for an Arabic interpreter is clearly recorded in the medical records. She would have been able to ring the surgery and speak to an Arabic speaking receptionist to make an appointment.

The IMR author notes that Adult G received an excellent service and evidence of good practice, for example in the extra work undertaken by Practice 2 to care for her and ensure she could access all the health services; there was consistent provision of interpreters; and practice staff advocated for Adult G and helped her make appointments when she attended opportunistically.

There was nothing in the medical records for Adult G that would alert a clinician to domestic abuse.

Adult GH saw a GP at Practice 1 twice before he transferred to practice 2. He requested documents for travel regarding depression but there is no record about depression in the notes or why travel documents in respect of depression would be needed. The IMR author discussed this with the GP who felt Adult GH had low level depression and that actually he wanted sick notes per se rather than specifically for travel.

The GP and staff at Practice 1 felt they knew Adult GH well. They felt he was kind to his mother, Adult GHM, and brought her to the practice regularly. The GP at Practice 1 told the IMR author that he was very aware of the Bidoon culture and has had other patients from this community as patients. He expressed a personal opinion that this community is uneducated and at times violent, and stated that he was aware of the incidence of domestic violence in this culture. This view was discussed further with the IMR author who clarified that the GP was very clear in interview that he had experiences of this community, which were not based on his own religious or cultural views, which evidenced these remarks.

The GP at Practice 2 conducted an in-depth depression consultation when Adult GH presented with anger, which included asking specifically if he had hit his wife or children. The GP asked Adult GH about his relationship with his wife and the ages of the children. On interviewing this GP the IMR author found that he is very experienced in caring for refugees and asylum seekers and that the GP routinely

asks direct questions regarding domestic violence and previous trauma when a patient is depressed, especially when they present with anger. The IMR author notes that this is good practice based on this GP's experience of working with refugees who often have been abused and need counselling and support.

Adult GH presented twice for follow up with this GP but then saw a different GP who insisted he was seen with an interpreter. These consultations were challenging interpreted consultations with friends attending with Adult GH and interjecting.

Adult GH was changed from one antidepressant to another one which is good practice when the first one was causing problems with sleep. He also reported urinary incontinence which was thought to be due to detrusor instability, a stress related condition; and his friend was concerned about his memory but this was thought by the GP to be due to depression. Adult GH did not give a urine sample to exclude an infection as requested.

Adult GH was encouraged to make the further appointments with the original GP again which he did not do. It is best practice to stay with one GP for an episode of care which gives an opportunity to build rapport but Adult GH made an appointment with a different GP and no further discussions regarding violence were made, and he improved and stopped the medication. He had antidepressant medication prescribed for six months which is the usual length of treatment although a patient would usually be reviewed before stopping the medication in order to tail off the medication and also assess their recovery. He did not attend for further review even though it was advised regarding back pain and depression. He did not attend two GP appointments or physiotherapy for his back.

Adult GH then re-registered with Practice 1 but was not seen until July when he had back pain again and was referred to the back clinic, but he did not attend. He was then seen requesting sick notes although he had been examined at a medical by Job Centre Plus and told he was fit for work. He was appealing and was therefore issued with three month sick notes subject to his appeal on 1.3.13 which was a year before the domestic homicide.

He was not seen again at the practice for himself. There is a record of a hand injury that Adult GH attended accident and emergency with in May, and a letter recording his nonattendance at hand clinic.

Adult G's mother-in-law (Adult GHM) [*redacted].* …accompanied by Adult GH who wanted to translate for her but the nurse insisted on using an in house interpreter; he resisted and the nurse stated she did not know why this was the case. The IMR author notes this is evidence of good practice that the nurse insisted, but in hindsight believes the nurse might have gone further and asked Adult GH to leave so she could discuss this with Adult GHM.

Child GS1 [*redacted].* Appointments were made and not attended which is not uncommon when children get better quickly but this may in retrospect be a sign of neglect.

Child GD1 [*redacted].*

Child GS2 [*redacted].* Child GS2 was also seen in walk in appointments and other siblings' appointments. He was seen with both parents and with his mother alone and his father alone. His immunisations were completed.

Child GD2 is the fourth child of Adult G and was born in this country. She was seen for an eight week check with a GP which is a routine appointment. The GP did not record who was present at the appointment but it would usually be the mother. The GP noted that a CAF had been completed in pregnancy and was aware of frequent house moving which has been shown to be a risk factor of neglect in children's serious case reviews. There were concerns that the baby hadn't been registered at the practice which is another example of the family not knowing how to access health care appropriately or perhaps not bringing the appropriate documents to the practice for this to be processed.

A further example of perhaps not understanding how to access health care appropriately relates to the failed 'call back' when GH had another appointment but then presented the next day without an appointment despite being told the day before to present to the walk in centre.

Child GD2 should have had one year old immunisations in May 2013 but no appointment was made. A reminder would have been sent to the family from the Child Health Surveillance Department advising them to make an appointment with the nurse. This was followed up when the practice was advised that the data had not been recorded; appointments were sent but Child GD2 did not attend and this was not followed up initially. The IMR author notes that this is in retrospect a missed opportunity to talk to the health visitor about any concerns regarding neglect. The GP did not address the lack of immunisations when Child GD2 was seen for minor illness after not attending for the immunisations. It is good practice to check immunisations status in all paediatric consultations and it was another missed opportunity to advise about immunisations. She was acutely unwell so immunisation would have been delayed until she was better.

The issue of outstanding immunisations was not followed up again until February 2014 when a practice nurse noted that Child GD2 was still not up to date with them. At this point a further appointment was sent. The receptionist did follow up this failure to attend and spoke to Adult G with an interpreter and Adult G accepted another appointment. This was very good practice by the receptionist.

Organisational analysis:

Practice 2 serves a community which consists a higher than average percentage of patients from black and minority ethnic backgrounds. As such, the practice is unusual in offering in-house interpreters including receptionists and medical staff speaking a range of languages including, in this case, Arabic. As a practice accustomed to working with refugee and asylum seeker families, the IMR author found that general practitioners, nurses and reception staff demonstrated flexibility and patient focus in ensuring that individuals were seen quickly when they did present. An opportunity was lost to follow up the lack of immunisations for the baby on 16.9.13 and in general it would appear that Adult G and Adult GH were not conversant or not compliant with the need for immunisations for their youngest child.

Adult GH changed practices to register with Practice 2, the practice nearest his home address, along with his family, when his family arrived in the UK. He subsequently re-registered with Practice 1, for reasons not recorded, whilst his family continued to attend Practice 2. The IMR author suggests that as a refugee, Adult GH may not have understood the need to register with one practice and thought he could attend either. In further discussion with the IMR author, it was clarified that there was no suggestion that Adult GH was attempting to be evasive by returning to Practice 1. His mother remained at Practice 1 throughout and he accompanied her there. The IMR author has discussed with the practice staff and believes that Adult GH may have thought he could consult either doctor. This is further supported by the evidence that Adult G did not know how to access medical services systematically, and other IMRs which suggest the family was poorly organised.

The practices do not have a domestic abuse policy however the IMR author established that the GPs who were interviewed were aware of guidance on the CCG website relating to the Domestic Abuse, Stalking and Honour-based Violence (DASH) risk assessment and they told the author that they are sure that all staff would recognise and report violence. There was nothing in the consultations that triggered concern for domestic abuse other than the question raised by one GP when Adult GH presented with depression. This was not based on guidance but on his personal opinion and experience of refugees presenting with anger and in the view of the IMR author signified excellent practice.

The IMR author considered whether Adult G's presentation for several minor ailments during the consultations for her children presented a 'calling card'; it is known from research that many victims of domestic abuse use apparently unimportant symptoms to seek help indirectly. When Adult G was examined there was no injury apparent and as she gave no indication of being abused, this would not have triggered an inquiry.

The IMR details that records in all cases were complete and correctly coded.

Conclusions:
The IMR author identifies a number of examples of good practice. This includes offering a thorough new patient check, which was no longer a requirement of practices; responding proactively to the chaotic presentations of the family, using reminders, advising on how to use health services, ensuring family members were treated when presenting in a child or sibling appointment.

The IMR highlighted that Adult G and Adult GH had a history of missed appointments, often presenting opportunistically, neglecting to attend follow-up appointments, not co-operating with treatment or advice, and not complying with important medical requirements such as the immunisations for the baby. Adult G often presented her medical needs during a child's appointment and similarly presented children during one another's appointment. The IMR considered whether Adult G's pattern of presentation could have been a 'calling card' but established that there had been nothing to trigger an inquiry in these consultations. It was not possible to establish, with the exception of some children's appointments, at which of the consultations Adult G was alone and at which she was accompanied by Adult GH, and this may be a factor in her ability to disclose abuse.

In hindsight, the IMR author notes that there could have been indicators of child neglect, such as the family not taking medical advice and not presenting the baby for immunisations; and that child neglect can be associated with domestic abuse. Equally however, this pattern of use of health services could reflect that as refugees the family had little experience or understanding of how to use health services properly. It was noted that the family had homelessness and financial hardship issues which had led to a CAF being completed by the midwife, and this would also be associated with the hygiene and health issues presented by family members.

As the overview report author I am in overall agreement with the findings of the IMR author. I have noted that the family used services chaotically either because Adult G and Adult GH did not understand how the health services work, or because of personal and familial disorganisation. It could be that as stateless refugees who had experienced barriers to primary health care in their home country, Adult G and Adult GH may not have understood the system. This would be expected to be a common situation in urban practices working with refugees and asylum seekers anywhere in the UK. There is evidence of excellent service provided by both practices, in support of the asylum seeker and refugee community. The question of domestic abuse was addressed directly with Adult GH because of the specialist knowledge and personal viewpoint of that GP. This inquiry is unlikely to have been triggered in a practice without that expertise. Whilst Adult GH denied being violent towards his wife, it was in any event considered.

Having spoken to the family, I believe that Adult G was always accompanied to GP appointments by her husband or her mother-in-law, and that this would have inhibited her; her sister believes this is why she did not keep her appointments and presented her own health concerns during the children's appointments, when she was alone. The IMR author considered this, and suggested, in hindsight, that Adult G's pattern of presentation at health appointments could have been a 'calling card'; that she may have been inhibited from drawing attention to injuries by being accompanied by Adult GH; that there may be wider cultural issues that would trigger an inquiry into domestic abuse, such as neglect of the children, particularly the daughters, for example in failing to bring the baby for immunisations, and the general hygiene issues.

During the trial, there was considerable information and assessment suggesting Adult GH may have been suffering from psychosis at the time of the offence, that there was history of mental illness in Kuwait, and that following treatment in a secure hospital setting this condition has been stabilised. Information about a psychiatric history was not available to the GPs treating Adult GH when he presented with depression. His brother felt that more could have been done by the health services to diagnose his condition when he presented, and that this might have influenced the outcome in that he may have been provided with treatment. I asked the IMR author to consider, in the light of this new information, whether anything could have been done by health services to make Adult GH safe. The IMR author reviewed the report and responded that: *Adult GH did not present for a whole year before the death and there was no reason to question him about mental health then as he was presenting with back pain. The last time he was seen was on the 1.3.13 so previous mental health appointments would have been irrelevant to a new psychotic presentation. He had no psychotic symptoms documented when he was seen previously in* 2011.

Both these discussions have required hindsight. I cannot identify any steps the general practitioners could have taken with foresight, to recognise either that Adult GH was violent in the home, or that Adult G was experiencing domestic abuse. This IMR has identified where lessons can be learned and services developed further with the knowledge from the DHR process, but these would not have influenced the outcome.

2.4.2 Sheffield Teaching Hospitals NHS Foundation Trust

The organisation:
Sheffield Teaching Hospitals NHS Foundation Trust is England's second largest NHS Trust and one of the largest teaching Trusts in the country. It consists of five acute hospitals, the Northern General, Royal Hallamshire, Weston Park, Jessop Wing and Charles Clifford Dental Hospitals; and community services. The Trust provides midwifery services in the hospitals, and in the community.

For brevity and clarity, this Report refers to STHFT throughout.

Summary of involvement of STHFT with the family from 19th October 2010 to 4th March 2014:
Adult G
STHFT had contact with Adult G for midwifery care from 02.11.11 to 28.5.12. It is recorded in the first antenatal contact documentation that Adult G was of Kuwaiti origin with her preferred language being Arabic. Her religion is documented as being "unknown".

Adult G commenced her midwifery care with STHFT on the 2.11.11, during the ante-natal period up to the birth of Child GD2 on 27.5.12. Adult G had 17 ante-natal contacts with community and hospital midwives, 13 were with her named midwife. At the first meeting with the midwife Adult G declared that she and her husband Adult GH were asylum seekers from Kuwait. A referral was made for Adult G to have midwifery led care at The Jessop Wing. As Adult G could not understand English an interpreter was used at each appointment both in hospital and community.

Adult G was expecting her fourth baby; all her previous children had been born normally in Kuwait. However her first pregnancy had been confirmed as twins but unfortunately the first twin was still born, an intra-uterine fetal death (IUFD) with no reason being recorded.

On the 2.11.11 at the first ante-natal appointment at 12 weeks gestation Adult G attended the ante-natal clinic at the Jessop Wing accompanied by her husband. Adult G voiced concern that although she did wear glasses she felt her vision had deteriorated, the doctor assessing her at the booking clinic referred Adult G for an ophthalmic assessment. Due to a family history of diabetes an arrangement was made to perform a Glucose Tolerance Test (GTT) at 26 weeks gestation. Midwifery led care was confirmed, to be provided by the community midwife (homeless team).

On 27.1.12 Adult G was seen at home (interim accommodation) by the community midwife and an interpreter. At this visit the midwife completed a Common Assessment Framework (CAF) which was sent to the Multi-Agency Support Team (MAST) with copies sent to Health Visitor, General Practitioner, Jessop Wing and

Tenancy Support. The midwife recorded that the indication for the CAF was due to issues with accommodation and delay in financial benefits being approved resulting in the need for support obtaining food and essential equipment for the baby. Adult GH and all the children were present during the visit; however the community midwife was able to perform routine domestic abuse inquiry which was recorded as negative.

Between 7.2.12 and 16.2.12 (23 to 25 weeks gestation) the community midwife visited Adult G at home on three occasions. The pregnancy continued to progress normally and the midwife attended frequently to offer additional support and deliver food parcels. It is recorded that the children and husband, Adult GH, were present in the accommodation during all the visits.

On 23.2.12 Adult G did not attend the community clinic for the planned GTT. A new appointment was made for it to be performed in the community clinic.

Between the 27.2.12 and 9.3.12 there was one failed visit by the community midwife at the home address and two failed attendances by Adult G at the Jessop Wing ante-natal clinic.

On 10.3.12 (28+4 weeks gestation) the community midwife visited Adult G at home, and recorded that the pregnancy continued to progress normally with no concerns about maternal or foetal wellbeing. A further routine domestic abuse inquiry by the midwife is recorded as negative and children were present during this visit.

Between the 26.3.12 and 4.5.12 Adult G and family were visited by the community midwife in new accommodation.

On the 4.5.12 (36 weeks gestation) Adult G was seen in hospital for an ultra sound growth scan which was within normal limits, but a further scan was arranged to be repeated in two weeks. Adult G declined the GTT therefore the doctor recommended the community midwife to perform the GTT at home. On this date in the evening, the community midwife visited Adult G at home to provide additional support as she had been concerned about the financial situation and lack of availability of food. During the visit Adult G reported that the family had no money and no food. The midwife contacted Children's Social Care Out of Hours service who attended and delivered food and money.

On the 10.5.12 the community midwife updated and re-submitted the CAF requesting a family support worker; she highlighted the problems the family had been experiencing obtaining benefits and the frequent use of food banks. In the referral the midwife requested that the case be reviewed as a matter of urgency as there had been no contact made with the family from any agencies from the initial referral made in January 2012.

On 21.5.12 (38+3 weeks gestation) during a routine visit by the community midwife Adult G reported that the family was moving back to the previous area as they did not like the new accommodation. Adult G said the family had received a crisis loan and had some equipment for the baby delivered. Routine domestic abuse inquiry by the midwife was recorded as negative.

On the 27.5.12 Adult G was admitted to the labour ward at Jessop Wing in advanced labour and Child GD2 was born normally and healthy. Adult G and Child GD2 were transferred to the care of community midwives on 28.5.12. Post-natal recovery of mother and baby was uneventful and they were transferred to the care of the Health Visiting Service on 11.6.12. The Health Visitor performed an early visit on 13.6.12.

The Health Visiting Service is reviewed under the SCHFT IMR.

Adult GH

STHFT had contact with Adult GH for one episode of emergency care from 5.5.13 to 17.5.13. On 5.5.13 Adult GH attended the Accident and Emergency department at the Northern General Hospital with an injury to his right hand. He reported that he had “punched a door the previous evening”. An X-ray confirmed a fracture to his right little finger and a follow up appointment was arranged for him to attend the fracture clinic. On 7.5.13 Adult GH attended the fracture clinic where he reported to staff during his examination that the injury was caused when he “hit his hand on a wall when he found out a cousin in Kuwait had died”. He was accompanied by a friend who interpreted for him. Conservative treatment was advised with an arrangement for a follow up appointment in 10 days. He did not attend that appointment and a letter was sent to his GP with no further plan to follow up. It is recorded in the records that Adult GH was of Kuwaiti origin and his religion is recorded as being Muslim.

Children GS1, GD1, GS2, GD2

STHFT had no contact with the children of the family other than Child GD2 within maternity services as described above.

Analysis of STHFT involvement:

Analysis of involvement with individuals:

Adult G presented for care with STHFT during the first trimester of her fourth pregnancy. Adult G engaged well with Midwifery services throughout her pregnancy and was cared for by a named midwife in the Homeless and Traveller Health Team, with experience in caring for refugee and homeless families. The care was shared between the hospital team and the community midwife.

The IMR author found good evidence within the midwifery hand-held records and hospital records that the level of care provided was of a high standard and states that throughout the episode of care there is excellent documentation regarding the social circumstances of the family; and the efforts made to support the family from the midwifery team exceeded expectations. It is recorded at each contact which family members were present and domestic abuse routine enquiry was confirmed as negative on at least three separate occasions.

The community midwife clearly recorded and detailed the issues within the family regarding lack of money and food. The midwife completed a CAF early in the pregnancy to highlight the need for support; when no support had been provided, the midwife updated and resubmitted the CAF some months later.

The community midwife recorded that there were challenges in working with Adult G, notably that Adult G was isolated due to financial hardship and her poor command of English. This is a common problem encountered by the midwife working with homeless and travellers team as the women often do not have their own mobile phone and rarely have a landline to use; appointments are mostly done in the home as travelling on public transport is expensive and difficult if English is not their first language. The midwife was able to visit Adult G in her visits at home due to her specific role. The midwife confirmed that she had a good relationship with Adult G and at no point during the time she cared for her was she concerned about the risk or signs of domestic abuse.

As the use of interpreters during the midwifery service was not recorded, at the request of the Review Team the IMR author undertook further inquiries. This established that whilst it is not practice to record the gender of the interpreter, it is accepted practice to request a female interpreter for all face to face contacts, that this is booked in advance and the community midwife would rearrange appointments in order to ensure a female is present. The community midwife noted that it is not always possible to ensure a female interpreter is available when using the Language Line, but that the midwife would never use a male interpreter to discuss sensitive information, and would call back when a female would be available.

The birth of Child GD2 was uneventful and Adult G was successfully breast feeding the baby at the time she was discharged from midwifery care. There are no records of concern regarding care of the baby at any point during the time span reviewed.

During the time that Adult G was engaging with care for her pregnancy there is no indication within the records that Adult G was subject to any form of violence or abuse by any close family members. It is noted in the midwifery documentation and CAF that Adult G was from a large family with siblings living in the UK and also other siblings and parents who had remained in Kuwait. It is noted that Adult G and Adult GH had both left school at around the age of 13-14 years and neither had received

any further education. Adult GHM was recorded as staying with the family; however it is not clear where the remainder of the family were living.

As English was not the first language an interpreter was used at each visit, this was via the telephone interpreter service. This was recorded as being essential. There is documentation that due to a poor phone signal on the final visit it was re arranged and a face to face interpreter was used to ensure Adult G understood that the Health Visitor would be taking over her care. Information about the gender of the interpreter is not on record during this part of Adult G's care.

There was a brief episode of care provided to Adult GH via A&E following an injury to his Right hand. The IMR author finds the injury was managed appropriately and although follow up was arranged he did not attend the planned appointment. It is recorded that Adult GH was accompanied by a friend who was used to interpret and there are noted discrepancies in the documentation as to the cause of the injury. It is not recorded if an independent interpreter service was offered.

During the visits of all midwives' visits to the family home, no evidence of neglect of children was observed or recorded.

Organisational Analysis

It is not recorded whether the interpreter service was provided by a male or female and this could be significant in working with a culture in which gender roles are clearly defined. For example, Adult G may not have disclosed domestic abuse if the question was posed by a male interpreter.

The IMR author notes there was no specific understanding within the organisation of the Bidoon culture, and had there been, this may have influenced the care Adult G was offered. For example, the IMR author refers to research to indicate that Bidoon women could be more reluctant to report domestic abuse; they would fear that their husbands could lose security clearance and be unable to find work.

The IMR author believes the review has highlighted the need for targeted training and enhanced information being available to staff involved with hard to reach communities. This case highlighted the benefit of having named midwives caring for vulnerable families.

Conclusions:

The IMR identifies good practice in the support and care offered to Adult G by the community midwife, which includes a CAF, a referral to Children's Social Care for emergency help with food; and practical help with baby equipment. It clearly highlights the value of the homeless team midwife who is experienced in working with vulnerable people.

The reference to information about Bidoon women being less likely to disclose domestic abuse as this could affect their husbands' security clearance and therefore cause further hardship, is likely to apply to other refugee groups within the UK. This would therefore be valuable training for the Homeless and Traveller Health Team

The overview report author agrees with the findings in the STHFT IMR and notes the good practice that is evidenced. Specifically that despite a language barrier, routine domestic abuse inquiry was used on three separate occasions by the community midwife. There has been discussion within the Review Panel in regard to asking questions relating to domestic abuse of asylum seekers and refugees. First, the use of male or female interpreters is seen as significant, in that female interpreters should always be used; it is advisable to use interpreters not belonging to the same community where possible as this would inhibit disclosure. Whilst there are assurances, from interviews with practitioners, that midwives would always use female interpreters, this is not recorded, and this is seen as an area for development in order to both ensure female interpreters are routinely offered and to monitor the availability of female interpreters (as other agencies have suggested there is a shortage of females). This has been picked up as a lesson learned, and monitoring has been in place since October 2014.

Secondly, the questions asked need to be clear and specific, as the inquiry could be lost first in the translation and then in the cultural understanding of abuse. The IMR author reported that the community midwives understood and used direct questioning and that they are accustomed to working in this way. It may not be the case in a hospital or health visitor setting. Therefore, it was agreed by the Panel, that domestic abuse questions for staff working with asylum seekers and refugees need to be scripted, and this is a point for further development which is discussed later in this Report.

During discussion of this Report in the Panel, in relation to Adult GH's hand injury, it was asked what guidelines could be put in place in A&E departments when people present with barely plausible and/ or conflicting accounts of an injury that may have been caused by domestic abuse. It was agreed that given the context of volume and urgency of interventions in these departments, that it would not be reasonable to expect medical staff in A&E to inquire beyond the patient's account of an injury, unless there were other reasons to do so (for example a corresponding injury of another party). It was agreed that there was no reason in this case that could have alerted staff.

This IMR and subsequent discussions with the Review Team and in the Panel indicate that there were no missed opportunities, and best practice was evidenced, by STHFT, in all contact with the family. The lessons learned relate to use of interpreters and training and development and these are shared across the Partnership.

2.4.3 Sheffield Children's NHS Foundation Trust

The organisation:
Sheffield Children's NHS Foundation Trust provides a wide range of general and specialist services for children and young people across Sheffield, South Yorkshire and beyond. These include School Nursing and Health Visiting Services (HVS). The School Nursing and Health Visiting Services involved with this family are both in the Community Wellbeing and Mental Health (CWAMH) Division of the Trust.

The Health Visiting Service leads and delivers child and family health services from pregnancy up to the age of five years when the child starts school. The services include formal health and developmental reviews relating to children; other assessments including parenting capacity and environmental factors, providing additional or specialist services as appropriate to vulnerable children and families.

The School Nursing Service provides health education, health and developmental screening of children aged from five onwards; administers specific immunisation programmes to school age children and young people.

Munro emphasised the importance of early help at any stage in a child or young person's life. Failure to meet the health needs of children and young people can lead to problems or difficulties in the future and have a profound impact on their adult health. Munro highlighted the value of providing help at the earliest opportunity - as soon as a problem emerges to prevent the situation escalating. Health Visiting and School Nursing Services are crucial to both identifying need and providing a response through the service offer and in working with partners, thus ensuring effective early help is available.

For brevity and clarity, this Report refers to SCHFT throughout.

Summary of involvement with the family from 19th October 2010 to 4th March 2014:

The Health Visiting Service (HVS)
There is a health visitor based in the multi-agency Homeless and Travellers' Team, line managed by SCHFT. This health visitor initially met the family when they were in interim accommodation in January 2012; however contact was very brief, Adult G was pregnant and a midwife became involved; the family then moved to settled accommodation and the Health Visiting Service became involved as below.

