# SHEFFIELD FIRST SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# OVERVIEW REPORT

FOR PUBLICATION

January 2016

Victim Adult H

**CONTENTS**

## 1. INTRODUCTION

1.1 The principal people referred to in this report are:

| Title | Status |
|---|---|
| Adult H (H) (Female) | Victim |
| The Perpetrator (Male) | Perpetrator |
| Adult HS1 (HS1) (Male) | Son of H and the Perpetrator |
| Child HS2 (HS2) (Male) | Son of H and the Perpetrator |
| Adult HHF (HHF) (Male) | Father of the Perpetrator |
| Address 1 | Family home and scene of murder |

1.2 H, HS1, HS2, HHF and the perpetrator are British Asian.

1.3 In summer 2014 South Yorkshire Police (SYP) received a telephone call from the perpetrator stating he had stabbed H. Police officers attended address 1 and found H had received multiple stab wounds and she was pronounced dead at the scene. The perpetrator was arrested at the scene for the murder of H. Toxicology tests on samples taken from H did not indicate the presence of either alcohol of drugs. Similar tests on samples taken from the perpetrator indicated that he had used cannabis.

1.4 The perpetrator refused to answer any questions and did not provide an explanation to the police. He was charged with the murder of H and later appeared before a Crown Court. He did not give evidence and pleaded guilty to the murder of H on the basis that she came at him with a knife. His account was rejected by the prosecution. Some weeks later he was sentenced to life imprisonment and will serve a minimum of 23 years in prison.

## 2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

### 2.1 Decision Making

2.1.1 Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) informed the Home Office on 11.09.2014 that the death of H met the criteria for a domestic homicide review (DHR) as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set as 03.2015. This was delayed while the Chair sought to engage with both the victim's family and the perpetrator. The contribution from the family at section 4.1 was received on 18.06.2015.

### 2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author in 09.2014. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. The first of four panel meetings was held on 23.10.2014. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The Panel comprised;

| **Member** | **Role/Agency** |
|---|---|
| ➢ David Hunter | Independent Chair & Author |
| ➢ Paul Cheeseman | Assistant to Chair |
| **Standing Panel Members** | |
| ➢ Jo Daykin-Goodall | Safer & Sustainable Partnership Board |
| ➢ Kevin Clifford | NHS Sheffield CCG |
| ➢ Pete Horner | South Yorkshire Police (SYP) |
| ➢ Victoria Horsefield | Safeguarding Children Board |
| ➢ Simon Richards | Sheffield City Council (SCC) Adult Safeguarding & Quality |
| ➢ Steve Eccleston | SCC Legal Services |
| ➢ Zlakha Ahmed | Independent Voluntary Sector (Co-opted) |

**Co-opted Panel Members**

| | |
|---|---|
| ➢ Max Lanfranchi | National Probation Service Sheffield |
| ➢ Dawn Walton | SCC CYPF education MAST |
| ➢ Edna Asumang | Sheffield Children NHS FT (Acute) |
| ➢ John Tolland | Doncaster Prison |
| ➢ James Scott | Crown Prosecution Service (CPS) |
| ➢ Chris Morley | Sheffield Teaching Hospital |
| ➢ Ronda Ninkovic | NHS Sheffield CCG |
| ➢ Quentin Marris | Addaction |
| ➢ Alison Watts | Her Majesty's Courts and Tribunal Service (HMCTS) |

**Co-ordination Team**

| | |
|---|---|
| ➢ Alison Higgins | Sheffield Drug & Alcohol/Domestic Abuse Coordination Team (DACT) |
| ➢ Helen Phillips-Jackson | DACT |
| ➢ Alison Howard | DACT |

## 2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- South Yorkshire Police (SYP)
- GP (Sheffield Clinical Commissioning Group)
- Sheffield Children's NHS Foundation Trust (SCHNHSFT)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- Addaction (Provider of Sheffield Drugs Intervention Programme)
- National Probation Service (NPS)
- Her Majesty's Prisons (HMP)
- Her Majesty's Court Service (HMCS)

2.3.2 Other agencies provided chronologies and supplied relevant information as requested. When this material is used within the body of this report it is attributed accordingly.

## 2.4 Notifications and Involvement of Families

2.4.1 The DHR Chair wrote to the families of the victim and perpetrator on 28.02.2015 inviting them to contribute. The brothers and sister of the victim were provided with a copy of the DHR report and they gave a picture of their sister in their own words which is incorporated into section 4.1 (paragraphs 4.1.4 to 4.1.9).

2.4.2 A letter was sent to HM Coroner. The CPS and Senior Investigating Officer were present at the first Panel meeting and therefore were aware that the DHR had commenced.

## 2.5 Terms of Reference

### 2.5.1 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;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

### 2.5.2 Timeframe under Review

The DHR covers the period 01.01.1993 to the homicide. The panel recognised this was a lengthy time period to review however they felt there were important issues in relation to the marriage of the couple and the perpetrator's offending history that needed to be explored within the review.

### 2.5.3 Case Specific Terms

1. There are indications that there may