The Health Visiting Service (HVS) initially became aware of Adult G and her family in March 2012 when the Health Visiting team receiving a completed transfer summary

sheet from the Homeless and Traveller Health Team, informing the Team that the family had moved into their particular area of the city.

The first health visitor visited the family at home on four occasions. During her initial visit the health visitor accessed Language Line to communicate with Adult G. Subsequently the health visitor made arrangements for joint visits with an interpreter.

The health visitor identified that the younger child needed stimulation to support and help their development and discussed with Adult G the need for the older children to attend school regularly. Adult G was reluctant for the children to attend school as they had been offered placements in different schools. The health visitor completed an assessment using the Common Assessment Framework (CAF) to obtain funding for a nursery placement for Child GS2. She also referred the children to 'Ready Steady Go' (a support group run by Action for Children) where the family would get support with stimulation of the children and their development.

The health visitor communicated on a number of occasions with the Support Worker from the refugee team who was working with the family, and clarified that the support worker was providing on-going support to this family and could work with the family for up to a two year period. The health visitor had identified the financial situation the family was in and communicated this to the Support Worker. The family was provided with a crisis loan on one occasion as there were issues regarding this family's eligibility in claiming state benefit. In order to support the family, the health visitor supplied the family with toys and clothing for the children.

The assessments undertaken by the health visitor indicate that Adult G had a warm relationship with all her children. The children were observed to be well nourished and responded positively towards their mother. No concerns were identified or reported by another service. Adult GHM was also living with the family and Adult G was pregnant. The health visitor knew the family was planning to move to a larger property; however, the family then moved without the health visitor's knowledge so the records could not be transferred immediately.

Following the birth of Child GD2, a second health visitor visited the family at their new address, with no knowledge of an Arabic interpreter being required for the visit. The health visitor undertook two further home visits to the family and completed the required assessments relating to the children and the family health. It was recognised by the health visitor that there was a lack of stimulation regarding the younger children. The health visitor identified the need for Child GS2 to attend nursery to assist his developmental progress. The older children had obtained placements in a local school.

The second health visitor saw Adult GH on just one occasion, when he left the house shortly after she arrived. It was observed that during all the home visits family, friends or extended family were present.

The School Nursing Service

On 17.5.12 the School Nursing Service sought and received consent from the parents for routine health screening in respect of Children GD1 and GS1 and this was provided in the school setting. Routine screening of a child's height, weight, vision and hearing is offered to all children when they start school. If any issues arise requiring further investigation appropriate referrals can be made.

Between June 2012 and May 2013, Child GS1 failed 2 hearing and orthoptic tests in school carried out by the school nursing service. Audiology and orthoptic screening is offered to all children in school following consent by parents. A letter was sent to the parents informing them of the failed screening and referrals to audiology and the orthoptic screening department for further assessment were made. Audiology contacted the family and later informed the Service that the family had failed to arrange an appointment for Child GS1. The Orthoptic screening department also advised the Service that Child GS1 had not attended an appointment for further assessment.

These non-attendances for further screening were not taken further by the school nursing service. This is not unusual as screening follow ups are not always taken up by families. The school nursing service follows up defaulted health appointments of children who are known to be vulnerable and there were no signs to suggest that Child GS1 was a vulnerable child.

On the 22nd January 2013 the School nursing service received a request for support from MAST. This was in respect of Child GD1 and the request highlighted *[redacted]*. It was noted that the family had previously received input from an intervention worker for poor school attendance (this refers to Child GS1 and is discussed later). The school nurse contacted the Child Protection Liaison Officer (CPLO) at the school and was informed that the CPLO would contact the parents and arrange for them to attend school and meet with the CPLO and the school nurse for an informal meeting to assess the situation and offer appropriate support. The meeting was arranged for the 6.2.13.

On the day of the meeting the school nurse and the CPLO met, however the parents did not attend. The outcome of the meeting was that the school would monitor the situation and contact the school nursing service if their support was required. The school nurse would contact the parents and ask them to provide consent for routine screening for Child GD1.

Following the meeting the school nurse attempted to have a telephone conversation with Adult GH but there were language difficulties; the school nurse was unaware that the parents' knowledge of the English language was very limited. The school nurse understood from this conversation that the parents would collect Child GD1 from school later that day and would meet the school nurse. However, the parents did not collect Child GD1; instead Child GD1 was collected by a male adult family member (now known to be Adult GH's brother). The school nurse spoke to this family member to request that parents completed a consent form for routine screening. No other information was disclosed to the family member by the school nurse.

The school nurse contacted the CPLO in May to enquire if there was any need for support for Child GD1 by their service and was informed that there had been an improvement and support from the school nursing service was not required.

There was no further involvement by the school nurse with any of the children.

Analysis of CWAMH involvement with Adult G and Adult GH:

Analysis of involvement with individuals

The Health Visiting Service had contact with Adult G and the younger children from March 2012 after the family left interim/temporary accommodation until May 2013 when the one year review of the baby was completed. Health Visiting Service has clarified that there would be no further routine contact until the baby's second year review, (which fell after the homicide) unless contact was requested. During home visits by the Health Visitor Adult GH and Adult GHM were both seen.

The health visitor recognised Adult G's social isolation and made arrangements for her to access English lessons. Adult G was also advised and encouraged to attend local groups to address her social isolation. Adult G accessed English lessons and the health visitor observed an improvement in Adult G's attempt to speak English. The health visitor noted that the children were in need of stimulation and development and applied for a funded nursery placement for Child GS2, and referred Child GD1 and GS2 to Ready Steady Go, a local group.

Health visitors offered a clear client focus in the practical support and advice in relation to hardship faced by the family and Adult G's social isolation. The IMR states that the services to which the family was referred were local and accessible; as Independent Author I have disagreed with this analysis. English lessons were by home visit (provided by SAVTE), which is good practice. However, the children's resource was in a neighbouring community which she could not access, as she could not speak English, use public transport, or leave the home unaccompanied by her husband. In discussion, SCHFT points out that the health visitor may not have been aware of these restrictions on Adult GH's access to the community, and it is

true that, in hindsight, we know how much Adult G's freedom was restricted. I believe that with foresight, health visitors could have been aware that in some refugee communities, gender roles are closely defined and the freedom of women to move outside the home can be very limited. As this is likely to affect many refugee women, cultural awareness was seen as an area for development for health visitors, as discussed in the conclusions.

The IMR author notes that both health visitors were aware of the financial situation the family was in and the support that was available. The record observed a warm and loving relationship between Adult G and all her children and health visitors were confident in her ability to parent her children.

The last contact with Adult G was during a routine review of the baby, in May 2013, ten months before the death of Adult G. There was no indication of domestic abuse. However there is no documentation to indicate that there was routine domestic abuse inquiry during this contact. Routine domestic abuse inquiry is required practice as outlined in the Sheffield Health Visiting Service Plan 2012-2015. The IMR author investigated this and reports that the question about domestic abuse was not asked as the health visitor considered it was not appropriate to do so. The second health visitor stated that each time she visited Adult G at home there were family members or friends present. In situations where it is not appropriate to enquire about domestic abuse it would be best practice for the practitioner to document clearly in records why it was not possible to do so, including a plan of how this could be addressed. The practitioner should consider alternative options and create an opportunity for domestic abuse enquiry to take place. This was not done in this case, and in further discussion within the Panel, SCHFT states that it was not possible; that it was clear the health visitor was unable to create that opportunity and it would have been inappropriate to have assessed domestic violence in the presence of others. There is evidence that SCHFT has learned lessons from this case, and has since developed a framework of accountability in similar cases: health visitors are now required to discuss cases where they feel unable to address domestic abuse, with their supervisor, and develop a plan to ensure the inquiry is completed. This framework offers an example that can be used by other agencies working in challenging home environments.

There was evidence of good communication with the support worker involved from the Refugee Team and health visitors were aware of the on-going support provided by this service to the family and understood that the service would continue to be involved for a period of two years.

The records from the first health visitor were not available to the second health visitor because the family moved address around the time of the birth of Child GD2 and the first health visitor was unaware. The IMR states this was unfortunate but that it could not have been avoided. This has raised a concern which is noted in the conclusions.

The School Nursing Service had minimal contact with the family outside of health screening regarding Child GS1. This is not unusual as School Nurses do not routinely have contact with parents/carers, unless there are identified health concerns. Thus, School Nurses are required to work closely with CPLOs in Schools and as required liaise with GPs and HVs. Following consent from parents both Child GS1 and Child GD1 were seen by the School Nursing Service for routine health screening. The school nurse made referrals for further assessment for Child GS1 and the parents failed to take up these appointments. In a separate event, in January 2013, the school nurse became involved at the request of MAST to set up a meeting regarding concerns about GD1, and had a brief telephone conversation with Adult GH about this.

The IMR author found evidence in school nursing records that policies relating to children's health screening were followed appropriately. There was a failure to attend follow-up appointments for routine screening which would not in itself have raised an alert. In a separate event, the school nurse responded to a request from school to attend a meeting regarding concerns about Child GD1. The school nurse and CPLO had a meeting which parents were invited to but did not attend. Had parents attended this meeting, it would have provided an opportunity to gather information and assess whether further support was required, including completing a FCAF and/ or referral as appropriate. The outcome of the meeting was for school staff to monitor the situation and request support from the school nursing service if required. Adult G was never seen by the Service and there was nothing in the contact with children or Adult GH which would have triggered an inquiry into domestic abuse.

The School Nurse was not aware at the time that the parents did not speak English. Adult GH seemed to have understood the conversation and that the parents needed to meet with the school nurse later that day, hence an Arabic interpreter or Language Line was not required.

The role of the school nurse was discussed in the DHR Panel and there appeared to be a lack of clarity about whether, in terms of local multi-agency procedures, the school nurse or the CPLO was the lead professional in the TAC process. It is clear from the record and the investigations and interviews of the IMR author that this was not clear to the school nurse. As such, it highlights a gap in the implementation of local procedures that needs to be picked up and resolved during the implementation and staff training for the new TAF (referenced in the MAST section of this Report).

In Sheffield the school nurses work in small teams managing a corporate caseload. The school nursing team covering the school that Child GD1 and Child GS1 attended also covers a number of other primary schools and secondary schools in North Sheffield. The team primarily completes immunisation and screening programmes, manages some medical conditions and is included in the multi-agency

teams working with child protection and safeguarding issues regarding children who have health needs and their support and expertise is required.

Conclusions:
The IMR identifies good practice in relation to the client focus, in that health visitors demonstrated a holistic approach, with recognition of the hardships faced by the family and an understanding of the services available to support them. However, the Independent Author has raised a concern about accessibility of community resources for women in Adult G's situation and this has been noted as an area for the development in that all staff working with asylum seeker and refugee families should make inquiries to ensure services can be accessed.

The lack of transfer of records between the first and second health visitors appears to have been because they were hand-held records and the first health visitor was not aware the family had moved. I am told this is not an unusual situation: families may move and health visitors be unaware of their whereabouts unless and until there is another event triggering health visitor involvement. In this case, it was the birth of GD2 that led to further involvement. This is a historical concern in safeguarding vulnerable people and/ or chaotic families, not only asylum seekers and refugees, which should be at the heart of multi-agency procedures and entirely manageable by statutory agencies. In the case of the SCHFT, it is one organisation working across all localities and it would be reasonable to expect that there should be one system accessible in all locations. The SCHFT reports that with the recent implementation of 'SystmOne' electronic health records there is better access and better transfer of electronic health records and this issue should not arise again.

There is no evidence to suggest that this gap led to missed opportunities in this case; contact with the family was not ongoing during the months leading up to the homicide. Intra-agency communication (i.e. passing information within the agency) emerges as a theme in this Review, not only in relation to SCHFT. In cross-referencing and analysing the chronology across the whole Review, we identified that this family was able to disengage with most services. Whether this was because they were living chaotically and/ or did not have the knowledge of local services to understand how to transfer; or because Adult GH was systematically isolating his family, specifically his wife, from contact with external agencies as part of a pattern of abuse, is not known, and I have considered this point further, with hindsight, later in this Report.

The lack of routine inquiry regarding domestic abuse in this case is a concern. The IMR describes a professional view that it may not be appropriate to ask about domestic abuse where other members of the family or friends are present. I agree it is complex and challenging for professionals to work with families who speak limited English and may be accompanied by family members to appointments; however it needs to be urgently addressed. Elsewhere this Report documents the need to

ensure that female interpreters are used; and to develop a clear 'script', with questions that an asylum seeker or refugee, who has a different cultural concept of domestic abuse, might understand and be able to answer. It cannot be said with any confidence whether a routine domestic abuse inquiry might have created an opportunity to make Adult G safer.

The IMR identifies that the lessons to be learned for SCHFT from undertaking this Review are the importance of routine inquiry and the need for further attempts to be made for the inquiry to be completed where it is complex or challenging situation. The IMR also identifies that embedding cultural competence in health systems continues to be a challenge, and that in this case little was known or understood about the culture of the family by either health visitors or school nurses. I support this conclusion, which is a cross-cutting theme referred to in the conclusions.

The IMR evidenced close working by the School Nursing Service with the Child Protection Liaison Officer which was considered by SCHFT to be the school nurse's primary responsibility in the multi-agency procedures. There did appear to be a lack of clarity around the meeting of 6.2.13 being a Team Around the Child meeting (TAC) as set out in local procedures, the perception of the school about the role of the school nurse in multi-agency procedures; and whether the non-engagement of the parents with the process should have triggered a referral by the school nurse to MAST. The IMR author evidenced that the School Nurse communicated with the School, liaised with the CPLO at the school, and attended a meeting at the school. The outcome of the meeting was that staff at school would monitor the situation and contact the School Nurse if the School Nursing Service was required. The School Nurse made contact with the school a few weeks after the meeting to enquire about the situation and to ascertain whether the School Nurse was required and was informed that the Service was not required. The outcome of the meeting was for school to contact the school nursing service if this was needed. However, it was not clear whether the situation had improved in relation to Child GD1 and whether the improvement had been sustained.

The lack of clarity about responsibilities in multi-agency safeguarding procedures needs to be picked up during the implementation of the new Family Common Assessment Framework. There was no suggestion that this lack of clarity affected any of the outcomes of the case.

Sheffield City Council - Children, Young People and Families

2.4.4 Early Prevention and Intervention (Multi-Agency Support Team, MAST)

Organisation:
The Early Prevention and Intervention Service within Children, Young People and Families (CYPF) includes three Multi Agency Support Teams (known as MAST). These three teams provide services to children and families across the City. MAST is now co-located with the social care teams for the three areas enabling more effective joined up and responsive working.

Referrals can be received from any agency via a 'Request for Support' (RFS) form, a 'Family Common Assessment Framework' (FCAF, which was previously, and at the time of the events of this Review, the 'Common Assessment Framework' or CAF); or, in the case of Social Care, via an Initial Assessment; or a direct request in writing from a GP. Once a referral is received, it will be screened, further information requested if necessary and then an assessment made as to the most appropriate level of support. Many referrals into MAST for support can be directly allocated whereas more complex cases will be presented at the weekly Multi Agency Allocation meeting (MAAM) as a fuller assessment is required. Alternatively, cases will be presented at the Prevention and Assessment Daily Meeting where an assessment visit may be arranged and carried out with colleagues from other agencies. A decision will then be made as to which service can provide the best level of support based on the identified need. The MAAM is attended by partner organisations involved with the individual families and at present, the Daily Meeting is attended by colleagues in MAST, Social Care and Health Visiting.

Cases are allocated to MAST workers or to contracted organisations which are commissioned to deliver services on MAST's behalf. MAST works closely with Early Years settings, Schools, GPs, Health Visitors, Midwives, Social Care, Community Youth Teams, voluntary, community and faith partner agencies and the Police, and is able to refer to commissioned services for support, or to specialist services. In addition, cases may be signposted to other more appropriate organisations.

Summary of involvement of MAST with the family from 19th October 2010 to 4th March 2014:
In February 2012 a CAF was submitted to West MAST from the Community Midwifery Team for support for Adult G with accessing benefits and housing issues. The case was allocated to an Interventions Worker in West MAST.

The worker from West MAST liaised with the Asylum Support Worker from the Metropolitan Support Trust who was working with the family at that time, and found that the family was in the process of being re-housed, and so the worker suggested that a joint visit with the new worker in the East MAST would be appropriate. The

case notes identify that the Metropolitan Support Worker would be working with the family for the next 12 months.

The CAF was updated by the community midwife and re-submitted. An additional CAF for Child GS 2 requesting a 'Two Year Free Early Learning' (nursery) place was submitted to East MAST from the health Visitor. Both CAFs went through the East MAST screening process. The case was allocated to the Family Development Project (FDP), a contracted service, to deliver the support required.

Records show that the nursery place was agreed and a place secured at the Community Nursery closest to the family's current address. The East MAST processed this. The FDP was allocated this case at the end of May 2012, but was unable to make contact with the family. The worker made contact with the Health Visiting service for the area covering their current address, and was informed that the family was not on their records. She then contacted the Community Midwifery Team and was informed that the family had moved to the North of the City; however this did not happen until the end of June 2012.

The case notes from FDP indicate that the case was going to be taken back to the East MAAM but there is no record of this happening either in the notes from the FDP or the MAAM minutes. The case was therefore not transferred to the North MAST at this time.

On 19th June a RFS was received by North MAST from School 1 in relation to Child GS1's poor attendance (47%); parents not meeting the needs of the children; and requesting help accessing benefits. This was allocated to a MAST Worker in the North MAST. The Worker contacted Adult GH, the Admissions Service and School 1 with the support of an interpreter in relation to the attendance issues of Child GS1. This intervention brought about improvements to Child GS1's attendance, and the worker further managed to secure a place in a local school in September 2012. However no support was offered in relation to the additional needs of the family and there was no contact with members of the family other than Adult GH. The case was then closed in September 2012.

A further RFS was received from School 2 by North MAST in January 2013 relating to issues of suspected neglect for Child GD1 [*redacted]*. This referral was screened by North MAST and a decision made to refer to the School Nursing Service (SNS).

Analysis of MAST involvement:

Analysis of involvement with individuals:

The family moved from the West to the East of the City following the first referral and the case was transferred to the East MAST. The record indicates that the worker in West established that the refugee support worker was very involved with the family on issues that were included in the referral to MAST, and therefore recommended a

joint visit between the new MAST project worker and the refugee support worker. There is no indication that this took place in MAST East. There are no records to support the transfer.

The CAF was re-submitted by the community midwife, and an additional CAF was completed by the Health Visitor with a request for a nursery place. The case was heard at the East MAAM and was allocated to the Family Development Project (FDP), a commissioned service, and a 2 year free nursery place was secured; however, the FDP was unable to make contact with the family and later found that the family had moved. The family was therefore unaware of the allocation of the nursery place. The case was then closed to the FDP.

The family had moved to North of the City. The case was taken by East MAST to MAAM for transfer; however there is no paperwork to support this and no transfer was received by North MAST at that time.

The first contact with the family came as a result of the referral by School for GS1's poor attendance. This contact was only with Adult GH. There was no contact with Adult G or the children during this intervention. Whilst the referral included a request for support for family needs, the worker focussed exclusively on Child GS1's school attendance and worked only with Adult GH. The worker established that the problem was the distance of the school from the family home and a transfer to a closer school would resolve the problem. The IMR states the worker intervened effectively by agreeing a part time timetable for Child GS1 until he could attend a more local school; liaised closely with the LA Schools Admissions Service and the transfer was put in place during September 2012. The problem was therefore resolved and the case closed.

This Worker used an interpreter to communicate with Adult GH. The IMR states that the worker helped Adult GH to access English courses that fitted in with school times, though there is a query about this as it was also reported that the DfEE had required Adult GH to attend English classes. However, it is recorded that the worker was involved in changing the times of the classes to fit in with Adult GH's need to collect children from school.

The IMR author reports that there had been a redesign of the service provided by the Multi-Agency Support Teams in 2010, to include other family support services and roles, to form Prevention and Early Intervention Services of which MAST is now a part. This worker, having an education welfare background, appears to have received little recorded supervisory oversight of his decisions about this intervention. As such, he focussed on the area for which he was trained and instructed, which was attendance, and received no direction from his organisation at that time to address the other issues in the referral.

A new referral was received by MAST in January 2013 from School 2 regarding possible neglect of Child GD1. MAST passed this to the school nurse who dealt with the matter as detailed in the next section.

Organisational analysis:

The original two CAFs (from the community midwife) received into MAST requesting support for Adult G and her family were detailed and comprehensive and gave a clear description of the issues the family was facing, their wishes, and the support that was required.

The case was appropriately transferred to the East MAST with the knowledge that the family had moved area; however, the case should not have had to go through the screening process a second time and should have been transferred immediately to a worker in the East MAST, whether this was a MAST worker or a worker in a contracted organisation. There seems to have been no hand over of the case from the West MAST.

When the case was allocated to the worker in the Family Development Project, she could not make contact with Adult G, and this situation continued for three weeks before she began to question the family's whereabouts. The IMR author established that it is not service policy within FDP to do unannounced visits as this could jeopardise the relationship with the family, but this would have highlighted that the family no longer lived at the property and alerted FDP to the need to find out where they had moved and to transfer the case.

In cross-referencing the chronology, it was clear that both the Community Midwifery Service and the Health Visiting Service were aware of the family's move to the North of the City; however this information was not communicated to the FDP, again missing an opportunity for support to be put in place at an earlier stage.

It is recorded in the notes of the FDP worker that the case was going to be presented at the forthcoming East MAAM following the family's move to the North of the City. Although the manager of the FDP can recall doing this, there is no record of this in the minutes of the two MAAM meetings at that specific time, and the case was not transferred to the North MAST at that time. It is also concerning that the chronology indicates that the health visitor followed up the request for the nursery place on two occasions with East MAST when staff did not seem to be aware that the place had been approved, and was assured that the case would be transferred to the North MAST. There is no evidence of this taking place.

In addition to this, when Child GS2 did not take up the nursery place at the Community Nursery, no attempt was made to find out where he was by the nursery and why he had not attended. Contact was not made with the MAST central team

who manage and monitor the free places to inform them of the non-take up of the place. It is the responsibility of the Central Team to collate attendance data on the take up of places for the DfEE.

These two incidents resulted in the family not accessing the support that had been requested in a timely way and was not in line with organisational expectations highlighting a missed opportunity to intervene at an early stage.

It was not until School 1 sent in a Request for Support to the North MAST that the family was allocated a worker, a full month later. When the case was received into the North MAST and screened, details of the case were recorded. At that time, only the details of the child referred would have been checked, therefore no other referrals or involvement in relation to other family members would have been highlighted e.g. the previous referral to East MAST for support for Adult G and as the case was not transferred from the East no connection was made.

The MAST worker undertook some comprehensive work around the poor attendance of Child GS1. The IMR author believes the worker was effective in engaging Adult GH and agreeing arrangements with the school in relation to Child GS1's attendance which produced significant improvements. The worker ensured there was an interpreter to enable Adult GH to fully understand the content of their conversations, and he facilitated a transfer with the School Admissions Service for Child GS1 to a more local school. All contacts and meetings are clearly recorded in the notes on the ONE system which is where MAST workers record their interventions.

The worker focused exclusively on improving Child GS1's attendance. Issues affecting the wider family were not addressed. The Request for Support clearly identified the additional needs relating to access to benefits and the possibility that the family was not meeting the basic needs of their four children, which included a very young baby. However, due to the checklist being limited in its information and the absence of the previous documentation (CAF) from East MAST, these complex needs were not identified. In discussion with the Review Team, MAST senior managers recognised that there was worker error in failing to engage with these issues and with the wider family, including Adult G.

Adult G and her children were therefore never seen by MAST. When school finished for the summer break in July 2012, there was no support to the family until the start of the school year in September 2012 by MAST. No help was offered regarding the benefits and the welfare needs of the children were not assessed. This level of support does not meet service expectations in terms of addressing the needs of the whole family.

In addition to this, although there is reference to staff supervision in the case notes, there are no supervision records on file. The manager was unable to explain the

absence of supervision record. It may have been assumed that this worker, as a thorough and experienced worker, would have managed the issues with minimal supervision.

Conclusions:
There were two episodes during which opportunities for assessment and intervention by MAST and its contracted services were missed: in February – June 2012 when there was no contact with the family by MAST in the West and then the Family Development Project in the East, due to their moves of home, and the case was then not correctly transferred when the family made a further home move to North; and in July – September 2012 when the service focussed on resolving one child's school attendance and not on the family needs that were identified in the referral. A further referral in January 2013, regarding school concerns about Child GD1, was referred appropriately to the School Nursing Service, as detailed in the relevant sections of this Report. The contact that did take place between this service and the family was with Adult GH and Adult G was never seen.

The IMR author notes that at the time of these referrals, the FCAF (Family Common Assessment Framework, a whole family assessment) was under development and had not been introduced; therefore the 'whole family' approach had not been fully embedded within MAST. These two developments – whole family focus and FCAF – are supported by target-setting and outcome driven action plans for the whole family, and this is now an established way of working for all MAST workers.

The FCAF is a universal assessment methodology which is an enhanced version of the CAF – which focussed on individual needs – and forms a more holistic assessment of the needs of the family. At the time of this Review, implementation of FCAF was underway with 1125 workers having been trained in the use and completion of the FCAF and the training having been delivered to all organisations working with children and families. Following implementation, all universal agencies will need to undertake this Family Assessment in order to process any referral. As such, senior management in CYPF has made an informed judgment that in cases such as the one under Review, there is confidence that the gaps in service identified in this case would not now arise. However, CYPF is concerned that other agencies may not have ownership of the new FCAF, and this could become an issue. Discussion in the Panel suggests that there is no evidence at this time, that there is any agency not committed to the FCAF process, and it is therefore a matter for monitoring.

The IMR author detailed other developments within the MAST Prevention and Intervention Service since this case was worked in 2012 – 13, leading to significant changes to working practices and the systems and procedures. Significant changes to working practices and the systems and procedures to support these have been developed and implemented. Examples which have been evidenced during the DHR

process, by the IMR author, are: all referrals to MAST are now entered onto 'Sharepoint', a database which logs and tracks cases; screening is undertaken by Level 2 Qualified Social Workers experienced in undertaking assessments and identifying risk. This process now includes checking details of all individuals within the family and not just the person who is the subject of the referral which was the case in 2012. In this way, the needs of the whole family are identified and in addition any previous involvement for any member of the household with other services. When the Request for Support (RFS) was received from School 1 for Child GS1 and the further RFS from School 2 for Child GD1, the current system would have picked up that this family had been referred into MAST on a previous occasion and so a more intensive package of support would now be put in place.

After screening and a decision to support, referrals are now transferred via the SharePoint system to the Duty Team Manager who checks the referral and approves the decision. This is a further opportunity for good decision making in relation to support needs.

Whole Family Action Plans are now in place in MAST. These are completed by workers and are a computerised record of all actions required and which are agreed by the family. These are used as a working document to record outcomes and are reviewed at each visit. Opportunities are therefore in place to re-assess the situation at each intervention with the family and identify any changing needs.

'Team Around the Family' meetings have now replaced the 'Team Around the Child' meetings, with the intention of ensuring that the family is seen as a whole unit and not as separate individuals within it.

A new Supervision Policy is in place with supervision returns being completed by managers monthly. Case supervisions with all workers are undertaken on a 4/6 week basis by Team Managers. In addition, there is now a dedicated Domestic Abuse Specialist in MAST who can offer advice and guidance to workers where this is felt to be appropriate and agreed at supervision. Any issues relating to cases can be discussed with the manager and decisions as to appropriate action can be made.

Case File Audits are carried out at three monthly intervals auditing the quality of the information held by the MAST workers. These audits include checking the quality of the case file supervision and the advice given by managers relating to individual cases and to ensure appropriate advice is being offered and decisions made. MAST has a dedicated officer who attends the MARAC who coordinates information and actions in respect of cases known to MAST and those that might need MAST involvement.

Improved training is in place: a new training plan has been developed for managers and workers in relation to Domestic Abuse, the MARAC and the findings from recent

DHRs in Sheffield; DASH training has been rolled out to workers and managers are trained to ensure their workers are competent in the use of the DASH assessment.

The Prevention and Intervention Service undertook a Service re-design of MAST in late 2010. Many of the workers transferred from the former Education Welfare Service where the focus of the work was purely attendance. The IMR author notes that this impacted on the service offered in this case. Now, all workers are recruited to work with the whole family and to look at all the presenting issues. In the case of Adult G, this approach would have ensured that all the needs as identified in the RFS were addressed.

A new Case Closure and Case Transfer process is now embedded within the MAST structures and systems, ensuring that cases are transferred to appropriate workers within given timescales and that cases are not allowed to 'slip through the net'. There will be a record of these held on the system.

The allocation of the free nursery places has now changed in that parents and carers can access places themselves rather than having to be referred. However in some circumstances a nursery place will form part of a package of support following assessment as detailed above. Any non-take up of a place would be followed up by the nursery itself, the MAST worker or the original referrer and the reasons for non-attendance discussed.

A citywide Attendance Strategy has been developed which includes processes relating to non-attendance at Early Years settings.

In addition to these improvements which are in place or in implementation, there is currently a re-design of the Early Years locally based services which will address the importance of key links and protocols with Early Years childcare providers and will ensure good safeguarding practice is established across all provision.

The Review Team queried why there was no contact with Adult G, who may have had a view, or taken responsibility for the attendance problem, including picking up the children from school. In the light of later conversations with the Focus Group and with Adult G's sister, we reflected how the fact this worker was male may have impacted on this intervention. I have discussed these points at length with the IMR author and we concluded that the focus of the worker was the main driver for the intervention; that in other cases being worked on at this point in time, the worker would have been solely concerned with the attendance of one child, and would have worked with one parent without considering the role of the other parent. In this regard we found no evidence of gender or race bias in this intervention.

The evidence indicates that service standards fell short of what is acceptable in a number of ways. Opportunities were missed for assessing and meeting the needs of

the whole family. Appropriate services or timely interventions were not offered. Professional supervision appeared to be lacking so that practitioner's direction and decision making were not supported. This is not to say that the lack of service made the victim less safe, or that the outcome could have been averted; there is evidence elsewhere to indicate that the complex and challenging situation in which Adult G found herself would have made it very difficult for her to disclose or seek help in any event. The IMR author points out that although it cannot be assumed that if the worker had visited the home the domestic abuse would have been disclosed or observed, equally, had a trusting relationship been developed with Adult G, this may have been possible. Given these clear organisational failings, it cannot be said with confidence that the outcome could not have been otherwise.

The Review Team and CYPF senior managers have discussed these findings at length. Clearly there are lessons to be learned. Whilst many improvements have been made in the MAST service particularly and in the wider children's services, which are expected to create better, safer services, this needs to be monitored. CYPF has plans in place to review the effectiveness of the new arrangements. During the deferment period, when this Review was on hold pending the outcome of the trial, MAST undertook a review of the current service, systems and processes, against this case, and feels able to reassure the SSCP that the errors in this case would not recur.

2.4.5 Sheffield City Council – Education Services

Two primary schools were engaged with the family during the time period: School 1 was attended by the eldest son (GS1) and was close to the family home in East Sheffield; School 2 was attended by the eldest daughter (GD1) who started school in September 2012 after the family's move to North Sheffield; GS1 transferred to School 2 to be closer to the family's new home.

Summary of the involvement of School 1 and School 2 with Adult G and Adult GH from 19th October 2010 to 4th March 2014:

School 1 referred the eldest son (GS1) to MAST on 19.6.12 when due to poor attendance (47%); the Request for Support (RFS) included a request to help the family to access to benefits, help with finances, and to assist with travel to and from school. Following contact between the MAST worker and Adult GH, as described in the section above, and the Admissions Service and School 1, with the support of an interpreter, attendance improved. The problem was assessed as the distance between school and home now the family had moved to another area, and the worker and Admissions Service agreed a place in School 2, which was close to the family home, in September 2012. The MAST worker did not offer support in relation to the additional needs of the family and there was no contact with members of the

family other than Adult GH. The case was then closed in September 2012 when the transfer was completed.

School 2 submitted a RFS to North MAST on 23.1.13 relating to issues of suspected neglect for the eldest daughter (GD1) [*redacted]*. The MAST worker screened the referral and spoke to the school nurse, and made a decision to refer the matter to the School Nursing Service (SNS).

Subsequently, as reported in the SCHFT section above, the school nurse arranged a meeting in school on 6.2.13 but the parents did not attend. It was recorded that the school nurse made contact with the parents and arranged to meet later that day – their English was very poor and again the parents did not attend, so the meeting did not take place. GD1 was collected by her uncle (Adult GH's brother) on that day and the school nurse gave him a consent form to take home to the parents. In May 2013 the school nurse contacted School 2 for an update and was informed by the school that the school nursing service was no longer required.

School 2 reports that the attendance of both GS1 and GD1 was poor – approximately 75%. Attempts were made by the school staff to speak to Adult GH when he collected the children from school, about this, but the language barrier was an issue.

The school has a Designated Safeguarding Officer and a Deputy, who had responsibility for contact with the family. It is recorded that this member of staff spoke to Adult G on the phone about the children's attendance but found her understanding of English appeared to be less than that of her husband. The member of staff recollects both children as being needy: GS1 being attention-seeking and GD1 quiet and withdrawn. The attainment of both children is described as low.

The Deputy Safeguarding Officer states that she finally spoke to the brother of GH about the concerns regarding GD1 and asked that he raise this with GH; after this, GD1's presentation improved and no follow up meeting was arranged. The school nursing service undertook a follow up conversation with the school in May 2013 and was informed that there were no further concerns.

School 2 reported to the IMR author that around the same time as this referral for GD1 to MAST, there was an incident in which Child GD1 was left at school by Adult GH. The member of staff believed this was a deliberate act on behalf of Adult GH and Child GD1 was very upset. She was finally taken home by her uncle. Social Care was contacted in relation to this by the Deputy Safeguarding Officer and was advised to call a TAC meeting. This was included in the discussion noted above.

The Review heard conflicting reports of this incident: first, that it was not Adult GH, but his brother, collecting his own children and when he was asked to take Child GD1 he refused because Adult GH was due to arrive and collect the child, which he duly did. Neither man speaks good English, they have a strong family resemblance, and took turns to take the children to and from school. As such, it is not surprising that school staff might not know them apart. This incident, along with the report that a school member of staff discussed personal, confidential issues about Child GD1 with Adult GH's brother, and tried to hold a telephone conversation with Adult G who did not speak English, raises an important concern about the communication barriers that were clearly evident between School 2 and the family.

The Deputy Safeguarding Officer visited the family home on two occasions: prior to Child GD1 starting school, on which occasion she recalls bring allowed into the front room but only Adult GH was present. Another home visit was made just prior to the homicide as the children had been sent to school with no dinner money or food for lunch. The School reports that this had been occurring often and attempts to address this at school had failed. Adult GH stood on the doorstep with the door closed whilst the deputy safeguarding officer explained why she was there. Adult GH gave her some money for the children's lunch.

There was no contact with Adult G at any time. This was not considered unusual because of what the school knew of the family culture. Neither parent attended parents' evening on any occasion. When Adult GH collected the children, he spoke only to other Arabic speaking parents.

Analysis of involvement:

The school appears to have provided the children with a stable, settled environment through a difficult period, and continues to do so.

There were concerns around the children's attendance at both schools. This was resolved in School 1 by achieving a transfer of GS1 to School 2 and his attendance improved but continued to be unacceptable. This was addressed in part by speaking to GH and attempting to speak to Adult G. The language was a significant barrier and maybe some consideration should have been given to engaging the services of an interpreter when the situation didn't improve to ensure that the message was received.

There does not seem to have been any handover of records from School 1 to School 2 in relation to Child GS1. Reference to these records would have highlighted that there had been a previous referral to MAST that had included welfare and attendance concerns and there might have then been an earlier referral to MAST when other significant issues within the home could have been identified.

School 2 sent an appropriate referral to MAST and this was passed appropriately to the school nursing service for advice regarding Child GD1. A meeting was arranged and the parents invited. However because the parents did not attend the meeting did not take place. This would have been a good opportunity to discuss and agree a way forward. No further meeting was arranged. A follow up call to School 2 in May 2013 by the school nursing service indicated that there was no further need for support from their service and the case was closed. This again highlights the difficulty in communicating with the parents, and the use of an interpreter could have assisted.

When the dinner money was not being paid and the children had no lunch, the deputy safeguarding officer made an unannounced visit to the family home to try to address this issue. However, there was no follow up on this matter, although it had been an ongoing issue, in terms of possible neglect.

The School reports a number of developments since the incident which are in place and which would ensure a better response in the future. Clinical supervision was is now in place for relevant staff. There is better recognition within the school of the complexities of safeguarding and that all aspects need to be thoroughly understood and that training in this is required. Consent forms have been changed to include information about parental responsibility and details of as many family contacts as possible. The incident has raised the profile of domestic abuse amongst parents at the school and the School reports that more are now seeking advice and requesting help.

Conclusions:

This part of the Review has highlighted a number of communication issues; first, intra-agency communications in that School 1 did not provide information about GS1 to School 2 upon his transfer and there needs to be assurance that this has been resolved. Secondly, the communication barrier between the School and the parents, which is evidenced by the School's inability to discuss concerns about the children with Adult G; the misunderstanding about who was collecting Child GD1 during the incident described in the IMR; and giving personal confidential information about Child GD1 to her uncle (although in interview it was clear that the uncle did not understand the information that he was given).

There were a number of examples in this Review of Adult GH not allowing agencies access to Adult G. In the previous section I considered that this could have been because the MAST worker was male. This is not the case with School 2, where the member of staff was female. The IMR describes two such examples: at the home visit before Child GD1 started attending School 2, only Adult GH was seen; when the member of staff visited the home to resolve the dinner money problem, again only Adult GH was seen and this time the staff member was not admitted to the house. I would think that whilst the school might understand there could be cultural reasons why a mother in Adult G's circumstances might not attend school (and this would be

accurate as it has been verified to us by the family), it would be culturally acceptable on a home visit for a female worker to meet the mother. Given that there was a history of concern about attendance of both children, and neglect of one child, and this visit was about not providing money for food, the lack of contact with mother should have triggered a concern, and been referred on. With the benefit of hindsight we know that Adult GH had withdrawn Adult G's contact with the outside world, and a referral to MAST at this point could have helped. With foresight, the School could not have known this; however, I would expect the School to reflect on this practice and learn from it. Specifically, the School should be able to identify when contact with one parent may be being 'blocked' by the other, and consider that this may be part of a wider picture of neglect and abuse. I will ask MAST to pick up this point in the review of policies and procedures.

2.4.6 Children's Social Care:

Organisation:
Children's Social Care is responsible for the delivery of social work services for children in need, including those at risk of harm or offending, in need of accommodation and children with learning and physical disabilities.

Summary of involvement of Children's Social Care with Adult G and Adult GH from 19th October 2010 to 4th March 2014:

The first contact relating to the family was on 4.5.12 when the community midwife in the homeless team called the Out of Hours Service. No concerns were expressed by the midwife other than to advise that the family had recently moved from homeless accommodation; they had no money as benefits had yet to be determined; Adult G was 36 weeks pregnant with Child GD2 and the family was from Kuwait having sought asylum in the UK. The Out of Hours social worker gave the midwife the DSS emergency telephone number to request a crisis loan on behalf of the family as they spoke little or no English. On the 5.5.12 the Out of Hours social worker contacted the DSS and was informed that an emergency payment had been made to the family to enable them to purchase food and top up gas and electricity. The contact record was re-assigned to the area team for further checks. Between 8.5.12 and 11.5.12 attempts were made by the Screening social worker to contact by telephone the community midwife and the family however on all occasions there was no response. An assumption was made that the family's financial situation had improved and the contact record indicated that letters were sent to the midwife and the family that should further support be required a referral to MAAM panel would seem appropriate. The IMR author was not able to locate copies of the letters.

There was no contact with Children's Social Care for a further eight months until 23.1.13 when a contact was made from School 2 where Child GS1, Child GD1 and Child GS2 attended. The concerns raised by school and recorded in the contact record were in relation to poor school attendance; Child GD1's presentation, [*redacted]*. This was in stark contrast to Child GS1 and Child GS2 whose presentation was appropriate. Staff at school had never met Adult G despite home visits being undertaken. Adult GH and on occasions an uncle collected the children from school. The social worker advised the School to make further attempts to address the concerns with the parents with an interpreter and to arrange a Team around the Child (TAC) meeting which Social Care would attend. The contact was closed pending further details in respect of the TAC meeting. From the chronology it appears that the meeting held by the school nurse on 6.2.13 was the; parents did not attend and there was no record that social care was invited.

Analysis of involvement:

Children's Social Care had no direct contact with any members of the family prior to the homicide. The two contacts were by other professionals and on both occasions advice was given with no direct contact taking place with the adults or children pertinent to this DHR. On both occasions the response, actions taken and advice given were proportionate to the nature of the issues raised. The concerns being expressed were as in the first occasion resolved by providing the family with crisis intervention through financial support through signposting to a DSS crisis loan. On the second occasion advice was given to School on addressing the concerns with the family and arranging a TAC meeting. Neither contact met the threshold for further intervention from Children's Social Care.

The IMR author notes that practitioners employed within the Out of Hours service and in Area Screening Teams are experienced Level 2 social workers. In particular the social workers who dealt with the two contacts are trained in identifying potential indicators of domestic violence and are aware of their responsibility in taking appropriate action in accordance with the policies and processes in place. There is no concern about the practice of any of the social workers involved.

The contact record indicates letters were sent to the midwife following up the first contact. These letters are not on record and therefore cannot be said to have been sent. Whilst this gap needs addressing organisationally, letters would not have affected an outcome as, cross-referencing with the chronology, it is clear that the midwife had already completed a CAF to MAST on 16.2.12 and the family was allocated to an Intervention Worker on 20.2.12. In hindsight there could have been some follow up with, in particular, the notification of the TAC meeting.

The information presented did not require implementation of the policies and procedures relating to Domestic Violence or Asylum Seeking families. There was no evidence that Adult G was a victim of domestic violence and both Adult GH and Adult G had had their claim for asylum approved thus giving them access to financial support.

Conclusions:
The IMR identifies that this was not on the surface a complex case; that it is not untypical of families seeking asylum being faced with homelessness and financial insecurity. Appropriate advice and support was provided in dealing with the presenting issues and decision making reflected the level of need. Practitioners exercised their duty within the parameters of the organisation and the professional standards expected. Actions taken and decisions made were timely and appropriate based on the information available.

The IMR identifies some organisational issues such as ensuring that letters are processed and follow up takes place; and asking other agencies to notify Social Care of ‘Team around the Child’ (now ‘Team around the Family) meetings; Social Care may not attend but it ensures the record is complete and action may be triggered when necessary. These issues had no impact on this case and the Overview Report author suggests these administrative issues are fed back in order that practice can be improved.

Sheffield City Council Housing Services

2.4.7 Housing Services

Two SCC housing departments were engaged with the family during this period: Housing Solutions, and the Housing Service, as described below.

The Organisation:

- **The Housing Solutions Service** provides advice and assistance to households that are homeless or threatened with homelessness with a view to preventing homelessness in the first instance or relieve homelessness where possible. Also, to fulfil the Council's statutory duty on homelessness for vulnerable households. Where inquiries are needed to decide whether the Council have a statutory duty, interim accommodation is offered where the applicants can stay on a temporary basis until any duty the Council have is discharged.

- **Sheffield Council's Housing Service** provides secure social housing and temporary accommodation in Sheffield. The main functions of temporary accommodation are to provide supported temporary accommodation for service users referred by the SCC Housing Solutions Team, to enable them to sustain a tenancy and make a successful transition to a permanent home. There is a temporary accommodation team based within the temporary accommodation which works with Family Support Visitor, Health Visitor and Midwife based at a local GP practice, and holds regular meetings to discuss families resident in the accommodation.

SCC operates a First Point system, at a central point in the City where all initial contacts are made with the public, including Housing Solutions.

Summary of involvement of SCC Housing services with Adult G and Adult GH from 19th October 2010 to 4th March 2014:

On 1.2.11 Adult GH registered for rehousing as a newly granted refugee. At this point Adult GH was a lone male. A rehousing registration number was given. There was no further contact until 6.1.12.

On 6.1.12 Adult GH, Adult G and children GS1, GD1 and GS2 presented as homeless at First Point. Adult GH stated they had been evicted from their previous address at Address 1 through non-payment of rent on 12.12.11 and since then had been staying with his brother in Leeds, but could not stay with him any longer. On investigation it was decided that there had been a Housing Benefit delay, and that this had now been resolved. It was decided that the loss of accommodation at

Address 1 was due to that housing benefit issue and was not intentional and therefore the Council took a duty on 13.1.12 to offer further suitable accommodation.

The family was placed into a guest house at Address 2 and referred for temporary accommodation at Address 3. They moved into Address 3 on 17.1.12. A Housing Solutions Assistant arranged the move for the family and observed nothing unusual about the family. The interview with the Housing Solutions Officer was conducted with an Arabic Interpreter over the telephone through Language Line.

The family was given priority status on the housing register and was offered a property at Address 4 with the assistance of the HomeFinders Team in Sheffield Homes. The family took the tenancy at Address 4 and moved out of Address 3 on 19.3.12.

The case was closed to Housing Solutions and there was no further contact.

The Housing Service IMR records that the family arrived at Address 3, interim accommodation, on 17.1.12. An interpreter was present. Adult GH signed the tenancy agreement in the office. The Tenancy Support Officer went to the flat so that Adult G could also sign the tenancy agreement. The family already had a support worker from another support provider (Metropolitan Housing) when they signed for the temporary tenancy.

The family was in temporary accommodation at Address 3 for a short period (2 months), as they had already been awarded a rehousing priority. The chronology records that contact was regular during that period. Most contact was with Adult GH during their stay. Adult GH cancelled/ rearranged a total of 3 appointments with the Tenancy Support Worker on 18.1.12, 25.1.12 and 10.2.12. On 25.1.12 a friend of Adult GH called and advised that Adult GH would not be able to attend his appointment. No reason was provided. The Tenancy Support Officer saw Adult G on three occasions: on 17.1.12 when he went to the flat to ask Adult G to sign the tenancy agreement; on 20.1.12 when a Family Support Worker came on site with items for the family: food, toiletries and toys, and the Tenancy Support Worker accompanied the FSW up to the flat and Adult G opened the door; and on 8.2.12 when a further food parcel was delivered for the family.

There were no reports of anti-social behaviour, noise nuisance, or indications that any type of abuse was taking place.

An interpreter or Language Line was used in all meetings and interviews with Adult GH. There is no record of whether there was interpretation when Adult G was asked to sign the tenancy agreement on 17.2.12; however the IMR author has investigated and confirmed that the officer was accompanied by Adult GH.

On 20.1.12 the Tenancy Support Officer received a message to call the Midwife concerning Adult G; the Officer called back on the 23.1.12 and was unable to speak to the Midwife as she was with another client and agreed to call back the next day. The call back did not happen so the reason for the call is not recorded.

In line with procedures an Assessment of Support Needs was completed on the 25.1.12 and a follow up review was completed on 6.2.12. It was noted that support was being provided by a health visitor and midwife as Adult G was pregnant. The notebook also indicates 'no issues with children'. Further support was in place from an external support provider. Adult GH had applied for welfare benefits and was in receipt of Job Seekers Allowance; however the family was struggling with money and were borrowing.

On 1.2.12 a new Tenancy Visit was carried out by the Customer Services Assistant. The only issue raised was that of benefit problems as no Child Benefit or Child Tax Credit had been received. It was at this visit that the Assistant noted that an elderly lady was in the property, and was advised that it was the mother of Adult GH.

There was a problem with obtaining some welfare benefits for the family and it is recorded that the Support Worker from the external support agency referred Adult GH to a law firm in Sheffield on the 16.2.12 to intervene re his benefits applications. This is believed to refer to Metropolitan, and the Northern Refugee Centre, as set out later in this Report.

On 16.2.12 Adult GH was seen with his Support Worker and it was agreed that Adult GH would come into the office each week to see the Tenancy Support Officer and place bids for 3 bed houses in nominated localities. On 7.3.12 the family was offered a property in East Sheffield at Address 5. That property is managed by Arches Housing Association. The Tenancy Support Officer assisted Adult GH to complete an application form for the Housing Association, and the Support Worker arranged a viewing of the property for 12.3.12. Adult GH and Adult G accepted the property and moved into the property on 19.3.12.

There was no further contact with the family.

Analysis of SCC Housing Solutions and Housing Service involvement:

Analysis of involvement with individuals:

Housing Solutions had a brief engagement with the family based on their homelessness; the assessment was a Statutory Homeless Assessment and the decision to rehouse appears to have been made appropriately. The family was interviewed by an officer experienced in dealing with homeless families; no other needs were noted. Domestic abuse did not feature in the interview or the notes and the IMR author states this is not a question that would be routinely raised with a

family presenting from a landlord eviction. All decisions were made and actions taken within timescales as set out in policy and procedures.

Following discussions with the Review Team, the homelessness decision was reviewed by the IMR author and it was determined that there may have been insufficient scrutiny of the reason for homelessness as discussed below.

At **Housing Service** interim accommodation, the case was managed by the Tenancy Support Officer. All contact with Adult G, Adult GH and support providers was recorded on the Housing Management IT system. The IMR author states that needs were identified and referrals were made to ensure the family received the relevant support, and regular contact was maintained with the other agency support worker. An Interpreter or Language Line was used in all meetings. The TSO's impression of Adult G was that she was very quiet and reserved.

An Assessment of Support Needs completed by the TSO indicated that health visitors and midwives were already involved with the family as Adult G was pregnant and it was noted that the midwife was visiting regularly. The family also had a support worker from an external agency. The review of the initial support plan was followed up appropriately by the TSO.

The family was struggling with money and help and advice was given to apply for additional benefits by the TSO and the Family Support Worker who also made a referral to a law service in Sheffield to intervene regarding benefits issues.

The Temporary Accommodation Team works very closely with the local medical centre and regular weekly meetings are held between Health Visitors, Midwife and temporary accommodation team staff to discuss families currently resident. In 2012, these meetings were held every two weeks.

The TSO had regular contact with Adult GH; however Adult G was rarely seen around the building. There were no reports of Anti-Social behaviour or noise nuisance at the property whilst living in the temporary accommodation, nor were there any indications or behaviours noted which may have indicated an abusive relationship.

<u>Organisational analysis:</u>
The engagement of Housing Solutions was procedural and related to implementing statutory duty and then referring the family on for housing. An interpreter was used for the purpose of interviewing, and whilst ethnicity is recorded for monitoring purposes, there is no further reference to ethnic, religious or cultural needs, as this was not the focus of the service. The IMR author notes that it may have been helpful to gather information at this stage about cultural identity, and the Overview Report author agrees there could be a discussion about how this might help to provide

support to asylum seekers and refugees in future. However, there is no evidence of missed opportunities in relation to Housing Solutions.

The family was temporarily accommodated in bed and breakfast and then provided with supported temporary accommodation for families at Address 3 which is in line with procedures. The decision to rehouse was made within an acceptable timescale of 7 days of presentation and the family was then referred on for a tenancy.

Housing Service provided interim supported accommodation from 17.1.12 to 19.3.12 when the family accepted the offer of a tenancy with Arches Housing Association at Address 4. The IMR author notes that this is a relatively short period compared to many families in interim accommodation and was probably because the family had already been awarded a rehousing priority when they moved in.

The IMR author noted that all staff in the Council Housing Service receives training in domestic abuse and safeguarding and that procedures are in place and all staff know the correct referral routes for Safeguarding and Domestic Abuse. Staff in temporary accommodation work with some SCC's most vulnerable tenants and need appropriate training to enable them to carry out their work. The IMR indicates that policies and procedures were implemented and service standards were at the expected level. This included using an interpreter or Language Line at interviews.

The IMR author noted that an opportunity to liaise with the midwife was lost and that ensuring staff follow up calls is important. This is not considered to have impacted on this case, but is a lesson to be learned.

Conclusions:
Both IMRs identify that policies and procedures and practitioner standards were at the expected level and there was no indication during the involvement of the housing staff that would have triggered closer inquiry into domestic abuse. There does not appear to be a system within SCC housing services for routine domestic abuse inquiry; however, it is known that Adult G was always accompanied by Adult GH when not at home and there is therefore no suggestion that there could have been an opportunity.

There is a recommendation from one of the IMR authors that procedures are updated to make sure that missed contact between agencies is followed up to ensure that relevant information is shared. This refers to the lost opportunity to liaise with the midwife when both parties were busy when they called back.

Both IMRs highlight that little is known in the housing services about the Bidoon people and this cross-references with a number of agencies which recognise that there was low cultural awareness and will be considered further in the overall conclusions.

There was further discussion between the Review Team and Housing Solutions in relation to the decision that housing benefit problems led to this family's homelessness in January 2012. It was a concern as it suggested that delayed benefits is leading to cases where tenants are unable to pay rent and are evicted. As a result, the IMR author reviewed the homelessness decision and found that on reflection it was by no means certain that homelessness was a result of housing benefit problems. The decision to accept a statutory duty to rehouse the family may have been taken with insufficient investigations into non- payment of rent as the main factor of their previous tenancy failing. If the Housing Solutions officer had felt that housing benefit was the only issue, then an eviction may well have been unlawful and the IMR author would have expected this to have been referred to the Tenancy Relations Team. In hindsight, if a different decision had been made, i.e. that the family had intentionally made themselves homeless, there would have been no duty to rehouse under the legislation. In that scenario, a referral would have been made to Children's Social services to alert them to the risk of street homelessness of this family which may in turn have alerted them to any issues within the household.

I see these observations as important as they identify a potential flaw in decision-making; however, the scenario of intentional homelessness is hypothetical and there is no suggestion that there could have been a different course of events. Hindsight indicates that the family would have secured further privately rented housing or accommodation with family members rather than be subject to the involvement of social care. The family was placed in supported interim housing as a result of the decision that was made, and this in turn resulted in the allocation of social housing through Arches Housing Association, which was a good outcome for the family at that time.

2.4.8 Arches Housing

Information was requested and received from Arches Housing Association. This was not an IMR but a statement in response to a set of questions from the Review Team.

The Organisation:
Arches Housing is a black & minority ethnic housing association providing affordable homes for people in housing need in Sheffield and Rotherham. The Association is committed to providing properties and housing services for people with diverse needs and work with various partners to promote community cohesion in the areas where it works. Arches works with a number of housing support providers who help tenants to sustain their tenancies and provide other support including welfare, benefits, employment, etc.

Contact with the family:
On 6.3.12 Sheffield City Council sent a Nomination Form to Arches Housing Association nominating Adult GH for re-housing stating he had priority. The nomination included details of a Support Worker (at Metropolitan, *see Section 2.4.8*) and noted that an Arabic interpreter may be needed.

Following receipt of the nomination Arches made an offer of Address 4 by letter to Adult GH dated 6.3.12. Records show that an interview took place on 12.3.12. On that day the property was viewed, terms of tenancy were explained, copies of passport and other documents were made. On 13.3.12 the tenancy agreement for Address 4 was signed and house keys issued along with procedural requirements including tenant's handbook; and a furniture store letter was given. It was recorded that Adult GH was eligible for full housing benefit. Adult GH stated they would move in on 19.3.12. Adult GH, Adult G, and their 3 children Child GS1, GD1 and GS2 moved in.

The Housing Officer made two attempts to undertake a Post Allocation Visit to Address 4 on 28.3.12 and 4.4.12. The record shows that Adult G was at home but as she could not speak English the officer left a card asking Adult GH to contact the Housing Officer. On 5.4.12 there is a record of a message left on Adult GH's mobile followed by a note of a phone conversation with the support worker who said the family should be home on that day. The officer completed the visit later that day. It was noted that a female relative was present who gave help during the visit. Further notes record Housing Benefit issues which in the housing association's view are typical with new tenancies and resolve over time.

Records show that on 21.5.12 Adult GH attended the Arches office interview and advised the Housing Officer that he was moving to another locality. The Housing Officer spoke to the Refugee Support Worker by phone. It was recorded that the support worker will not support their move to a private landlord and that she had explained this to Adult GH.

Analysis of involvement:

In 2012 Arches Housing did not have its own housing waiting list and like most other housing associations relied on the Council's Housing Register from which individuals would be nominated for housing. This is what happened in this case.

Records show a normal sequence of events regarding support with the Housing Benefit claim but there is also a record of problems with gas supply as it had been capped and electric heaters were provided.

The information provided by Arches indicated that policy and procedures were implemented.

There were a number of contacts with Adult GH regarding the tenancy, and Adult G was seen on one occasion when the worker called at the home. There was no evidence of domestic abuse or any other incidents during the tenancy.

Arches expected that support for the family was provided by the refugee support worker from Metropolitan. There was evidence of good liaison with the support worker.

Conclusions:

The tenancy with Arches Housing Association was short, just 2 months, and the family then moved to privately rented accommodation at Address 5. It is not recorded why they made this decision, to move from secure to insecure housing, although Adult GH's brother told us it was because they needed more space when his mother came to the UK. Adult G's sister told us that he had needed two reception rooms to have business meetings with his visitors.

Subsequently the family lived in private rented housing and had no contact with housing services.

Asylum Seeker and Refugee Services

2.4.9 Metropolitan

The organisation:
Metropolitan is a housing association providing good quality, low cost housing. In 2009 it merged with The Refugee Housing Association which was contracted to support refugee households in South Yorkshire from 2004. Contact in this case was solely through the refugee support service. The Service was notified in December 2012 that funding would end in March 2013, since when there has been no refugee support service in Sheffield.

Summary of involvement of Metropolitan Housing with Adult G and Adult GH from 19th October 2010 to 4th March 2014:
On 10.1.12 Adult GH was referred to the Metropolitan Refugee Floating Support Service by Sheffield Housing as Adult GH needed support to access benefits, housing and debt advice.

On 20.1.12 a Support Worker who was Arabic speaking visited Address 3 to complete an assessment of support needs and Adult G was present. The key points identified were support with moving out of temporary housing, setting up utilities in the new property, and applying for correct benefits. Adult GH and Adult G were advised that they would hear from Metropolitan within 7 working days about being accepted for support.

On 30.1.12 the Support Worker contacted Adult GH by phone to say that the family had been accepted into the Service and that support would be provided by an Arabic speaking worker on a 2-weekly basis either in the community or at the home. The nature of support was set out, and contact details were given to Adult GH. The Support Plan was started by the Support Worker based on the needs identified.

On 3.2.12 Adult GH contacted the Support Worker by phone to ask for support with Adult G obtaining a National Insurance Number.

On 10.2.12 Adult GH was supported in attending the Job Centre and HMRC for support to claim Child Tax Credit and Child Benefit for Child GS1, GD1& GS2.

On 2.3.12 the Support Worker made a routine home visit and saw both Adult GH & Adult G.

On 5.3.12 Adult GH requested a visit for support with completing housing & council tax benefit form, a letter about rent arrears, water bills and a speeding ticket.

On 12.3.12 the Support Worker met Adult GH at the Arches Housing Office to attend an appointment about the families housing application and the offer of a 3 bedroom property at Address 4. The Support Worker made a referral to St. Vincent de Paul Charity for furniture for the family and also supported an application for a community care grant.

On 21.3.12 the Support Worker visited Adult GH and Adult G at their new address as part of ongoing support and delivered a Moses basket for their expected baby. It was noted that Adult G was very welcoming and the children were very playful. The Support Worker checked that furniture had been delivered from St. Vincent de Paul.

On 23.3.12 the Support Worker did a routine home visit and saw Adult G; Adult GH was out. The gas pre-payment meter was not working so the Support Worker arranged for a gas engineer to visit. The children GS1, GD1& GS2 were watching an Arabic speaking television programme. (On 28.3.12 British Gas attended the property and re-set the meter.)

On 1.5.12 the Support Worker made a routine home visit and saw both Adult GH and Adult G; they informed the worker that Adult GH's mother, Adult GHM, would be coming to live in the UK with them.

On 9.5.12 the Support Worker made a routine home visit when both Adult GH & Adult G were present.

On 30.5.12 the Support Worker was contacted by the family's health visitor and told that Adult G had given birth to Child GD2 and that the family had moved to a new property, Address 5 on 20.5.13. The Support Worker was not aware that the family had moved to a new address since her last home visit to Address 4.

On 31.5.12 the Support Worker visited Adult G at the family's new address and all benefit and other support-related matters were discussed with Adult G. Adult GH was not in; his mother Adult GHM was present. She was awaiting a decision on her asylum status. This was the first time the Support Worker had met Adult GHM.

On 21.6.12 the Support Worker received a call from the family's Health Visitor who wanted to know what kind of support Metropolitan was providing to Adult GH & the family. This information was provided.

On 11.7.12 the Support Worker made a routine home visit and completed the 6-monthly support plan with Adult GH. Adult G was also present.

On 9.8.12 there was a routine home visit when Adult GH and Adult G were seen and no issues were raised.

On 20.9.12 there was a routine home visit with Adult GH and Adult G and no issues were raised. The family was advised that a colleague would be covering the Support Worker's annual leave.

There were further routine monthly home visits on 5.10.12 and 6.12.12 when Adult GH & Adult G were seen and no issues were raised. There is no record of a monthly visit in November.

On 3.1.13 during the monthly home visit Adult GH said they were planning to move to Manchester. At the next visit on 30.1.13 Adult GH told the Support Worker that the family was moving to Manchester to live closer to Adult GH's older brother. Adult GH was advised by the Support Worker that Metropolitan's support would come to an end as the organisation can only support people who live in Sheffield. The final support plan was discussed & agreed.

Records indicate that on 4.2.13 the Final Support Plan completed with Adult GH and the family. There was no contact after this time as it was understood that the family had moved out of the area.

Analysis of Metropolitan Housing involvement:

Analysis of involvement with individuals:

The chronology clearly shows the work to prepare and sustain a tenancy with 6 visits during March 2012 prior to the family's move to their new home at Address 4. There was practical support in ensuring the family was provided with benefits, furniture, and baby equipment, and problems were resolved once they had moved.

There was a clear client focus up to the point the family informed the worker of the plan to move; during that time, needs were identified and a support plan completed and reviewed. Communication with Adult G was in Arabic, with a worker who had relevant cultural awareness, so that there was a full understanding of the process and the anticipated outcomes. Adult G was provided with support at home. Adult GH was given contact details for the worker.

There was good liaison with other agencies including Health Visitors, Housing Solutions, Arches Housing, in order to ensure the family's needs were met. There was no liaison with MAST as the Refugee Support Service was not aware of MAST and as identified in the MAST IMR, MAST was not active in establishing what other services were engaged.

After the baby was born and the family had moved to Address 5, the service continued with visits on a monthly routine basis. The Support Worker observed that Adult G was very welcoming and that the children had access to Arabic TV and were playful.

The Support Worker was able to communicate with both Adult GH & G in Arabic with only a few dialect changes as the family were from Kuwait and are Bidoon. The Support Worker came from the United Arab Emirates and was aware of the cultural values of the Bidoon community.

Organisational analysis:

The Refugee Floating Support Service met the criteria of both local and national service and practitioner standards. The Service was commissioned and funded through Supporting People. The Support Planning and Risk Assessments formats were agreed and approved by them. The service was graded as 'B' in the most recent audit by Supporting People. The electronic record keeping system, Service User Model (SUM) was the recording method for care and support Services across Metropolitan, as the practitioner standard model.

The Support Worker had previous domestic violence experience through her work in a women's refuge, has attended recent training and was confident to report any concerns to other agencies and was fully aware of Metropolitan's Domestic Violence policy and information published by Women's Aid on their website including safety planning, resources for survivors and for children. The Support Worker had regular supervision where she could discuss any concerns.

The IMR author demonstrated that practitioner and service standards were all within expectations and guidelines. Support plans and reviews; regularity of contact; support offered, were all of a good standard. All relevant risk assessment and domestic abuse policies and procedures and staff training are in place.

The IMR evidences good practice, for example: Adult G was given as standard operating procedure a Welcome Pack which was in Arabic with pictograms. The Pack included advice and contact information on social and cultural laws, including domestic abuse, child protection and abuse of vulnerable adults. This is a service accustomed to working with a wide range of cultures; in addition to the Support Worker speaking Arabic, the staff of the service is ethnically diverse.

Whilst there was good inter-agency liaison, the IMR author notes that there was some duplication of services and a lead agency was not always evident. Perhaps understandably the family appears to have raised immediate concerns with whichever presenting agency they met rather than being clear about which agency was best equipped to support them beyond meeting an immediate need (through food parcels, for example).

The referral into the Refugee Service by the Local Authority was recognition that Adult GH needed support and that there was a service in place that could meet the family's needs and provide them with the support to maintain their finances and maintain a tenancy.

There were no identified domestic abuse concerns or incidents witnessed during the support that was provided. As part of routine visits, the support worker would ensure that she met the children and also that she called on occasions when only Adult G was present so there would have been opportunities to discuss any matters in confidence. The Support Worker believed Adult G was comfortable with the visits and would have felt able to disclose had she wished to do so.

The IMR author notes that with hindsight, two events would have been worth further consideration. The first was the fact that the family did not inform the worker of their move to Address 5 and secondly, their stated intention to move to Manchester. It is unexpected that a family would move without informing their Support Worker they had done so, particularly as the family had relied upon her previously to maintain their benefits and to resolve other problems. The worker noted that there was overcrowding in the house which may have motivated the move; however, the IMR author believes that attempts could have been made to establish whether the failure to inform her of a change of address reflected disengagement due to difficulties within the family. The same applies to the family announcement of a move to Manchester and withdrawal from support.

Conclusions:
The Metropolitan Refugee Service has been able to demonstrate meeting its organisational and practice standards and evidenced a number of examples of good practice. Support was intensive and focussed, supported by assessment and support planning, and regular contact with the family. The support was provided by a trained and experienced worker who spoke Arabic and had personal and professional knowledge of working with refugee communities including understanding Bidoons. The worker provided information in an accessible form that ensured Adult G would have understood that she could report domestic abuse; and had a number of contacts with Adult G which, having developed a relationship with her, would have provided opportunities for Adult G to disclose abuse had she wished to do so.

The IMR author concludes that there are two occasions when opportunities to inquire into potential difficulties in the family, were missed: when the family moved to Address 5 without informing the Support Worker, who learned of the move from the health visitor; and when Adult GH told the Support Worker they were to move to Manchester, which led to closure of contact.

Metropolitan noted a number of lessons to be learned, including the duplication of work by different agencies involved with the family. The worker noted overcrowding at Address 4 with the arrival of the new baby and of Adult GHM, and could have undertaken a new risk assessment in relation to this. This may then have raised indicators of potential harm and enabled the Service to support the family in seeking a solution whereas the family made a decision to move to Address 5. The arrival of a

new baby meant that a support visit should have taken place earlier than 22 days. When the family informed the Service that they were planning to move to Manchester, this information was shared with the Health Visitors, which was good practice. However, the IMR author believes that further cross-checking could have been done with other agencies to see if the plan to move was widely known or whether it reflected a pattern of reduced engagement and rising concerns with Services generally.

As a result of this Review, Metropolitan intends to improve future support planning. This service in Sheffield has now closed; however Metropolitan intends to take this learning into other areas providing refugee services.

I appreciate that Metropolitan has taken a positive stance in learning important lessons from this Review. I agree there are issues for Metropolitan to consider internally such as the need to cross reference and verify information when vulnerable families try to disengage from an otherwise positive working relationship. There are also issues to take forward locally, including the apparent duplication of activity when a number of agencies are engaged with a vulnerable family; this would be something for the MAAM to consider.

During discussions of this Report in the Panel, it was highlighted that the focus switched from client to agency at the point the worker was notified of the plan to move to Manchester. This highlights a risk in safeguarding which has been seen in other cases, where families move, or state the intention to move, in order to avoid contact with agencies. The Panel noted that no attempt had been made to verify the plan or refer the family to any support service in Manchester. It was proposed by the Panel members that rather than allow families to disengage at this point, workers should become active: getting details of the plans, notifying other services, cross-referencing and communicating in order that any concerns can be identified.

I do not believe that any of these improvements would have enabled Adult G to disclose abuse, or the Support Worker to believe that abuse was taking place. Given that this Support Worker was one of very few practitioners who had a rapport with Adult G, saw her regularly, provided information about abuse and was alert and trained to respond to any indication of abuse, it is difficult to see how that could have been different. Analysis of the chronology indicates that there was a withdrawal of the family from most services during the last year of Adult G's life, and there is unlikely to have been a positive outcome to a different response to their plans to move. However, there are important lessons to be learned about disengagement and in discussing with managers when vulnerable families are ending contact, for whatever reason, to ensure there are no missed opportunities.

Conversely, this IMR provides evidence of good practice from which other agencies can learn in working with asylum seeker and refugee communities to raise

awareness of domestic abuse; for example, the use of literature with pictograms which the Service uses to demonstrate social and cultural laws, particularly with regard to safeguarding and abuse.

The Metropolitan IMR author references the need for a multi-agency meeting, however a multi-agency structure already exists in Sheffield in the form of the MAAM. This raises the question of what other support services are not aware of the MAAM structure and how to exchange information with other agencies. It is for CYPF to consider how to ensure that the voluntary and community sector understands the role of MAAM and is able to make referrals.

It has been noted during this Review, in discussions between authors and in the Panel, and in the focus group where we discussed themes emerging from this Review, that people in Muslim communities can feel threatened by being asked to work with professionals who belong to the same ethnic or faith community. This discussion related to interpreters but it could be extended to other professionals. There may be value in reflecting on the contradiction of expecting vulnerable people to establish a rapport and trusting relationship with professional staff who may represent the ethnic or faith group they are fleeing; or indeed may live within the same local community. There is a linked point about the availability of female interpreters which is referenced in the overall conclusions.

2.4.10 Sheffield Association for the Voluntary Teaching of English (SAVTE)

Information was requested and received from SAVTE. This was not an IMR but a statement in response to a set of questions from the Review Team. We met with SAVTE to discuss their service in relation to this incident.

The organisation
SAVTE aims to help adults whose first language is not English by equipping them with English language skills for everyday life. Individuals are referred to the Service through health visitors, social workers, community workers, etc. Contact is by home visit with one to one teaching delivered by trained volunteer tutors using the ESOL Curriculum over an initial period of six months.

Summary of involvement of SAVTE with Adult G and Adult GH from 19th October 2010 to 4th March 2014:

The volunteer tutor allocated to Adult G had eight contacts with her at the family home. In July 2013, Adult G showed the tutor a large bruise on her arm. When the tutor inquired about this, Adult G said she had walked into a door, but the tutor reported that it didn't look like it could be caused by a door. The tutor reported the bruise to her mentor at SAVTE and was advised that the mentor would not report this to an external agency unless the tutor saw any further injuries. On another occasion the tutor witnessed a bite mark on Adult G's neck, but felt unsure whether it was a 'love bite' and therefore did not report this. After the homicide, the tutor reported that she had heard what she thought was one of the children being hit. She noted that Adult G had once appeared anxious when her husband returned home unexpectedly with a male friend during the tutor's visit; the tutor was moved hurriedly to a different room and then out of the house. In October 2013 the tutor observed another bite mark on Adult G's neck and did not report this.

Analysis of SAVTE involvement:
The SAVTE representative stated that had further incidents been reported, the agency would have reported it to the health visitor who was the referrer. This in turn could have triggered a response. However, the volunteer tutor did not think that the two bites were linked to the bruise and assumed they were from lovemaking (and indeed this may have been the case). As such, she did not inquire into or report these marks. It is not clear whether her mentor would have considered that these marks merited reporting.

The worker had been provided with awareness-raising in safeguarding, but as a small community sector agency, this was not at the level provided to professional workers in statutory agencies. We met with the SAVTE management team and established that there was little awareness of the domestic abuse pathway within the organisation. Further, the agency gave examples of having made referrals when

there were concerns about safeguarding children, and these not being progressed by the statutory agency. Whereas a professionally trained worker in health and social care might have put together the known factors – bruising, an unlikely reason, fear, possible corporal punishment of a child – and escalated a concern, this level of training and supervision is not routinely available to the volunteer tutors.

The report from SAVTE states that it can be difficult at times for some volunteers to distinguish between unacceptable behaviour and cultural norms but this Review will make it clear that domestic abuse in any culture is not acceptable, and must always be reported by professional workers.

There was evidence of excellent practice from the volunteer tutor. Adult G's sister joined some of the lessons and whilst this was not within policy, the tutor allowed her to participate, which is an example of proactive engagement with isolated women. Adult G's sister came to see learning English as vital to integration, and has now enrolled for English lessons. We were told by Adult G's sister how much Adult G looked forward to these visits; her sister told us that this was the single, most important relationship with any professional worker. She particularly valued that the tutor brought items from the world outside such as flowers and sweets, which made her feel less isolated. Her sister says that it was 'very significant that she showed the English teacher her bruise'. She would have shown no one else. Her sister explained that she 'just wanted her to see it'; she didn't want her to do anything, and had she reported it, her sister would have denied it. In this context, it was evidence of the rapport she felt she had with the tutor.

Conclusions:

The Review Team met with SAVTE for two purposes: first, to feed back to the volunteer tutor, through the organisation, that her work was held in high regard by Adult G and her sister; secondly, to discuss the need to develop domestic abuse policies and procedures within the organisation; and finally, to ensure that volunteer tutors access domestic abuse training. SAVTE has welcomed all these development actions as lessons learned from the Review.

With hindsight, it is tempting to conclude that this was a missed opportunity for making Adult G safe. Had the mentor reported the bruise to the health visitor; had the tutor reported her further observations; had SAVTE provided the tutor with reflective supervision in which she could have reflected on her other observations about the family dynamics; had the tutors received training in domestic abuse, would any agency have intervened? It is very doubtful. The information available to the tutor and her agency might have led to the health visitor making an unannounced visit, but we have heard from the family that Adult G would not have disclosed and, if directly asked, would have denied abuse. A report about a child possibly being hit is indistinct and unlikely to have been linked to other information as there was no concern about the son at that time.

2.4.11 Northern Refugee Council

Information was requested and received from Northern Refugee Council. This was not an IMR but a statement in response to a set of questions from the Review Team.

The NRC is an independent charity which promotes the welfare of refugees, asylum seekers and migrants. The NRC had contact only with Adult GH who attended the office to ask for assistance with a letter from the Home Office Travel Team regarding a travel document application. This advice was provided.

There was no further involvement with individuals subject to this review. The NRC has reflected on this case to identify any learning; staff are trained in safeguarding and domestic abuse; and there appears to be nothing further that an advisor could have done given the limitations of the one contact.

Community Safety Services

2.4.12 South Yorkshire Police

The organisation:
South Yorkshire Police is responsible for reacting and responding to incidents of a domestic abuse nature. Public Protection Units are located at each District to provide support and guidance to victims via the Domestic Violence Officers. Within SYP there are specific roles dedicated to dealing with Domestic Violence. Each district has a dedicated Domestic Violence Co-ordinator and Officers, whose roles include the day-to-day management of domestic abuse cases. The Domestic Violence Officer (DVO) will work with 'high risk' and 'repeat' victims and conduct safety planning and management of the risk. The DVO will work closely with the Independent Victim Advocates (IDVA).

Summary of involvement of South Yorkshire Police with Adult G and Adult GH from 19th October 2010 to 4th March 2014:
On 28.9.11 Adult GH was arrested during the investigation of an offence of "Help Asylum Seeker to Enter United Kingdom" which was alleged to have occurred at St George Dock, Hull on 14.6.11. Adult G was initially placed on police bail in order for further statements to be obtained. However, he was cancelled from bail by the investigating officer prior to the bail date, as there was insufficient evidence to proceed with the case.

On the same day (28.9.11), officers attended the address of Adults G and Adult GH in order to search the premises as part of the investigation. Adult G was present, together with males believed to be Adult GH's brother and nephew. Two toddlers were also present, potentially Child GS1 and Child GS2 (unconfirmed). A number of documents were seized in relation to the investigation. Officers noted that the occupants did not speak much English.

On 31.10.13 a 999 call was received at the police call handling from a child. An adult female came on the line to advise that she only spoke Arabic, before disconnecting the call. The call handler rang back and spoke to an older child to advise them about keeping the phone away from younger children.

There was no further contact with Adult G or Adult GH until 4.3.14 when following the death of Adult G, a full murder enquiry commenced.

Analysis of South Yorkshire Police involvement:
There were two unrelated contacts during the period under review. In the first, in September 2011, the evidence against Adult GH amounted to suspicion that he had assisted 8 males to enter the country illegally, by providing phone support (directions and guidance) to the group of males whilst they were travelling to England via

Belgium. Although there was some circumstantial evidence to corroborate this, the decision was taken by the officer's Sergeant that there was insufficient evidence to charge.

In relation to the search of Adult GH's address on that date, though officers noted Adult G being present, no further information is recorded. Adult G was not of interest in the case and therefore contact with the searching officers was only minimal.

The IMR author having reviewed the circumstances, agrees that the case would not have had a realistic chance of conviction at court and that releasing Adult GH without charge was the appropriate decision.

The police call centre at Atlas Court receives significant numbers of false / silent / accidental 999 calls on a daily basis. There are Force procedures setting out the response. Each incident is assessed on the basis of information available and if any concerns are raised then an officer is dispatched to check on the welfare of the occupants. In cases where a child is on the line the call handler would normally ask them if one of their parents could come to the phone and the parent would be asked if everything was ok and then (where appropriate) suitably advised regarding child's use of 999.

The IMR author having listened to the recording of the calls on this date, reports that it is clear there are no sounds of disturbance or indications of distress. When spoken to, a woman, who may or may not have been Adult G, clearly didn't understand English. Her child then came on the line and he relayed the message about keeping children away from the phones.

The IMR author notes that in terms of opportunities missed, it would have been advisable for the call handler to have asked, for example, "are you ok" or "do you need the police". Similarly, efforts could have been made to establish what language was spoken and then a welfare check could have been completed using Language Line. Confirming the wellbeing of the caller would be standard practice in calls of this nature, and it may be that the language barrier prevented this occurring. However, there was nothing on the call to indicate that this was anything other than a child playing with the phone.

Conclusions:
The IMR identifies that this case offers minimal opportunities to review police response and actions. If we include the search at the home address as a separate incident, there were only three occasions when the police had any involvement with the immediate family. In relation the immigration matter, procedure was followed correctly and there are no recommendations that could have altered the outcome in this case.

In relation to the 999 call, it would have been advisable for the call handler to have used Language Line in order to have provided the level of service normally offered to an English-speaking caller. While this might not have altered the outcome, it would have provided some level of assurance that all possible action was taken to offer assistance.

I agree with the conclusions and recommendations of the IMR author, to use the findings from this case as an opportunity to review procedures for taking calls from non-English speakers.

SECTION THREE – CONCLUSIONS, LEARNING LESSONS

In this Section, I will draw on the information in the previous sections and other information available to the Review in order to establish what lessons are to be learned and what needs to change; and identify actions for agencies in order to make those changes and prevent domestic violence homicide in the future.

3.1 Conclusions of the IMRs

This section is a synthesis of the responses of individual agencies in relation to the questions raised in the Terms of Reference.

3.1.1. **Did agency awareness and understanding of relevant cultural, race, religion or nationality issues, and consideration of equality duties, impact on interventions?**

Health services:

- Adult GH moved practices which is said to be common among refugees who move a lot; he may not have understood that patients are registered with a specific GP practice. It is important that patients have a good relationship with their doctor and are able to communicate well. It is not uncommon for Arabic speaking men to register at Practice 1 where there are Arabic-speaking GPs; while the family is cared for by a practice nearer to the home.
- In the short period of time the family was in the country a lot of different practitioners were involved and no one was able to establish relationships or continuity of care. In the case of Adult GH, he arranged to see a different GP during a course of treatment for depression; it is not known why he did this. The family generally presented chaotically, not keeping appointments, using the walk-in service, which meant individual practitioners could not develop consistent relationships.
- Adult GH's GP at Practice 1 stated that in his personal opinion the Bidoons are a 'marginalised stateless people and a lawless culture in which men could become violent if they didn't get what they wanted'; however Adult GH was noted to be pleasant even when the GP was reluctant to give sick notes. The GP experienced no threatening behaviour from him. Reception staff felt they knew him well and that he was normal; and kind to his mother when he brought her to the surgery. The IMR author established that this GP had a direct personal experience which had led to his forming this view, and in further discussions with the Review Team, it was considered that the GP was not negative towards any culture, race or religion.
- The GP at Practice 1 believed that Adult GH's faith (Muslim) allows violence towards women if it does not leave a mark and is not on the face but stated that he, the GP, did not personally condone domestic abuse; he expressed the view that domestic violence was rare in the Islamic population that he cared for and

more common in cultures that use alcohol. This viewpoint was discussed with the IMR author who clarified that the GP was not himself a Muslim and that this view was based on his own experience of working with those of Muslim faith. As such, it may highlight that there is a need for wider understanding of domestic abuse within the Muslim community. The Report will reflect further on this point in the Conclusions.

- The GP 2 at Practice 2 is experienced in caring for asylum seekers and refugees from the Middle East. He was not familiar with the Bidoon culture and his experience of looking after and working with Muslims is that domestic violence would be offensive and that domestic abuse is common in all cultures and religions.
- The GP at Practice 2 used direct questioning of Adult GH in relation to his anger and domestic abuse; this is not the recognised way of consulting and demonstrates a good understanding of cultural differences; the GP believes it is good practice to ask about domestic abuse when someone presents with depression, especially when they are an asylum seeker and may have suffered trauma.
- The GPs in both practices are experienced in providing care to refugees from similar countries to this family and are aware of the culture including the prevalence of domestic abuse. Staff at both practices are trained in domestic abuse and aware of the domestic abuse pathway.
- Practitioners providing maternity and midwifery services were not aware of cultural complexities, i.e. Bidoon, and the IMR author believed that had this been known, the information may have influenced the care provided. For example, there may have been more emphasis on understanding the family dynamic. Efforts were made to support the family to ensure adequate food, money and accommodation was secured, however the impact of that intervention on the family is not clearly defined.
- There was a limited understanding of the cultural background of the family by the Health Visiting and School Nursing Services. More knowledge of the cultural background of this family may have influenced the way these agencies worked with this family.
- In the Health Visiting Service whilst there was a lack of awareness of the specific cultural group to which this family belonged, there was no evidence that a lack of awareness impacted on interventions. Health visitors communicated with Adult G through an interpreter to discuss and address the family's health needs. The IMR author believes there are cultural factors that can prevent questions about domestic abuse being raised or asked, however, that these issues are covered in current domestic abuse training. In this case further attempts to enquire about domestic abuse could have been made and documented in the health records.
- The School Nursing Service had minimal contact with the family and during their contact communicated with Adult GH and a male family member (documented in the School Nursing records as an uncle). An interpreter was not used by the

School Nurse. It is recorded that when telephoning the home, the school nurse was not aware there was a language barrier and believed Adult GH understood the concerns and the invitation to attend the meeting regarding Child GD1. Had the School Nurse believed there was a language issue, she would have used a language service. Although this does not have a bearing on this case, the effectiveness of this communication is not known and it is not clear whether this communication may have had an impact on any assessments or decision making.

Children, Young People and Families:

- The MAST worker engaged in resolving Child GS1's school attendance problem used interpreter services to communicate with Adult GH, and clearly there was discussion with Adult GH about attending English classes. MAST staff did not meet the family and as such the agency finds it difficult to identify any cultural awareness issues. As overview report author I have a number of queries about the agency's awareness, understanding and consideration of cultural, race, and religious issues. I understand that as workers did not meet the family, any analysis would be limited. However, in relation to the work that was undertaken around the school transfer, the record begs questions such as: why was the worker only engaging with Adult GH and not making attempts to engage with Adult G? Why did the worker believe Adult GH needed support to work around school times, without having that conversation with Adult G who also had parental responsibilities? What assumptions was the worker making about this family that impacted on his practice? This would include a question of gender bias. Did the worker know that in this culture, as a man he would not gain access to Adult G? As such, these are issues on which the Service needs to reflect and take into account in implementing the recommendations, which do include development of cultural awareness.

Housing Services:

- The Housing Solutions IMR author notes that cultural identity was a factor that could have been identified at the point of re-housing and information shared. The Review has not found any gap in this regard: the family was referred to the Refugee Service for support when they were in interim accommodation which suggests there was recognition of their refugee status and need for support, and relevant action was taken.

Refugee and Asylum Seeker Services:

- Metropolitan states that the worker came from United Arab Emirates and was aware of the Bidoon culture. This is highlighted as good practice. There has been discussion as to whether this is a paradox: members of the Review Team and the Panel reflected on experience which indicates that troubled individuals within ethnic minorities often do not wish to have workers from the same ethnic minority.

This may be because they perceive a threat to their confidentiality or a judgement by their own community on their ability to manage their lives. This remains a point for discussion within agencies. I take the view that whilst it is good practice to have a multi-ethnic workforce, it is not necessarily advisable to expect workers and service users from the same ethnic or religious community to work together effectively; the wishes and feelings of the service user about this, need to be established. The Review raises a question as to how this paradox affected the working relationship between Metropolitan and the family as we know in hindsight that Adult GH twice tried to end contact with the service. It appears that although the service had provided substantial practical support and advice for a prolonged period, the worker did not get close to the family. The Review Team and Metropolitan held further discussions and learned that the support files indicate clearly that Adult GH became less engaged with the support worker when she transferred her support from doing tasks with or for him (benefit and housing applications, phone calls to Immigration, debt agencies, police for vehicle offences, etc.) to encouraging and enabling him to do the tasks himself. There is a file note of Adult GH becoming 'loud and upset' with the worker when she refused to carry out several tasks directly and advised him instead of the steps to do them himself, in June 2012.

- The Review Team has reflected that gender bias is likely to have been an important feature in the relationship between support workers, who were female, and Adult GH; and there could be a risk of underplaying the significance of gender given the complexities of culture, race and religion.
- Conversely, the disengagement from Metropolitan supports the view, expressed elsewhere, that Adult GH may have been disengaging with all professional workers who may have observed domestic abuse or provided Adult G with an opportunity to disclose domestic abuse.
- Information about the significance of the relationship between the white British tutor and Adult G supports the notion that it was easier for Adult G to develop rapport with a woman from a different faith and/ or culture.

3.1.2 **Were agency processes for facilitating communication sufficient for identifying or meeting their needs as non-English speakers?**

<u>Health services:</u>

- In GP services, most of the consultations used translators or the GP spoke Arabic. The practices used in house interpreters for consultations, phone calls and making appointments. The language barriers were minimised as much as possible despite Adult GH refusing interpreters on one occasion when he was with his mother and when the children had immunisations and on one occasion when no interpreter was available. The receptionists are experienced translators and advocate for the patients by helping them book their next appointments. A receptionist spoke to Adult G using an interpreter to follow up Child GD2's missed

immunisation. This could have been an opportunity for Adult G to ask for help if she was alone at home. She also attended some appointments without Adult GH and she could have used the interpreter to disclose any abuse she was suffering. It is not known if she felt the receptionist knew her well enough to be able to disclose.

- The GP practice could reflect on the suggestion that Adult G would have found it more difficult to disclose to members of the local community, which would include the receptionists.

- In midwifery and health visiting services, interpreters and Language Line were used to communicate with Adult G, but the IMR author notes that it is not clear if Adult G was comfortable with the interpreter service that was used. It is not recorded whether the telephone interpreters were male or female or if there was a choice of gender offered. Adult G may have felt more comfortable discussing personal issues with a female interpreter. It is good practice that the interpreter service was used at each visit but the quality of each individual interpreter is unknown. It was apparent that when using an interpreter, planning for the interview is essential in order to prepare the interpreter in advance. Home visits with interpreters can be lengthy and distracting when young children are present.

- The School Nursing Service had minimal contact with the family and during their contact communicated with Adult GH and a male family member. An interpreter was not used. Whilst the IMR author notes that it is not known how effective it was to communicate direct with Adult GH, or with the assistance of his brother, there is evidence elsewhere in this Review that Adult GH was able to communicate in English, as was his brother, and it is therefore not likely that communication issues had an impact on any assessments or decision making.

<u>Children, Young People and Families:</u>

- MAST notes that workers have access to 'Language Line' which is a provider of Interpretation Services and that this was accessed both when the case was allocated to the FDP (although not used), and when the worker had contact with Adult GH in relation to the school attendance issues for Child GS1.
- There were clearly communication difficulties between the school and the family, as a result of language. Interpreters were not used, although the school had concerns to discuss. It can be assumed the family would not have understood the need to attend the meeting to discuss concerns about their eldest daughter. There was evidence of a misunderstanding about who was to collect the child which could have been due to the language barrier. Schools need to reflect on how to use interpreters to support their work with parents.

<u>Housing Services:</u>

- Housing Solutions report that ethnicity is recorded for monitoring purposes but not specifically considered as a factor apart from language needs.

Asylum Seeker and Refugee Services:

- The Refugee support worker was Arabic speaking and all communication was therefore in the first language of the family.
- The Refugee Service evidenced using pictograms in literature, to communicate with refugees and asylum seekers about domestic abuse. This was the only service which provided examples of communicating with refugee groups who may have limited literacy or language skills.

Police:

- There was minimal involvement and no contact in relation to any of the matters under review. However, the police IMR has identified a lesson to be learned when a 999 call is made by a child of a non-English speaking family such as happened in this case. The IMR author recommends utilising Language Line in order that the Police provide the level of service that would be offered to an English-speaking caller.

The Review also found there to be a shortage of female interpreters which could impact on someone's ability to respond to questions about domestic abuse; and has become aware that interpreters sourced locally may represent the same community as the abused person, again impacting on the ability of a victim to speak freely.

3.1.3 **Neighbours and family members appear to have been aware of domestic abuse in the family – is appropriate information readily available to members of the public, including hard-to-reach communities, regarding the unacceptability of domestic abuse and how to seek help for someone they know who is affected?**

Health services:

- Practice staff was aware of the information on the Sheffield CCG website regarding domestic violence including the pathway for referral. The GPs and their staff reported that they look for the signs of domestic violence and would report it if it was suspected. Practice 2 has posters regarding the domestic abuse help line in waiting areas and consulting rooms. There were some concerns about putting up posters at Practice 1 because of fears of alienating patients who may think you are meddling in their affairs but it was accepted that this could be trialled.

- The STHFT IMR author noted that this Review has highlighted the need for targeted training and enhanced information being available to staff involved with hard to reach communities. Having a named midwife experienced in caring for vulnerable families is a huge benefit. Continuity of care improves communication as a relationship can be developed of mutual trust and understanding. Continuity of care was a positive factor in the care of Adult G and efforts to support the

whole family were clearly evident. An understanding of acceptable norms for communities at risk of domestic abuse is required if staff are going to be able to target the at risk groups to empower them to disclose concerns.

- There are posters, leaflets and contact cards with all the relevant information regarding domestic abuse, including the Domestic Abuse Helpline available and accessible in the health clinics in Sheffield. The Helpline for Domestic abuse is also on display in health settings across the city. Some information is available in a number of languages including Arabic however having posters in key languages could be considered.

3.1.4 **Concerns were expressed by agencies in contact with the children in relation to neglect and attendance. There also appears to have been little contact with their mother. Did agencies work together effectively to safeguard the children in the family?**

Health services:

- The children missed a lot of appointments and were sometimes brought the next day; there is no way of knowing what could have been missed or whether it had been a minor illness which just resolved itself.
- The failed call-back due to Adult GH having another appointment is not explained and is an example of chaotic presentation which may have alerted concerns about child neglect. This concerned a sick baby, Child GD2. The baby was seen the next day however, and was noted to be well and happy.
- Child GD2 was immunised with the primary course on time but was not brought for the one year old vaccinations and although this was followed up six months later it could have been opportunity to ask the health visitor if there were any other concerns about neglect or difficulties accessing health care.
- Child GD1 [*redacted]* which is detailed in NICE Guidelines on child maltreatment as a feature that should prompt consideration of emotional abuse if it is persistent and unexplained. [*Redacted.]*
- Adult G and Adult GH were educated about [*redacted]*. NICE guidelines state that [*redacted]* should prompt consideration of neglect. This could have been a missed opportunity to raise the question of neglect with other professionals such as the health visitor or suggest a MAST referral for further support around hygiene. However, the IMR author who is a GP, does not think [*redacted]* would have triggered information sharing with health visitors.

- The Health Visiting Service took action to address the needs of the children and encourage their development. All contacts by the Health Visiting Service were with Adult G. Adult GH was seen on only one occasion.

- The School Nursing Service was invited to a meeting in school regarding child GD1. Both the School and the School Nurse would have been aware of younger siblings in this family. It may have been helpful for the School Nurse or the practitioner who convened the meeting to liaise with the Health Visitor as it would have given the Health Visitor an opportunity to share information regarding the younger children's health, development and wellbeing. The Health Visitor was unaware of the concerns raised at school regarding Child GD1. Had the information been shared it might have prompted the gathering and analysis of further information to obtain a wider picture of this family. This could have influenced the decision making process regarding referral and support from other services including specialist services,

- It is not clear from the School Nursing Records whether there was an improvement regarding Child GD1 and whether the improvement was sustained. The School Nurse understood that the School was taking the lead on this particular issue and the plan was for school to contact the school nursing service if their support was required.

- There was consistent contact with staff of STHFT during delivery of maternity and midwifery services, including substantial contact by the midwife from the Homeless and Travellers Services, and no concerns were noted regarding possible evidence of neglect.

<u>Children, Young People and Families:</u>

- There were clear missed opportunities to engage with the family following the first referral from the community midwife. This is a gap in both inter-agency communications as the referral came from health and was passed to the Family Development Project; and in intra-agency communication, as it can be seen that MAST in one locality did not communicate effectively with MAST in another locality, on two separate occasions. It is not known what impact this had on opportunities to identify any neglect and address any safeguarding concerns.
- When MAST intervened as a result of a further referral, the wider, more complex needs of the family were not addressed and the focus of the work was centred on one child's attendance issues in isolation. There was no contact with Adult G. This has been highlighted as a significant gap in services, and improvements described in this Report. As referenced in the previous section, in writing this Report I have reflected on agency awareness and understanding of culture, race, religion and gender, and the impact of that on practice.
- The School had concerns about neglect which led to a meeting being convened by the school nurse. The Review found there was confusion about who would be the lead professional in convening this meeting, and that information was not shared with other agencies, including the health visitor and children's social care. It was not clear that this was a TAC meeting. The parents did not attend the

meeting and this did not lead to further action to engage with the parents. Lessons for the School to learn include clearly understanding and implementing multi-agency procedures.

- This concern about possible neglect appears to have resolved; however, the Review heard that on a later occasion, the children had no money for school dinners, and no food. When a member of staff visited the family home to discuss this, she was kept on the doorstep by Adult GH. This is a further example of lack of contact with mother. There were three key occasions when the School might have had contact with Adult G: at the pre-school visit to the family home; for discussion of concerns about the eldest daughter; and visiting the home to follow up concerns about school dinners. Yet lack of contact with Adult G did not raise a concern. The School should reflect on this practice and consider that one parent may be 'blocking' contact with another parent for a reason, and this could be escalated into a concern using the multi-agency pathways for communication. For example, communicating any of these incidents with the health visitor could have led to an unannounced visit to Adult G. Whilst this may not have resulted in keeping Adult G safer, it cannot be said that it would not have made a difference.

Housing Services:

- No safeguarding issues were observed or reported during the period of contact with housing services. At the time of the homicide, the family was in privately rented accommodation.

Asylum Seeker and Refugee Services:

- The IMR for Metropolitan identified good and regular liaison with other agencies working with the family. Information was shared either through accompanied visits or by regular contact calls.
- Metropolitan identifies that some areas of work were duplicated, where the 'lead' agency not always being evident.
- There was one piece of information within SAVTE, when the tutor may have heard an incident in which a child was being hit. This was not shared within the agency. The Review has found that there is insufficient training or systems within the agency in regard to safeguarding. It is not thought that raising this incident would have led to an intervention, however, if it had been communicated back to the health visitor (who was the referrer) it may have been linked to other data and led to an unannounced visit.

3.2 Faith and Culture:

This Review heard that faith and culture were relevant to the services provided to the family. In this section of the Report, I will be drawing upon the IMRs, on my own research; and on our discussions with a Focus Group when we consulted a group of local women, who represented the faith and culture of the subjects in this case. We

invited a representative of the City of Sanctuary (a local movement which aims to build a culture of welcome and hospitality for refugees and asylum-seekers) to the multi-agency meeting on 4th September, and to subsequent multi-agency meetings, to advise and assist us to consider the issues further.

3.2.1 Faith:

The family's religion is Shia Islam. This faith group is not uncommon within the multi-racial communities of Sheffield where the family lived. There would be local opportunities for integration into the religious life of the community, and I would expect services and their staff to be both representative of this faith, and able to ensure equal access to services for members of the Islamic faith. It is beyond the remit of this Review to consider the faith profile of the workforce; I assume that the demographic profile of the City is either reflected in that workforce, or steps are in place to achieve this. I do not assume that Islamic staff should work with Islamic service users; this would not ensure equal access. This Review has heard that members of faith communities do not necessarily want to work with staff that they identify with their own community because everyone knows everyone else and disclosing abuse or other family problems would be a matter for shame. We are told that Adult G would not have disclosed to a member of her own faith community and that she chose to show her bruise to someone she believed to be of a different faith.

Given that this is a religion in which gender roles are clearly defined it is not remarkable that Adult G was always covered when visible to the outside world. Whilst this might be thought to mask physical signs of domestic violence, there were opportunities when injuries could have been seen; for example, when Adult G was examined at the GP practice, by a female GP and/ or a nurse; during midwifery and maternity. It would be usual for women not to be covered when visited by a female worker, e.g. a health visitor, refugee support worker, or English tutor. No bruising was observed except for the occasion in which Adult G showed her tutor a bruise on her arm, and later, when her tutor noted what she assumed were love-bites and may well have been so.

The Review Team took the advice of colleagues working in these communities, and discussed emerging themes with a women-only Focus Group, in relation to Islam and domestic abuse, and is confident that there is no acceptance of domestic abuse within the faith. This is a faith that sets out the nature of gender relationships and a process for resolving disputes, and it is suggested that Adult GH did not follow the teachings of the Qu'ran by chastising his wife. Adult GH's brother told us that in difficulty the men would seek the support and advice of the *imam* as the worship leader at their local mosque; and Adult GH did not generally do this; instead he confined his religious activities to the home although we were told he sought advice from the Mosque regarding his mental health. Adult G's sister told us that whilst domestic abuse is not permitted within Islam, it is a matter of interpretation and she is aware of the teaching having been interpreted otherwise. In this regard, there

would be nothing to distinguish interpretations of Islam from interpretations of other faiths, in which perpetrators of abuse have been able to find justification for their actions.

Adult GH was said to be a dedicated Muslim whose faith became more prominent in his life once he was in the UK, and that prior to killing his wife, he had isolated himself from his faith community. There is no suggestion that the homicide was motivated by his faith, and although extreme religious expression may have become part of a set of delusions he experienced before the murder, any such discussion is beyond the scope of this Review.

3.2.2 Culture

This family is Kuwaiti bidoon. The word 'bidoon' is from the Arabic and means 'without'. Professor Longva[3] writes: '*Historically, men were recruited from neighbouring countries for the Kuwaiti military (mercenaries) and they were paid well but not given nationality. Following the Iraqi invasion of Kuwait many Iraqi mercenaries were thrown out of the army which created for the first time a group of discontented bidoons. Today's bidoons are found in all walks of life but they and their families continue to be without rights. The bidoons do not have cultural traditions, values and beliefs of their own, different from those of Kuwaitis, Iraqis, Saudis, etc. There is no bidoon culture as such; the bidoon people share the culture of their country. In terms of traditions, values and beliefs, especially regarding cultural practices related to family organisation and relations between the sexes, these men and women are not 'bidoon' but Iraqi, Saudi, Yemeni, Syrian, etc. Most of them however are Kuwaiti, culturally speaking, as they were born and socialized in Kuwait.'*

Refugee International[4] writes on its website that: '*Almost ten percent of Kuwait's population is stateless, known as 'bidoon', and are considered illegal residents. They are refused birth certificates, public schooling, marriage certificates, and the right to peacefully assemble. Bidoon also face barriers to health care; some bidoon can access limited health insurance and others are denied health care altogether… Despite their multi-generational presence in the nation, the bidoon are not recognized as legally residing in Kuwait, and in almost all circumstances, they are not permitted to leave because the government refuses to issue travel documents*.'

Professor Longva notes that Kuwait is a high income country which provides its people with a good level of material comfort and this contributes to a relatively low level of physical violence against women. Professor Longva has not studied the refugee bidoon. Being stateless, having the experience that led to seeking asylum, and having financial hardship and social isolation in this country, may suggest the

[3] Professor Longva, University of Bergen
[4] www.refintl.org

potential for domestic violence could be more significant. This however would not be by virtue of being a bidoon.

The IMRs reflected that there is little knowledge of the Bidoon community within agencies. On a number of occasions IMRs referred to the 'Bidoon culture'; and as we have heard, this would be a status rather than a culture. Staff reported that they believed this knowledge would have helped them to work with the family. As such, there may have been a barrier between services and the family through staff assuming first that they did not know about the family's culture; and secondly, that behaviours may be acceptable within this family's culture. Kuwaiti/ Iraqi culture, represented by this family, is not so uncommon in the local refugee community; professionals would have had knowledge of this. However, being Bidoon does mean the family would have had specific experiences leading to their arrival in the UK. The Bidoon community in Sheffield is very small and recently arrived.

The refugee support worker knew about Bidoons, and it was suggested that this could be equally problematic, as the family would be resistant to working with people closely identified with their own community. Indeed, the service may not have been as effective as it might have been, in that Adult GH placed certain expectations on the worker that may have been based on his assumptions of gender, and made two attempts to disengage. We heard from Adult G's sister that her most important relationship with services was with a white British volunteer of a different faith and culture. It is a complex consideration.

This discussion raises the need for workers to be prepared to find out about the specific needs of individual ethnic groups. The refugee demographic will continue to change in terms of their origin, their reasons for seeking asylum, and their experiences, often traumatic, in their own country. It would not be realistic or achievable for staff to be continually trained in the current refugee profile. This Review has concluded that the City Council could be more proactive in positively promoting and welcoming asylum seekers; it is easy for individual professional workers to research new groups. A suggested way forward, in which staff can easily access information and be able to deliver an accessible service, is included in the overall conclusions and recommendations.

3.2.3 Conclusions about faith and culture:

During this Review, myths about faith, culture and domestic abuse were expressed by staff with a white, British heritage, and staff from an Islamic, Arabic heritage. Professional staff expressed assumptions about faith and gender that may have influenced their work. For example, the lack of attempts to have face to face contact with Adult G; and the acceptance that a visit to the home would not include her. These assumptions contributed to the invisibility of Adult G from services.

There was conflicting practice, such as when Adult GH was asked about domestic abuse because he was presenting with depression, the same professional expressing that domestic abuse is rare in people of the Islamic faith, and more common in communities where alcohol is used. One worker expressed a belief that a level of chastisement is acceptable within this culture. It was not relevant to the case as this worker was not aware of the abusive situation at this time; however, that there is confusion is a matter for concern as it suggests that domestic abuse, when it is suspected in a different faith or culture, may not be challenged.

The conflicting and divergent views expressed by professionals may mirror perceptions of domestic abuse within the community. The trial heard that neighbours on either side of the family house heard assaults taking place in the days leading up to the murder, and heard the murder taking place over several hours. Neither set of neighbours reported these events; one was white British, and the other was Arabic.

These myths are for agencies to reflect on and address. The issue about cultural competence is that staff should be trained to be professionally curious about new groups presenting to the service in order to understand their needs and ensure equal access to the service; and in relation to domestic abuse, to ensure staff at every level is clear that domestic abuse in any language, faith or culture is not tolerated within UK law.

In our discussion with Adult G's sister, she expressed that what was most important in enabling domestic abuse was the values of the family. This applies to all families of all faiths and cultures. In her view, the most important barrier to the disclosure of domestic abuse was in the isolation of women who are part of refugee families, their inability to communicate in English, to understand the law and how they would be helped and supported. Given that she was clear that Adult G could not have disclosed abuse in her own community, because of her isolation, and the shame and prejudice she would have experienced in her own community, her view was that only better integration with British communities would help.

Having considered the influence of faith and culture, as they were expressed by agencies reporting to the Review, I would suggest that it is the migrant status of the family, and not their faith or culture *per* se, that is emerging as the significant theme. The barriers to services for migrant families, given their isolation; language; financial difficulties; poor, often crowded accommodation; psychological and physical health issues arising from their experiences or lack of treatment in their home country; all create a closed and pressurised environment in which violence could either be triggered or could escalate. Added to an individual's predisposition to violence, or a family's tolerance of domestic abuse, these factors can significantly raise the risk of abuse within the household.

3.3 Migrant Families

The following issues were highlighted in this Review, and are common to migrant families. Some have been raised as significant in previous DHRs.

3.3.1 Interpreters

There appear to be a number of barriers to using interpreters. First, the Review heard that there is a shortage of female interpreters – just one was available at the time of the interviews after the homicide; all the others were male. In the view of Adult G's sister, and of the Focus Group, the gender of the interpreter would be a key influence on someone's ability to respond to questions about domestic abuse. Quite simply, Adult G would not have disclosed to a male interpreter.

The Focus Group also reported that interpreters sourced locally may represent the same community as the abused person, again impacting on the ability of a victim to speak freely. This would be relevant to the use of staff as interpreters, for example in the GP practice (although it is not suggested that Adult G would have disclosed, for she was invariably accompanied).

Agencies reported that it was often difficult to source a female interpreter on the telephone when using Language Line. Health staff would generally defer an appointment if a female was not available. The precise extent of this problem is not known and is being monitored as a result of this Review in order to consider what action can be taken.

This case highlighted a linguistic / cultural issue in that the current questions used by health staff in routine inquiry, to ask about domestic abuse, may not be understood by people without English as a first language. It was identified for example that Arabic speakers understand and respond to direct questioning. The questions used in routine inquiry therefore need to be reviewed. Adult GH was asked about domestic violence by his GP using direct questioning, which is good practice. Adult G may not have disclosed; however we will not know, as she was not asked when the health visitor decided that it was not appropriate because of the presence of others during the visit. The relationship with the health visitors was one of the consistent relationships in which this may have occurred.

3.3.2 Support for migrant families

The Review learned that there is no support service for refugees once they move from National Asylum Seeker accommodation, i.e. once they are granted leave to remain as a refugee. Once Adult GH moved from supported accommodation, when he was granted leave to remain, he removed himself from that source of support. There is no ongoing support relating to refugee status, any traumatic experience they may have experienced prior to their journey, and any problems they may have in settling in the UK. Advice would have been available in relation to claiming benefits and Job Seekers Allowance, from Job Centre Plus.

When Adult G arrived, Adult GH and their extended family therefore formed her support network. Health advice and treatment was provided through the GP Service, which we have heard had expertise in language and in working with refugees; and considerable practical support was offered by midwifery and health visitor services. However, there was no targeted support inward to individuals or the household in relation to their migrant status. When the family became homeless, and was referred to the Metropolitan Refugee Support Service in January 2012, support was then offered. There is evidence that there was ongoing financial hardship and social isolation throughout that period.

The Review Team was concerned that Adult G had little direct contact with agencies; for example, the school and school nurse had contact only with Adult GH, as did the worker from MAST. Adult G did have face to face contact with midwives, health visitors, GPs, the refugee support worker and the English tutor. Within these contacts, there were relationships that were ongoing and consistent and which would have provided an opportunity to disclose had Adult G wished to do so.

The health visiting service offered advice to Adult G with the aim of helping her to reduce her isolation from the community. This included referral to English lessons, and a referral to Ready Steady Go to offer not only support for Adult G, but stimulation and development opportunities for the children. SAVTE was an appropriate referral as this service visited Adult G in the home and the health visitor noted an improvement in Adult G's English language skills.

The referral to Ready Steady Go is not considered to be appropriate considering that Adult G did not speak English, could not use public transport, was not allowed out of the home without her husband accompanying her; and as such, no service in the community would have been accessible to her without Adult GH's permission and involvement. It is referenced in the chronology that Adult G did not know her own address, and her sister confirmed that she did not know where she lived. The health visitor may not have been aware of these restrictions on Adult G's movements, which raises a broader question of cultural awareness. It also highlights the need to ensure that there are accessible support services available.

Sheffield City Council is a 'City of Sanctuary' which aims to welcome and provide opportunities for migrant families. The Panel received a presentation relating to the support and services that this entails. In the light of this Review, there is clearly much to be done to achieve the aim of a city of sanctuary to: '*encourage more local organisations to make a public commitment to welcoming and including asylum-seekers and refugees in their activities'*. It is noted in this Review that the Refugee Support Service is no longer funded and I am not familiar with the future plans for support. This is a very complex issue that relates to equality and diversity, community cohesion, and practical support for migrant families.

3.4 Good practice, missed opportunities and hindsight:

3.4.1 Good practice:

This Review identified evidence of good practice, of which the following are examples:

- The proactive approach to domestic abuse by GPs, including an assumptive stance when working with refugees and asylum seekers who have experienced trauma and are presenting as depressed and angry; the use of direct questioning.
- The family received primary medical services that were accessible and culturally sensitive from GP practices experienced in working with refugee families.
- The level of intervention and support by the community midwife, including providing practical support; inter-agency liaison; onward referral for support.
- The level of support provided by the Refugee Support Service (Metropolitan) which sadly is no longer funded.
- Individual agencies have evidenced positive practice examples, for example, Metropolitan uses some pictograms in its leaflets to help convey important messages, including domestic abuse and adult and children's safeguarding.
- There are a number of examples of important support being offered to new migrant families by well-trained, multi-ethnic teams; for example, in GP practices, and in housing and refugee support services in Sheffield.

3.4.2 Missed opportunities:

The abuse experienced by Adult G was never exposed to agencies and therefore there was no opportunity for any of the agencies to assess Adult G's risk using the 'Domestic Abuse Stalking and Harassment, and 'Honour' Based Violence' (DASH) risk assessment tool with a view to appropriate referral to support services as described in *Appendix 4*. With one exception when Adult G showed a bruise to her tutor, the abuse experienced by Adult G was hidden from the view of people outside the household and family. There were however opportunities where there could have been an intervention or other support, and these are described below.

The Review heard that the Health Visiting Service did not make a routine domestic abuse inquiry as required by their policy and practice guidelines because the health visitor considered it not appropriate to do so as Adult G was accompanied at all times by family members. This was discussed with SCNFT during the Review and agreed that 'not appropriate' was not accurate; that it was a professional decision by a health visitor not to seek an opportunity to speak privately to Adult G in order to make the routine inquiry. The midwifery service on the other hand recorded that routine inquiry had been made. The Review has emphasised the importance of finding confidential space to discuss domestic abuse in health and social care settings.

There were signs of neglect in the children. However, these were not clearly evident to any one agency: in the GP practice, issues were masked by infrequent attendances with normal childhood complaints and chaotic presentations. Failure to attend for immunisations and not attending appointments could have alerted the doctors and nurses to discuss the family with the health visitor; however, these potential signs of neglect would not have alerted the professionals to the possibility of domestic abuse.

The Review highlighted that there were communication barriers between the school and the family, and no use of interpreters to enable communication with the family to discuss the concerns about the children.

There may have been evidence of neglect had there been contact with Adult G in relation to the concerns about Child GD1, highlighted by School 2; however there was no such contact and no clear follow-up and resolution of the concerns. It is noted that Adult GH is thought to have actively 'blocked' contact by disengaging with services, and by not allowing access to the house. However, there are indications that the school could have linked information from a number of concerns to form a wider picture of possible neglect; and communicated this to others such as the health visitor. There was a lack of clarity in roles and responsibilities for multi-agency procedures.

The Review highlighted two episodes when MAST and the Family Development Project could have intervened with the family. When MAST did become involved, in the third episode, the service focussed exclusively on one child's school attendance. There was no contact with Adult G. Contact may not have identified domestic abuse; but contact with significant people in a household is an opportunity to develop rapport with families who are in need of support and where they may be other problems. MAST accepts that opportunities were missed to help support this family with all their needs. The IMR author reports that since this case was worked in 2012, significant changes to working practices and the systems and procedures to support these have been developed and implemented. During the timescale of this Review there has been further work by MAST and CYPF management to complete a case study in order to demonstrate that lessons have been learned and that the improvements in the systems, procedures and ways of working are sufficiently resilient to ensure these gaps would not recur.

The introduction of the FCAF (new assessment methodology) as described elsewhere in this Report, means this should not happen in future. However, as members of the Panel have pointed out, this requires that all partner organisations implement the FCAF fully and as the new assessment methodology requires more time to complete fully, this is not a given.

There were events which in hindsight may have alerted a worker to potential domestic abuse, such as Adult G's chaotic presentation at the GP surgery with a number of minor ailments which may be considered a 'calling card' but no injuries were ever observed and there was no reason to make the link.

Adult GH was asked about domestic abuse by his GP and denied this; Adult G was never asked. The family confirmed that Adult G was always accompanied to the surgery and she was only seen without him when she attended with the children. A lesson to be learned would be that where women are always accompanied outside the home, opportunities must be found where they can be encouraged to speak confidentially about their health and wellbeing. Health settings and health professionals are best placed to achieve this.

Both GP practices have access to current advice regarding domestic abuse and familiar with the Sheffield CCG resources but did not have a specific policy outlining responsibilities even though a recommendation was made as far back as Adult A to have a domestic abuse policy.

There may have been a missed opportunity when the Metropolitan support worker closed the case when Adult GH informed her they were planning to move to Manchester. In hindsight we know this was not true, and believe he was trying to disengage. It is accepted that the worker is very experienced and well trained in domestic abuse, and observed nothing to trigger further inquiry. Nonetheless, this shift from client focus (their support needs) to agency focus (closing the case) was considered by the Panel to indicate a lesson to be learned: that it would be good practice to seek to ensure that a family in receipt of support was offered continuing resources, even if that particular agency was not able to provide it. In this case, undertaking some continuity planning with the family may have highlighted that the Manchester plan was flawed and in turn this may have raised the worker's awareness of other issues.

We have heard that Adult G highly valued her meetings with the English tutor and had a good rapport. She showed her tutor a bruise, and whilst we are assured by the family that she would never have disclosed abuse, the absence of pathways and processes at SAVTE clearly did not provide her with an opportunity.

3.4.3 Hindsight:

With hindsight we know that the family had very little contact with external agencies during the last year of Adult G's life and we have speculated that this indicates that her husband was actively disengaging from external services. We are told that he had always been violent towards his wife and that this had escalated when in the UK. Evidence was presented at the trial proving that he assaulted his wife seriously prior to the homicide.

There is evidence that her husband took steps to ensure that Adult G and the family was not exposed to the view of agencies. Lack of contact with Adult G emerged as a pattern during the Review, in that only Adult GH had contact with services outside the home. Whilst the family explained that it is their family's routine that the adult males are responsible for the school pick-up as the mothers have smaller children to care for at home, Adult G became invisible to services during the last year of her life. The chronology highlights that contact with the refugee service ended on 30.1.13; there was no contact with the Health Visiting Service after 29.5.13 (the next automatic contact would have been at the baby's two year check which was after the homicide). The SAVTE worker visited the home until that service came to a normal conclusion in September 2013. The only agency that continued to be in contact was the GP surgery. On 31.10.13 a child made a 999 call believed to have been in error; and on 25.11.13 there was the curious incident at the GP surgery when Adult GH was resistant to an interpreter being involved in the consultation with Adult GHM. This indicates that Adult G had no contact with external people other than the nurse at the surgery, for the final six months of her life. During this time, her presentation at the surgery increased significantly. The IMR author considered whether this might be a calling card, and the Review Team has reflected that the minor illnesses may have been stress-related.

Adult G had no support and social network in the UK beyond her sister. She spoke no English. She did not know where she lived. She did not know her sister was just a short walk from her house. She was not allowed out of the home without being accompanied by her husband, and in the house she was supervised by his mother. She was not known to the school and to agencies that did not visit the home, with the exception of her visits to the GP.

Adult G's sister, and information from other members of the family as reported to the police during the investigation, verifies that Adult GH isolated his wife during the final months of her life. [*Redacted]*; she no longer had her mobile phone; her sister was not able to speak to her on the landline. Adult G's brother told the police investigation that they were increasingly worried for her in the last weeks of her life. We were told that Adult GH had stopped visiting the mosque and taken to praying at home.

It is therefore clear that there was no opportunity for agencies to observe the family during the last 6 months, and no contact with her sister for the last 3 months, of Adult G's life. As referenced earlier, the isolation of Adult G was so complete that, had a member of the family not called the police, the homicide may not have been discovered.

It is not possible to say whether any or all of the lessons and actions set out below, had they been applied earlier in Adult G's life, could have made her safe. Information from the family and from the police investigation and criminal trial, leads me to conclude that her husband's abuse of her was so persistent and determined, and the barriers against her disclosing it so insurmountable to her as a migrant woman, that

Adult G would never have been safe unless she had returned to Kuwait/ Iraq to be with her family. There was no suggestion in any of the information reviewed that this was ever an option for her.

This is not the first DHR where the victim is a woman in a migrant family, and there will be other migrant families in which the adult female is in a similar situation as Adult G prior to her homicide. It is therefore very important that the following lessons are learned, the recommendations noted and the action plan implemented.

3.5 Lessons to be learned

There are a number of lessons to be learned and specific actions to be taken by agencies, which in my view would help to prevent similar events in future. The following lessons to be learned have been identified by the IMR authors, and through discussions with the Review Team, and in the Review Panel. The headings reflect the areas IMR authors were asked to address in the Terms of Reference:

3.3.1 Where can practice be improved in safeguarding victims and managing the risk posted by perpetrators?

Health services:

- A recent study published in the British Medical Journal (O'Doherty *et al*) found that routine screening in high income countries moderately increased detection rates but not referral rates and that there was no evidence that screening increases wellbeing or reduces further violence or causes harm to women and that there was no evidence that universal screening was warranted.
- It is good practice to ask about domestic abuse when patients attend with depression and especially thoughts of self-harm and anger.
- Domestic violence and child neglect are often found together.
- GPs and practice staff need to be aware of the cultural issues relating to asylum seekers and refugees.
- Failure to attend appointments and chaotic presentations can be associated with child neglect and domestic violence.
- It is good practice to record the use of interpreters and who is present in a consultation.
- Health Visitors should routinely enquire about domestic abuse when undertaking family health assessments to complete the family health profile. The presence of family members or friends does not negate this requirement.
- This case highlights the importance of clear documentation when an assessment/ enquiry about domestic abuse has not been possible and the need for further attempts to be made for the assessment/enquiry to be completed.
- We need to continue the inclusion of findings of DHRs, implications for practice and lessons to be learned, in training and updates for Health Visitors, School Nurses and other Community Health Practitioners.

- The findings point to the importance of preparation prior to joint visits when undertaking an assessment together with an interpreter.
- When a safeguarding or child protection issue is raised regarding a school age child, and there are younger siblings in the family, the Health Visiting Service could be contacted by the School Nurse to seek any relevant information that could contribute towards assessment or decision making.
- Health practitioners need to be more aware of the cultural background of families and understand the implications this may have on the children and the family.

Children, Young People and Families:

- MAST has identified a series of lessons learned in this case, which are set out in Section 2, and has detailed a number of steps taken since 2012 that would lead to a different service being provided now. During the Review, MAST undertook an exercise to evidence these improvements.

- The lack of clarity about roles and responsibilities in the school safeguarding system should be clarified by the implementation of the FCAF; CYPF, the lead agency in developing the FCAF, will need to monitor this to ensure that lessons are learned and all agencies have ownership of the FCAF.

Housing Services:

- Missed telephone calls between professionals must always be followed up.

Asylum Seeker and Refugee Services:

- The Refugee Service will consider in future support planning that when families end contact, the Service should cross-reference with other agencies to explore whether disengagement reflects difficulties within the family.

3.3.2 Where can information sharing between agencies be improved?

Health services:

- There could have been better information sharing between the GP practice and the Health Visiting Service; for example when appointments for immunisations were not made for the baby and it was discussed with Adult G but was not communicated to the health visitor. Having access to this information would allow opportunistic reminders regarding immunisation by both the health visitor and the practice.
- This was a vulnerable refugee family who could have been flagged up to discuss at regular meeting with the health visitors.
- The School Nursing Service should liaise with the Health Visiting Service when concerns about neglect are raised at school in respect of an older sibling, as this may have had implications for the younger siblings in the household.

- Health visiting records need to be available to be shared by using electronic systems, rather than handheld records. This would resolve the problem of the health visitor in this case not knowing that the family was known in another locality.

Children, Young People and Families:

- There was evidence that in MAST that one locality was not talking to another. This issue has been raised in an earlier DHR and is addressed in MAST's action point.

3.3.3 There are similarities with other domestic homicides in Sheffield: two previous DHRs and one Serious Incident Review involved people from BME backgrounds and two of these previous DHRs involved recent migrants.

- STHFT references research which indicates that refugees and asylum seekers may require greater resources to access health care appropriately, for example: 'The Health Needs of Asylum Seekers' (Faculty of Public Health) which includes recommendations.

- A previous DHR highlighted that health professionals did not seek confidential space to ask about domestic abuse. This has recurred in this Review in a different health sector, and is therefore clearly still a concern.

SECTION FOUR – RECOMMENDATIONS

4.1 Agency recommendations:

The following recommendations have been put forward by the agencies as an outcome of their investigations and discussions with the Review Team, the Chair and in the Panel.

4.1.1 GPs:

Whilst there is no remedial action to be taken as a result of this particular case, GPs have made the following recommendations to support continuous improvement in relation to domestic abuse:

4.1.1.1 Sheffield CCG to share the learning from this review, specifically around the link between child neglect and domestic abuse, with lead GPs for safeguarding (adults and children), and for the lead GPs in turn to increase domestic abuse awareness within their practices.

4.1.1.2 Sheffield CCG to re-issue the recently developed template safeguarding policy developed for primary care, with practice lead GPs for safeguarding (adults and children), for them in turn to consider adopting within their practices.

4.1.1.3 Sheffield CCG to recommend to practices that GP and health visitor records should be shared where clinical systems allow but concerns should be communicated directly.

4.1.1.4 Sheffield CCG to encourage practices to display domestic abuse posters in GP practices to promote community awareness of the issue and encourage disclosures.

4.1.2 STHFT:

Whilst there is no remedial action to be taken as a result of this particular case, Sheffield Teaching Hospitals make the following recommendation as professional reflection on the findings of this Review may improve the quality of care provision in similar circumstances:

4.1.2.1 When using interpreters to ask women for sensitive personal information such as in “routine enquiry” the gender of the interpreter must be considered. A male interpreter could have an impact on the response.

4.1.3 SCHFT:

The following recommendations specifically address an issue raised in this Review. The concern was about health practitioners addressing domestic abuse where mothers are accompanied by husbands and the husband’s family. This learning is possibly transferable to working with other vulnerable families where the partner or

members of the partner's family are present during home visits and finding confidential space is difficult.

In relation to the **Health Visiting Service**, Sheffield Children's Hospital recommends:

4.1.3.1 Raise awareness amongst HVs of the need to discuss challenging cases with safeguarding children supervisors, so that HVs are supported to manage appropriately situations where an assessment of domestic abuse is difficult. For example where a mother is accompanied by her husband or family.

This would enable alternative ways of enquiring and assessing domestic abuse to be considered. Health Visitors should include routine enquiry regarding domestic abuse in their assessments of families in line with SSCB procedures. SCNHSFT guidance states, "Where making such an enquiry has not been appropriate or possible, the reason should be clearly documented in the health records, along with a plan stating what actions will be taken and how future enquiries regarding domestic abuse will be made".

In relation to the **School Nursing Service**, Sheffield Children's Hospital recommends:

4.1.3.2 Raise awareness amongst school nurses and health visitors of the need to liaise and share information appropriately where there are safeguarding concerns relating to children in the household - school aged and pre-school children.

School Nurses and Health Visitors should liaise to share relevant information including meetings held; the outcomes and plan. The liaison and plan of action should be documented on the SystmOne health record. Consideration should be given to the need for a family CAF to be undertaken as appropriate.

Following discussion with SCHFT, the wider implications for safeguarding are referenced in the Chair's Recommendations.

4.1.4 Children, Young People and Families:

MAST has recognised a number of actions required from the findings of this Review. The Review has heard of considerable improvement in services over the period which negates the need for specific remedial actions. In order to seek independent assurance that the issues raised in this Review have been resolved through those developments, and that systems are now sufficiently resilient to ensure there would be no recurrence, there is a Chair's Recommendation for MAST as follows:

4.1.4.1 Undertake a case study based on the events in the Adult G case and present the findings to the Operational Sub Group of the Local Safeguarding Children's Board. The findings will demonstrate that the missed opportunities to engage with this family would not occur following

the recent developments described in the IMR. Develop an action plan to address any gaps.

This work has been completed during the timescale of the Review and is awaiting sign-off.

MAST's own recommendation is:

4.1.4.2 Incorporate the findings from this Review into training and supervision for workers in order to help them to identify domestic abuse.

There are no recommendations for Children's Social Care.

4.1.5 Housing Services:

There are no remedial recommendations for Housing Solutions, but the Service has made the following recommendations in relation to lessons learned :

4.1.5.1 The archived paper case notes could not be retrieved to inform the author. There is a new ICT system being developed to eliminate this issue which needs to be implemented.

4.1.5.2 Quality checking of decisions by officers is now completed by a more senior officer. It is recommended that this is good practice and should continue as part of Procedures.

4.1.5.3 The use of Supported Family Accommodation for families with a history of a former failed tenancy is recommended as good practice and to be continued to be used.

4.1.5.4 Housing Solutions Officers to receive training to increase knowledge and awareness of:

- Homeless Legislation and Security of Tenure
- Interviewing different cultural groups including using direct questioning
- This is to be assessed within Individual Performance Reviews and one-to-one supervision.

Housing Services had minimal engagement and intervention was as set out in procedures. The following recommendation from Housing Services reflects a lesson learned about inter-agency communication:

4.1.5.5 Procedures will be updated to include the expectation that missed contact between agencies is followed up to ensure that relevant information is shared.

4.1 6 Asylum Seeker and Refugee Services:

No gaps were identified in this Service although there are lessons learned as identified above. As the service is no longer funded, lessons learned cannot be implemented locally. For the purpose of improving services in other areas, Metropolitan identified a number of recommendations, including:

1. Implementing a more individual client focused electronic record keeping system which reflects the individual diverse client's needs instead of a generic housing related system.
2. Review Support Planning and Risk Assessment training to take account of the lessons learned and potential improvements in practice that have been identified in this Report, particularly in terms of follow up where withdrawal from support occurs. Review to be completed by December 2014.
3. In working with other services working with refugees and diverse cultures, Metropolitan will encourage community groups and activities to display domestic abuse advice prominently.
4. All languages & dialects spoken in the area will be reflected in any literature and pictograms used to demonstrate social and cultural laws, particularly with regard to safeguarding and abuse.

Although the Service is no longer commissioned, the Domestic Abuse Strategic Board will include this action plan and request regular updates from Metropolitan.

4.1.7 Police:

The Police recommendation relates to learning lessons when children of non-English speakers use the 999 service:

4.1.7.1 It is recommended that Atlas Court (police call centre) reviews its procedures for 999 and 101 calls involving non-English speakers, and:

a. Where a call is made by a child, an adult should be spoken to in all cases to confirm that police attendance is not required
b. Where appropriate "Language Line" will be utilised to assist in communication
c. Where welfare cannot be established satisfactorily during the call, a police officer should be deployed to conduct a welfare check

Following discussion of these recommendations in the Panel, it is suggested that the Police consider that a child may be alerting them to domestic violence, the perpetrator may be present; and that any response needs to take this into account and ensure the safety of a child as well as any other person in the household.

4.2 Chair's recommendations:

The recommendations from the Independent Chair of this Review reflect the overall findings, having analysed all the IMRs for themes and discussed these with the Review Team, with individual agencies, and the Review Panel. These recommendations relate both to findings where opportunities for interventions were missed, and to where I have identified that services can be further developed to help prevent similar situations in the future.

4.2.1 MAST to complete a case study evidencing that following the restructure and redesign, the opportunities to engage with this family would not recur. Present to the Local Safeguarding Board Operational Sub-Group, by April 2015.

4.2.2 The Domestic Abuse Strategic Board to monitor the impact of the FCAF on the assessment of domestic abuse in families, by receiving a monitoring report from the CYPF member of the Board, in September 2015 and March 2016.

4.2.3 The Domestic Abuse Strategic Board to require all agencies to review systems in place to evidence that:

a) routine domestic abuse inquiries are made of women in migrant families, and
b) supervision and support to complete the task is in place, and used, where practitioners find it difficult to do so.

and to put an action plan in place to address any gaps, by July 2015.

4.2.4 All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.

4.2.5 The Domestic Abuse Strategic Board to organise a workshop with the women-only Focus Group (from this DHR) in order to develop a guideline for services working with migrant families to be able to ask appropriate questions about domestic abuse. The guideline to include:

a) A model script for staff, and guidance as to when this might be appropriate, i.e. when it is necessary to be flexible and culturally aware;
b) Guidance on preparing and using interpreters in domestic abuse inquiries, including ensuring the gender of the interpreter is the same gender as the service user.

4.2.6 Sheffield City Council to review the information on its website regarding City of Sanctuary and migrant communities and ensure that up to date

demographic information is provided about asylum seeker and refugees currently seeking sanctuary in the City. This should be a resource for staff and the public providing up to date information about new migrant groups, by September 2015 and ongoing.

4.2.7 Sheffield City Council to work with City of Sanctuary to develop a plan for improving the welcome to Sheffield for migrant families. In addition to meeting the SCC's own aims of reducing exclusion, this project should demonstrate meeting the key aim from this DHR, of reducing the isolation of women in migrant communities in order that they may feel safer. This will include provision of information about domestic abuse, information and support for women to access English classes. To consult and involve community, voluntary and faith groups in this process. Report on this plan to the Domestic Abuse Strategic Board by September 2015.

4.2.8 The Domestic Abuse Strategic Board to task a meeting with faith leaders to discuss the issues raised in this case and invite participation in the recommendations and the action plan. Of interest in this regard is the current work by the Metropolitan Police Service in developing a women-only initiative with local mosques to address domestic abuse in South Asian communities.

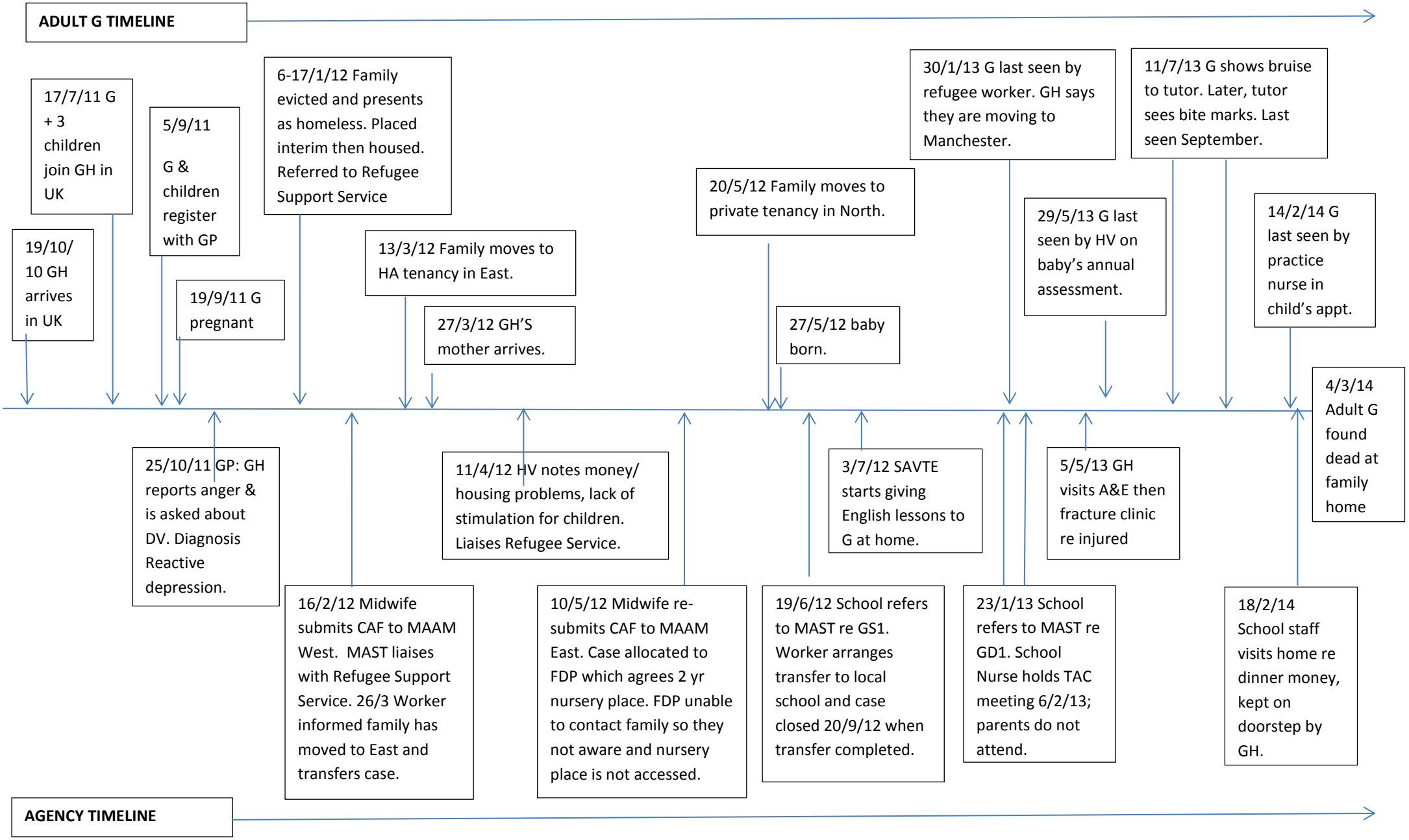
4.2.9 The Domestic Abuse Strategic Board to receive a report from those tasked with actions from the DHR for Adult D which are relevant to Adult G, to ensure these have been progressed, namely to report how migrant women can be referred for support for domestic abuse. It is recognised this wouldn't have helped in this case. However, for future assurance, how will vulnerable people from migrant communities be supported in relation to domestic abuse?

4.2.10 The Domestic Abuse Strategic Board to task an audit of voluntary, community and faith groups to assess awareness of, and compliance with, the domestic abuse pathway, and develop an action plan to address any gaps, by October 2015.

4.2.11 The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing:

- IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and
- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.

APPENDIX ONE: TIMELINE OF SIGNIFICANT EVENTS



APPENDIX TWO: ACTION PLAN

Key to status	
RED	Action Required
AMBER	Preparation Underway
GREEN	Preparation complete and action ongoing
COMPLETE	Action Completed

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status Aug 15	Evidence of outcome
Sheffield Clinical Commissioning Group (GPs)updated 31/07/2015							
Sheffield CCG	4.1.1.1	Sheffield CCG to share the learning from this review, specifically around the link between child neglect and domestic abuse, with lead GPs for safeguarding (adults and children), and for the lead GPs in turn to increase domestic abuse awareness within their practices	The learning from this case will be shared with lead GPs for safeguarding via: 1. the regular communications undertaken with lead safeguarding adult GPs. 2. the regular communications undertaken with lead safeguarding children GPs. 3. the SSCB newsletter. 4. the weekly CCG GP bulletin sent to all Sheffield GP practices. 5. training sessions for lead safeguarding GPs. Lead safeguarding GPs will be advised to share the learning within their practices.	Dr Amy Lampard	Mar-15	GREEN	Communications being drafted. Is in the self-assessment assurance tool.

Sheffield CCG	4.1.1.2	Sheffield CCG to re-issue the recently developed template safeguarding policy developed for primary care, with practice lead GPs for safeguarding (adults and children), for them in turn to consider adopting within their practices	Via all of the above communication methods the link to the template safeguarding policy on SCCGs intranet will be given. Lead safeguarding GPs will be advised of the recommendation and the recommendation made for practices to adopt the policy.	Dr Amy Lampard	Mar-15	**GREEN**	Communications being drafted. Is in the self-assessment assurance tool.
Sheffield CCG	4.1.1.3	Sheffield CCG to recommend to practices that GP and health visitor records should be shared where clinical systems allow but concerns should be communicated directly.	Via lead safeguarding GPs, via the above communication methods, practices will be advised of the recommendation. Additionally this recommendation previously made within Child H SCR. ('the programme to give HV access to the electronic health records of children where GP practices use System one should be completed by Dec 2014. Where GPs do not use System one they should ensure that written or electronic records are available to share with HVs'.	Dr Amy Lampard to make the recommendation to lead safeguarding GPs. Child H SCR recommendation lead Sue Mace	Mar-15	**GREEN**	Communications being drafted. Re the Child H SCR recommendation, a CCG & CSU working group have been created to address any technical and governance issues arising from that SCRs recommendation. Information governance issues have been resolved. Plans to implement procedure for record sharing by end of May 15
Sheffield CCG	4.1.1.4	Sheffield CCG to encourage practices to display domestic abuse posters in GP practices to promote community awareness of the issue and encourage disclosures.	Via all of the above communication methods the recommendation will be made to practices.	Dr Amy Lampard	Mar-15	**GREEN**	Posters on intranet and promoted at assurance visits

All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	To submit data on gender of interpreters used in domestic abuse inquiries (face to face and by telephone) to the DACT 6 monthly - in October 2015 and April 2016 and participate in the development of an action plan to address any gaps.	All	Jul-16	**GREEN**	Plan to do random snapshot of gender of interpreters with a small sample of GP practices over a one week period.
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**AMBER**	Already included in the assurance tool and training on intranet. Awaiting additional support from DACT which can be added to the SA lead GP letter.

Sheffield Teaching Hospitals NHS Foundation Trust updated 30/07/2015							
STH	4.1.2	The gender of interpreter to be documented in the midwifery records at each contact with women when using face to face and telephone interpreter service.	Information regarding recording of the gender of interpreter has been shared by the Midwifery Matrons and Clinical Midwifery educators & is being recording in all midwifery records both community & hospital. This commenced in September 2014 & is recorded manually in the hospital records & is collected electronically in the hand held midwifery records used by the community midwives. Electronic midwifery records were introduced into community at the beginning of 2014 & will be gradually incorporated into all records. Audit to check compliance to be done September 2015.	Marie Reid Community Midwifery Matron Marcia Baxter Labour ward/in patient Midwifery Matron Clinical Midwifery Educators	Jan-15	**COMPLETE**	The information regarding recording of the gender of interpreter is being recording in all midwifery records both community and hospital. This commenced in September 2014 and is recorded manually in the hospital records and is collected electronically in the hand held midwifery records used by the community midwives. The electronic midwifery records will be gradually incorporated into all records..
STH	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	To submit data on gender of interpreters used in domestic abuse inquiries (face to face and by telephone) to the DACT 6 monthly - in October 2015 and April 2016 and participate in the development of an action plan to address any gaps.	All	Jul-16	**GREEN**	STHFT have recorded gender of interpreter in hospital and midwifery hand held records since September 2014.Audit of compliance has been commenced for completion in September 2015.

STH	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**AMBER**	The learning brief from DACT has not yet been circulated however STHFT IMR author has met with midwifery staff involved in care of Adult G and messages shared. Assurances from midwifery team that enhanced training regarding Domestic Abuse has been received. Routine enquiry regarding DA is embedded within midwifery and midwives are developing skills in the use of clear language with non-English speaking families from diverse cultural backgrounds.
Sheffield Children's NHS Foundation Trust (Community) updated 30/07/2015							
SCH FT	4.1.3.1	All attempts to enquire and assess DA should be documented in HV records All discussions with safeguarding children supervisors ; decisions taken and actions agreed should be documented in the children's electronic health records on SystmOne. Chronology of key significant events in the children's records should be updated. Such cases should be reviewed and documented appropriately. Reinforce these messages in the provision of advice; training and Safeguarding Children supervision. Plan an audit of practice on systmOne by June 2015.	The main messages from this DHR have been cascaded appropriately to Practitioners; Line Managers; Service Managers; Safeguarding Supervisors; Trainer and Strategic Managers. Safeguarding Children Audit planning underway.	M. Palawan Named Nurse and Caroline Spencer Safeguarding Trainer	Cascade Information Sept/ October 2014 Plan an audit by June 2015	**COMPLETE**	Record of meetings - team meetings; EIP meetings; HCPLs meetings; meeting between Named Nurse and HV Service Manager. Record of Advice and record of supervision on systmOne. Emails Programmes for Safeguarding Children Training Updates. Outcome of Audit.

SCH FT	4.1.3.2	The liaison and information sharing between HVs and SNs should include safeguarding meetings or Child Protection Conferences held; FCAFs undertaken; their outcomes and plan. All liaison between HVs and SNs including plan of action should be documented in the children's electronic health records on SystmOne. Consideration should be given to the need for an FCAF to be undertaken as appropriate. Reinforce these messages in the provision of advice, training and safeguarding supervision. Plan an audit of practice on SystmOne by June 2015.	06.05.15 Update As above	M. Palawan Named Nurse and Caroline Spencer Safeguarding Trainer	Cascade Information Sept/ October 2014 Plan an audit by June 2015	**COMPLETE**	Emails Record of meetings - team meetings; EIP meetings; HCPLs meetings with HVs and SNs; Meetings between safeguarding team and HV/ SN Service Managers. Record of Advice provided by Safeguarding supervisors and supervision record Programmes of safeguarding children training updates. Audit outcome
All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	The requirement to document in records the Interpreters' gender when discussing domestic abuse has been cascaded to Managers and practitioners. Compliance with this recommendation will be reviewed in planned safeguarding children audit. Findings will be submitted to DACT in October 2015 and April 2016.	All	Jul-16	**Amber**	Record of meetings - team meetings; EIP meetings; HCPLs meetings; meeting between Named Nurse and HV Service Manager. Record of Advice and supervision on systmOne. Emails; Safeguarding Children Update Programme. Outcome of Audit.Health Visiting Record on SystmOne; Learning Brief when available.
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that	The Key messages from this DHR have been cascaded to Managers and Practitioners via emails; meetings; advice and supervision. The messages have been incorporated into safeguarding	All	Oct-15	**Amber**	Record of team meetings and meetings with EIP /HCPLs/Service/ Service Managers. HV Record on systmOne. Safeguarding Children Update

		domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and - In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	children training, including Updates planned later this year. In particular, an understanding of the background of migrant families; their needs and domestic abuse services available locally.				Programme. Outcome of Audit. Learning Brief when available.
CYPF - MAST updated 30/07/2015							
CYPF MAST	4.1.4.5	Conduct parallel report to evidence that the new systems and processes implemented in MAST since this incident would address the gaps in service identified in the DHR. Any remaining developments found to be required will form the basis for further development and training.	Report to be finalised by December 2014 and overseen by Victoria Horsefield.	MAST ASM	Jan-15		Report itself
CYPF MAST	4.1.4.4	Review policies and procedures to ensure they reflect the unique and diverse background of clients and that thes are incorporated in training packages for staff.	Consideration to be given to how training on these issues can be delivered. There is an established group that will be well placed to take this forward for development	MAST ASMs	Sep-15	**AMBER**	Policies/procedures/training
CYPF MAST	4.1.4.6	Incorporate findings from this review into training for staff in order to support them in the identification of DA	DA staff training for MAST workers is in place for MAST workers. eg DASH , MARAC, DHR,	MAST ASM	Apr-15	**COMPLETE**	Training programme to be delivered Mar/ Apr 2015

CYPF MAST		MAST to use female interpreters in DA cases	MAST to record this and incidences where this has been an exception	DA Specialist/MAST ASM	Sep-15	**RED**	data produced from MAST
All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	Discussion with Senior Managers needs to take place as to how this data will be collated and reported	All	Jul-16	**RED**	
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**AMBER**	Key messages from this review are incoporated into regular training and briefing sessions in relation to Domestic Abuse being unacceptable and illegal irrespective of faith or culture of service users.

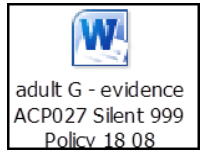
Housing Solutions updated 27/07/2015							
Housing Solutions	4.1.5.1	Implement new ICT system to ensure archived paper cases can be retrieved in future	New IT System that will also save documents and Casework to be implemented November 2014.	Zoe Young	Nov-14		New IT system implemented November 2014
Housing Solutions	4.1.5.2	Quality checking of decisions by Officers is now completed by a more Senior Officer. It is recommended that this is good practice and should continue as part of Procedures.	Quality Checking of Casework where the Council have a Duty to rehouse is in the Procedure Manual and entrenched in Working Practices.	Zoe Young	Oct-14		Quality Checking is in procedure Manual and part of Senior Housing Solutions Officers Role
Housing Solutions	4.1.5.3	The use of Supported Family Accommodation for families with a history of a former failed tenancy is recommended as good practice and to be continued to be used.	Support and Risk Factors for Families are part of the Assessment and will be matched to Supported tenancies as part of the Pathway Plan within the new IT Gateway System being implemented in November 2014.	Zoe Young	Nov-14		Supported Accommodation Pathway Project was implemented Nov 2014.
Housing Solutions	4.1.5.4	It is recommended that Housing Solutions Officers receive training on the Homeless Legislation and Security of Tenure and addressed within Individual Performance Reviews and 1-1s.	E- Learning and Pod Casts in Homeless Legislation is being run for all Housing Solutions Officers to be completed by January 2015.	Zoe Young	Jan-15		Training completed 31.3.15
Housing Solutions	4.1.5.4	Awareness and Training to all staff in Housing Solutions regarding Interviewing applicants using more direct questioning when required. With specific information on equality to ex Asylum Seekers.	Advice on Training and Awareness for this group to be sought.	Jayne Stacey	Jan-15	RED	Briefings to be arranged after DACT circular see 4.2.11

All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	To submit data on gender of interpreters used in domestic abuse inquiries (face to face and by telephone) to the DACT 6 monthly - in October 2015 and April 2016 and participate in the development of an action plan to address any gaps.	All	Jul-16	**AMBER**	Report requested for all DV cases that are not English Speakers.
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and - In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**RED**	Will book sessions when DACT Brief received
Council Housing Service updated 10/08/2015							
Housing Service	4.1.5.5	Ensure staff follow up on missed contacts with other agencies, to make sure that relevant information is shared between services.	update vulnerability procedure and include in staff training/briefings.	Penny Hicks	Oct-15		Procedure updated and included in staff training.

All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	CHS will add a section on the DA form to provide information on the gender of the interpreter and the ethnicty of the applicant. This information will be sent to LPU weekly. DA procedures will also be updated to reflect these changes	All	Jul-16	**COMPLETE**	Procedures and forms amended to reflect changes.
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and - In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Learning brief will be incorporated into staff training and procedure will be updated to reflect the need to question more about faith and culture	Liz Sayles	Oct-15	**COMPLETE**	Training materials have been updated to reinforce the message and prompts added into QA checklists about updating the Interpreter Monitoring Spreadsheet

Metropolitan Care & Support updated 07/08/2015							
Metropolitan	4.1.6.1	Metropolitan to review the requirements of it's new customer-focussed electronic recording system in light of the recommendations in the IMR and shared learning points of the DHR Overview.	Outcomes of the IMR shared with Project Lead for New IT Service Procurement.	Programme Manager			Outcomes shared with IT and with Safeguarding & Risk lead. Included in Board Report for actionable item. Already included in Team Briefings
Metropolitan	4.1.6.2	Support Planning and Risk Assessment training is reviewed to include areas of disguised compliance and withdrawal from support in more detail.	Outcomes shared with Safeguarding & Risk lead. Included in Board Report for actionable item. Training reviewed to include recognition of Disguised Compliance and actions. To be included in Team Briefings	Support Planning and Risk Assessment Training author	Dec-14	**GREEN**	
Metropolitan	4.1.6.3	Services display Domestic Abuse Advice publicity in areas that have community groups and activities.	Circulate local and national information and publicity to all Support Teams..	Team Managers	Nov-14	**COMPLETE**	Outcomes shared with Care & Support Teams, Communications and Safeguarding & Risk lead. Included in Board Report for actionable item. To be refreshed in Team Briefings
All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	Information circulated to all C&S Teams re good practice requirement of gender-appropriate interpreters where DVA is identified or suspected. Item for Team Meetings. Data capture sheets in place	All	Jul-16	**GREEN**	

All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**GREEN**	Domestic Abuse Policy and all DV core training have the principle of DA/DV is the responsibility of the perpetrator not the victim/survivor. To be refreshed in Team Briefings

South Yorkshire Police updated 10/08/2015							
SYP	4.1.7.1	Atlas Court to review its procedures for 999 and 101 calls involving non-English speakers: - Where a call is made by a child, an adult should be spoken to in all cases to confirm that police attendance is not required - Where appropriate it is recommended that "Language Line" be utilised to assist in communication - Where welfare cannot be established satisfactorily during the call, a police officer should be deployed to conduct a welfare check Consideration should be given to the fact that a child may be alerting the police to domestic abuse and the perpetrator may also be present - the safety of the child and any other persons present in the household should be paramount in determining the police response.	Review procedures Circulate via internal briefing system.	Tracy Potter	October 31st 2014		ACPO27 
All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	As reported in February, we are struggling to complete this action due to the volume of incidents including calls and face to face. A query has been sent to Capita (translation) to see if they have any data already gathered.	All	Jul-16	**AMBER**	

All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**RED**	
DACT / DASB 07/08/2015							
DACT / DASB	4.2.2	The Domestic Abuse Strategic Board to monitor the impact of the FCAF on the assessment of domestic abuse in families, by receiving a monitoring report from the CYPF member of the Board, in September 2015 and March 2016.	A monitoring report from the CYPF member of the Board, to be discussed at the DASB in September 2015 and March 2016. Letter sent to Dorne in June and August but not yet had a response	Dorne Collinson	Mar-16	**RED**	

DACT / DASB	4.2.3	The Domestic Abuse Strategic Board to require all agencies to review systems in place to evidence that: a) routine domestic abuse inquiries are made of women in migrant families, and b) supervision and support to complete the task is in place, and used, where practitioners find it difficult to do so. and to put an action plan in place to address any gaps, by July 2015.	Letter to be sent to agencies with learning brief by 17th August	Alison Higgins	Jul-16	**AMBER**	
DACT / DASB	4.2.5	The Domestic Abuse Strategic Board to organise a workshop with the women-only Focus Group (from this DHR) in order to develop a guideline for services working with migrant families to be able to ask appropriate questions about domestic abuse. The guideline to include:a) A model script for staff, and guidance as to when this might be appropriate, i.e. when it is necessary to be flexible and culturally aware;b) Guidance on preparing and using interpreters in domestic abuse inquiries, including ensuring the gender of the interpreter is the same gender as the service user.	Workshop held for women only focus group and guidelines drafted for agencies working with migrant families re. asking appropriate questions about domestic abuse. The guidelines to include:a) A model script for staff, and guidance as to when this might be appropriate, i.e. when it is necessary to be flexible and culturally aware;b) Guidance on preparing and using interpreters in domestic abuse inquiries, including ensuring the gender of the interpreter is the same gender as the service user.	Alison Higgins	Aug-15	**AMBER**	

DACT / DASB	4.2.6	Sheffield City Council to review the information on its website regarding City of Sanctuary and migrant communities and ensure that up to date demographic information is provided about asylum seeker and refugees currently seeking sanctuary in the City. This should be a resource for staff and the public providing up to date information about new migrant groups, by September 2015 and ongoing.	Locality Management service to review the information on the SCC website regarding City of Sanctuary and migrant communities and ensure that up to date demographic information is provided about asylum seeker and refugees currently seeking sanctuary in the City.	Angela Greenwood	Sep-15	**RED**	
DACT / DASB	4.2.7	Sheffield City Council to work with City of Sanctuary to develop a plan for improving the welcome to Sheffield for migrant families. In addition to meeting the SCC's own aims of reducing exclusion, this project should demonstrate meeting the key aim from this DHR, of reducing the isolation of women in migrant communities in order that they may feel safer. This will include provision of information about domestic abuse, information and support for women to access English classes. To consult and involve community, voluntary and faith groups in this process. Report on this plan to the Domestic Abuse Strategic Board by September 2015.	project planned and proposal received from City of Sanctuary to undertake this work. Unsuccessful funding bid to S&SCP in June 2015. Now working with partners to find funding for this work.	Angela Greenwood	Sep-15	**GREEN**	

DACT / DASB	4.2.8	The Domestic Abuse Strategic Board to task a meeting with faith leaders to discuss the issues raised in this case and invite participation in the recommendations and the action plan. Of interest in this regard is the current work by the Metropolitan Police Service in developing a women-only initiative with local mosques to address domestic abuse in South Asian communities.	Meeting arranged with faith leaders	Alison Higgins	Sep-15	**RED**	
DACT / DASB	4.2.9	The Domestic Abuse Strategic Board to receive a report from those tasked with actions from the DHR for Adult D which are relevant to Adult G, to ensure these have been progressed, namely to report how migrant women can be referred for support for domestic abuse. It is recognised this wouldn't have helped in this case. However, for future assurance, how will vulnerable people from migrant communities be supported in relation to domestic abuse?	Letter to be sent to agencies with learning brief by 17th August	Alison Higgins	Sep-15	**AMBER**	Letter to be sent to agencies with learning brief by 17th August
DACT / DASB	4.2.10	The Domestic Abuse Strategic Board to task an audit of voluntary, community and faith groups to assess awareness of, and compliance with, the domestic abuse pathway, and develop an action plan to address any gaps, by October 2015.	Letter to be sent to agencies with learning brief by 17th August - will also ask VAS to help promote engagement with audit. Joint VCF / DACT meeting on DA in planning for autumn which will contribute to this action.	Alison Higgins	Oct-15	**AMBER**	Audit conducted and action plan drawn up.

All agencies	4.2.4	All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.	To submit data on gender of interpreters used in domestic abuse inquiries (face to face and by telephone) to the DACT 6 monthly - in October 2015 and April 2016 and participate in the development of an action plan to address any gaps.	All	Jul-16	**AMBER**	
All agencies	4.2.11	The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing: - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and- In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.	Agencies will ensure that key messages from this review are incorporated into training and briefings. A learning brief will be circulated by DACT to assist dissemination of key messages in agencies, as will information sources re. background and needs of migrant families in the city plus sources of support and services will be circulated.	All	Oct-15	**AMBER**	Learning brief to be circulated by 17th August
SAVTE updated 12/08/2015							
SAVTE	New action added after DHR sub group June 15	SAVTE to develop awareness for staff and volunteers around Domestic Abuse risk factors and local pathways and ensure policies and procedures are adequate in this regard.	Organisation to access training for staff and volunteers on pathways and risk factors in relation to DA	Sara Saxon	Sep-15	**COMPLETE**	Training has been provided (May 15) - and has been embedded into training for volunteers going forward. Referral processes have been updated to ensure fuller background information is sought from referrers. DACT model DA policy has been shared.

APPENDIX THREE: REDACTION FRAMEWORK FOR DHR OVERVIEW REPORT

General principles

1. The DHR's aim is to ensure that a proper analysis of the issues relating to a homicide is obtained which enables lessons to be learned without blame being apportioned. The report is produced in accordance with Home Office guidelines

2. Any redaction within the report should seek to properly balance rights to privacy and confidentiality in a way which does not affect the proper analysis of agencies actions and what lessons should be learned.

3. Information already in the public domain should not be redacted retrospectively unless a specific barrier exists in law.

4. Where information is redacted this should be obvious to the reader. The majority of redactions are likely to be in relation to personal data and will in general require no specific explanation. Redactions other than for protection of personal data should be accompanied by a short explanation (at an appropriate place in the report) unless to do so would in itself place a person at risk of harm..

5. The identities of all professionals, family and associates shall be redacted in accordance with a standard scheme which reveals the professional status or family background, but not the name e.g HV1 for Health Visitor 1; GP1 for General Practitioner etc.

Safety Issues

6. Both Executive Summary and Overview Report will be published in accordance with Government guidelines. The nature of the information therefore entering the public domain may be such that children and Adults may be placed at risk of harm

7. If, in the opinion of the report author, facts which might be included in the report could place an individual at risk of harm then s/he shall redact it to remove such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Sensitive Personal Information, including health information

8. If, in the opinion of the report author, the inclusion of sensitive personal information about living individuals would infringe upon their legitimate expectations as to privacy or their rights to privacy under Article 8 The Human Rights Act 1998 or the Data Protection Act 1998, then s/he shall redact it to remove, edit or amend such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Audit & moderation

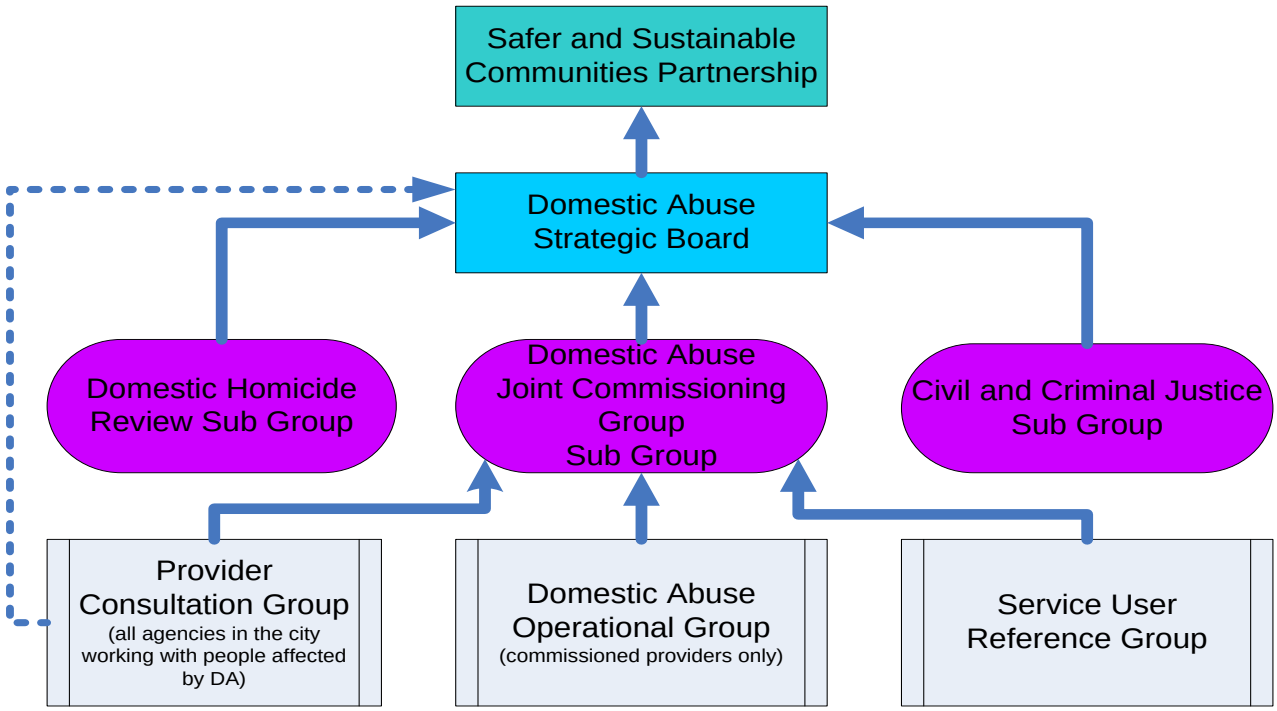
9. The DAP manager shall maintain a list of any such specific redactions which shall be submitted to the DHR review panel for moderation on such frequency as is appropriate to the case.

Redaction framework: DHR: Version 1: dated 29.11.11

Author: S G Eccleston, Assistant Director Legal Services, Sheffield City Council

APPENDIX FOUR: SUMMARY OF DOMESTIC ABUSE SERVICES IN SHEFFIELD

Sheffield Domestic Abuse ORGANISATION STRUCTURE
DIAGRAM OF GOVERNANCE STRUCTURE



Sheffield's domestic abuse governance structure above has been in place since late 2012. A robust commissioning cycle is supported by local needs analysis http://sheffielddact.org.uk/domestic-abuse/domestic-abuse-needs-analysis-2013/. The Domestic and Sexual Abuse Strategy for 2014-17 is available at http://sheffielddact.org.uk/domestic-abuse/resources/local-strategies/.

SHEFFIELD "AT A GLANCE"

In Sheffield 29% of the total recorded violent crime is as a result of domestic abuse; from April 2013 to March 2014 11,638 police incidents were reported, an increase of 1,196 incidents compared to the previous financial year. Of incidents classified as a crime 68% resulted in an arrest. There were a reported 7,209 unique victims; with 2,046 (28.4%) of victims reporting two or more incidents over a twelve month period. VIPER (2012/13) reports that the Sheffield crude rate of sexual offences is 0.65 per 1,000 population ranking 87/326 Local Authorities. During 2013/14 there were three domestic homicides in Sheffield, which is higher than the average of two observed over the last five years (however in one of these years there were no domestic homicides whilst five happened in 2010/11.

The Home Office 'Ready Reckoner' tool estimates that around 10,300 (+/-95% 7,320 to 13,240) women and girls (aged 15-59) will experience domestic abuse over a twelve month period. An estimated 6,741 will be a victim of sexual assault and around 12,131 will experience stalking and harassment in Sheffield each year (based on mid 2011 ONS

Census population figures), with Home Office research (2004) recognising some victims will be a victim of one (around 85%), two (27%) or all three forms (7%) of such violence. The Ready Reckoner estimates that the cost to Sheffield is around £135 million.

Domestic abuse support services are available for women, men, LGBT individuals, all ethnicities and nationality with interpretation services available and there is work on-going to increase the proportion of male and LGBT individuals accessing such support services.

Over the last financial year (2013/14) around 4,900 contacts with support services (standard, medium and high risk, including over 3,400 in contact with the helpline support service). The average number accessing support per quarter has increased in the last financial year; with a current average of 1,239 per quarter in 2013/14 compared to the observed average of 1,059 in 2012/13. Of those accessing domestic abuse support services 25% of those assessed are high risk, 57% medium risk and 18% standard risk (using the ACPO DASH risk assessment tool).

The number of (high risk) cases going to MARAC has increased to 867 in 2013/14 from 546 in 2012/13, this remains lower than the 930 cases CAADA recommends for Sheffield (based on an expected level of 40 cases per 10,000 of the adult female population using police reporting rates and the likelihood of high risk victims of domestic abuse reporting to the police). However, data for the period October 2013 – September 2014 shows that there have been 946 cases discussed at MARAC in those 12 months.

The Council's Housing Solutions service is the front line for homelessness in Sheffield and in the last five years between 2009/10 and 2013/14 -10% of their homelessness presentations were related to domestic abuse, and 13.4% of acceptances were related domestic abuse.

In 2013/14 a total of 296 households were supported via a refuge or supported accommodation provision; with 182 placed in a domestic abuse refuge and 114 in temporary supported accommodation (HIS 2013/14). 37% of these households were women with children and 65% were Sheffield residents.

In 2013/14 169 households left the refuges in Sheffield, of which 81 (48%) went to social housing (council and housing association), 12 (7%) went to private rented accommodation and 21 (12.4%) went to live with family or friends. The remainder, 55 (32.5%) returned home to the partner, returned to their home which the partner had since left or entered into other temporary arrangement including other refuges, friends or family.

Services for adults

Domestic and Sexual Abuse services locally commissioned in Sheffield consist of:

- Medium and Standard Risk Service *(Domestic abuse helpline, Outreach Service, structured group work and service user led support groups)*
- High Risk Service *(Independent Domestic Violence Advocacy service plus specialist training*)
- 2 general needs women's refuges (one provider)
- A young women's accommodation service specialising in sexual abuse
- A floating support service
- A rape and sexual abuse counselling service
- SWOPP - for women attempting to exit from prostitution.

The Isis Sexual Assault Referral Centre based in Rotherham offers forensic examination and crisis support to victims of rape and sexual assault in Sheffield and an Independent Sexual Violence Advisor service.

The Council's Housing Solutions delivers the 'Sanctuary Scheme' which offers a range of security measures to domestic abuse victims that do not want to leave their home but fear the perpetrator might return and inflict further abuse.

The ACPO[5] DASH[6] risk assessment is the nationally recommended tool to ascertain risk levels regarding the adult victim and thus enable appropriate referral to support services. This is also used in order to refer cases to MARAC (the Multi Agency Risk Assessment Conference) if a case is felt to be high risk.

Children and Young People

Children and young people affected by domestic abuse are generally supported through universal and / or Multi Agency Support Teams (MAST) or Social Care services including support for parents. However, it is recognised that specialist support is necessary for some children who have had traumatic experiences and this is impacting on their educational attainment, putting them at risk of becoming involved in anti-social behaviour and / or affecting their relationships in the family or with their peers.

Community Youth Teams and the Youth Justice Service offer support to young people who have or are at risk of offending in relation to domestic abuse and are collaborating to offer group work to young people who are violent to parents. The city also has a Sexual Exploitation Service based in Sheffield Futures.

A post, specialising in children and young people affected by domestic abuse is based within the Multi Agency Support Teams. The post links with the commissioned domestic abuse services in order to ensure children and young people are accessing support as necessary and also, where adults (parents or carers) experiencing domestic abuse are identified by Council Children's Services that they are risk assessed and referred or signposted appropriate to specialist domestic abuse services.

The definition of domestic abuse changed in March 2013 to include 16 and 17 year olds both as victims and perpetrators. Thus the MARAC now accepts referrals from this age group.

Perpetrators

Programmes for perpetrators of domestic abuse are provided by the Community Rehabilitation Company on a court mandated basis. A recognised gap is that there is no commissioned voluntary programme for perpetrators at present in the city although such programmes are by no means common across the country.

Multi agency working

Multi agency processes such as the MARAC are well established in Sheffield and was last reviewed in 2013. A fast track Specialist Domestic Violence Court process is in place across South Yorkshire, accountable to the Local Criminal Justice Board.

Two sub groups of the Domestic Abuse Strategic Board have been established: one to oversee the implementation of Action Plans in relation to Domestic Homicide and Serious

[5] Association of Chief Police Officers

[6] DASH stands for: Domestic Abuse Stalking and Harassment, and 'Honour' Based Violence

Incident Reviews, and one to oversee the multi-agency work in relation to civil and criminal justice including the MARAC.

COMMISSIONING FRAMEWORK

The Joint Commissioning Group reports to the Domestic Abuse Strategic Group. Pooled budgets have been established where possible.

A Provider Consultation Group keeps the Joint Commissioning Group and Strategic Board up to date with developments in the sector and among the client group; a Service User Reference Group exists in order to ensure customer focus.

The Domestic Abuse Strategic Board was established in February 2013 and oversees the implementation of the Domestic and Sexual Abuse Strategy for the city.

ACPO DASH RISK ASSESSMENT

The ACPO DASH risk assessment tool was launched in 2009. The aim of the ACPO DASH model is:

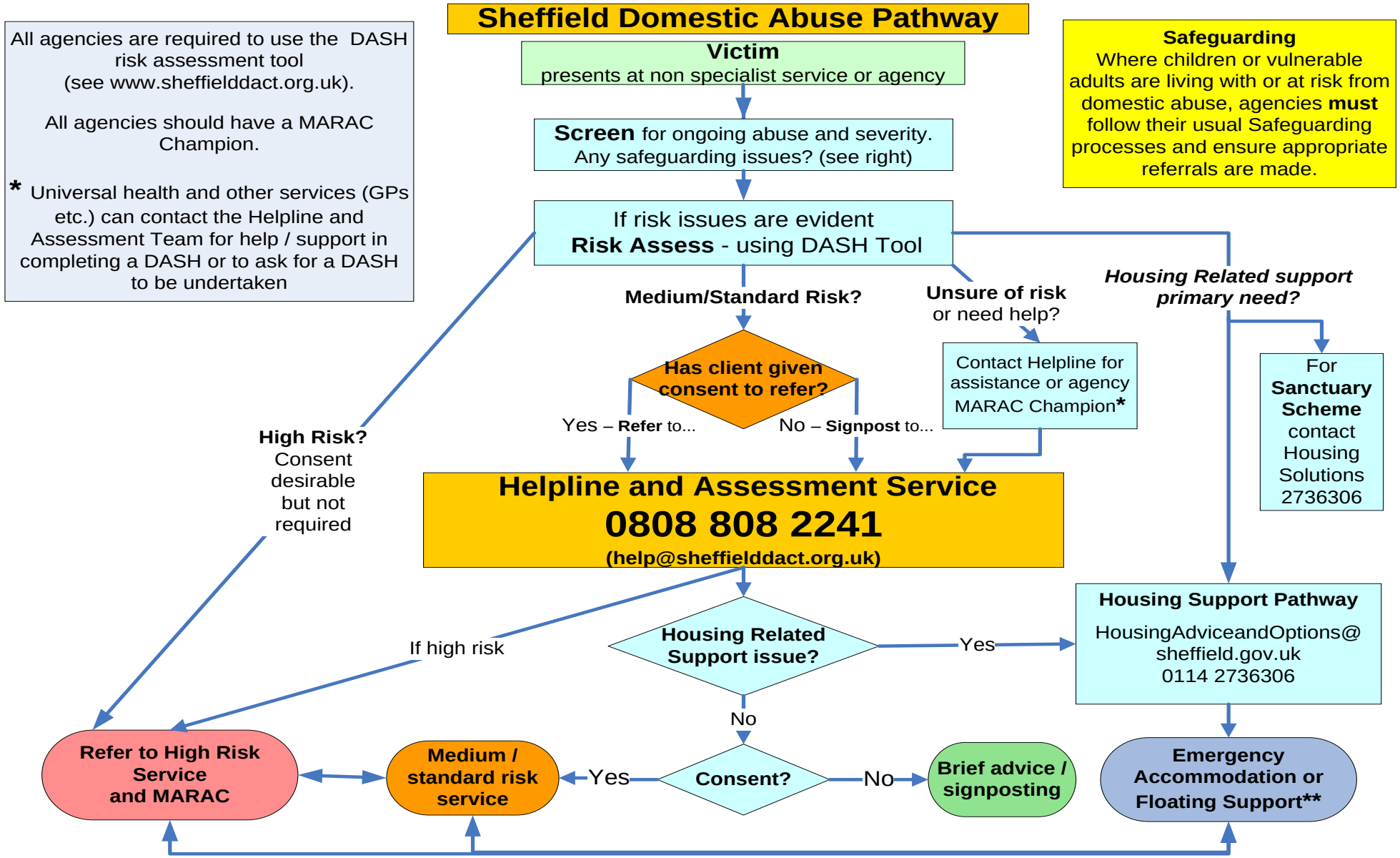
- To save lives through early risk identification, intervention and prevention.
- To create one standardised practical tool to refer cases to the Multi-Agency Risk Assessment Conference (MARAC), to share information and manage risk effectively.

It is intended to be used by all professionals who work with victims of domestic abuse and their children, stalking and harassment and honour based violence.

A key priority for the DACT is to ensure that the commissioned Domestic Abuse training is focussed on identification, risk assessment and appropriate referral to support for victims of domestic abuse.

PATHWAY DEVELOPMENT

A clear pathway has been developed that is promoted to all agencies that may identify domestic abuse. The pathway is aligned in accordance with identified risk levels of clients.


Sheffield Domestic Abuse Pathway
All agencies are required to use the DASH risk assessment tool (see www.sheffielddact.org.uk).
All agencies should have a MARAC Champion.
* Universal health and other services (GPs etc.) can contact the Helpline and Assessment Team for help / support in completing a DASH or to ask for a DASH to be undertaken
Victim
presents at non specialist service or agency
Screen for ongoing abuse and severity. Any safeguarding issues? (see right)
Safeguarding
Where children or vulnerable adults are living with or at risk from domestic abuse, agencies must follow their usual Safeguarding processes and ensure appropriate referrals are made.
If risk issues are evident
Risk Assess - using DASH Tool
Medium/Standard Risk?
Unsure of risk or need help?
Housing Related support primary need?
Has client given consent to refer?
Yes – Refer to...
No – Signpost to...
Contact Helpline for assistance or agency MARAC Champion*
For Sanctuary Scheme contact Housing Solutions 2736306
High Risk?
Consent desirable but not required
Helpline and Assessment Service
0808 808 2241
(help@sheffielddact.org.uk)
Housing Support Pathway
HousingAdviceandOptions@sheffield.gov.uk
0114 2736306
If high risk
Housing Related Support issue?
Yes
No
Refer to High Risk Service and MARAC
Medium / standard risk service
Yes
Consent?
No
Brief advice / signposting
Emergency Accommodation or Floating Support**

DOMESTIC ABUSE HELPLINE

The Domestic Abuse Helpline is the 'front door' for domestic abuse services in the city and is a key service in terms of early identification of people experiencing domestic abuse and prevention of harm. It is available from 8am – 6pm weekdays.

NEW REFUGE PROVISION

A new purpose built refuge was opened in November 2014 to replacing buildings that were no longer fit for purpose. The new building is of extremely high quality and provides 20 units of self-contained flats. The city's refuge provision is now all comprised of self-contained provision – amounting to 34 family units in total.

OUTCOMES

The domestic abuse commissioning plan is intended to help meet the outcomes set out in the Sheffield Corporate Plan (Standing up for Sheffield), relevant Public Health outcomes and the national 'Violence Against Women and Girls' Action Plan. These are:

Sheffield Corporate Plan 'Standing Up for Sheffield' Outcomes:

- A Strong and Competitive Economy
- Better Health and Wellbeing
- Successful Children and Young People
- Tackling Poverty and Increasing Social Inclusion
- Safe and Secure Communities
- A Great Place to Live
- An Environmentally Responsible City
- Vibrant City

Domestic Abuse is a cross cutting theme however as a priority area it sits under Safe and Secure Communities under the theme '*Protecting the Most Vulnerable'*.

Author: Alison Higgins, Domestic Abuse Strategy Manager, Sheffield City Council.

APPENDIX FIVE: GLOSSARY

ACM	Adult and Care Management Service, Communities Directorate, Sheffield City Council
A&E	Accident & Emergency
CAADA	Coordinated Action Against Domestic Abuse. CAADA is a national charity supporting a strong multi-agency response to domestic abuse. Our work focuses on saving lives and saving public money. CAADA provides practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those at risk of murder or serious harm.
CAF	Common Assessment Framework (at the time of writing, the FCAF – Family CAF – is being implemented as an updated approach to whole family interventions).
CCG	Clinical Commissioning Group
CIN	Child in Need
CPLO	Child Protection Liaison Officer
CYPF	Children, Young People and Families Services – this is Sheffield City Council's Children's Social Care Service and is referred to as CYPFS throughout the Report to differentiate it clearly from other Social Care services.
DACT	Domestic Abuse Co-ordination Team – the team responsible for implementing and co-ordinating the Domestic Violence Strategy and commissioning domestic abuse services in Sheffield under the auspices of Sheffield City Council.
DHR	Domestic Homicide Review
FCAF	See CAF, above
FDP	Family Development Project, a commissioned service within CYPFS
GP	General Practitioner
HS	Sheffield City Council - Housing Solutions, Care and Support
IA	Initial Assessment by Social Care

IMR	Independent Management Review
MAAM	Multi-Agency Allocation Meeting
MAST	Multi-Agency Support Team
MIU	Minor Injuries Unit
RFS	Request for Support to MAST or Social Care
SCC	Sheffield City Council
SCFT (AS)	Sheffield Children's NHS Foundation Trust – Acute Services
SCFT (CWAMHS)	Sheffield Children's NHS Foundation Trust - Community Wellbeing and Mental Health Services Division
STHFT	Sheffield Teaching Hospitals Foundation Trust
TAC	Team around the Child, the process in which agencies concerned about a child calls a meeting of those involved with a family, and decides actions, one of which could be a referral to Social Care. Children's Services would be notified of a decision to call a TAC meeting, but would not attend if the family was unknown.
SYP	South Yorkshire Police
YAS	Yorkshire Ambulance Service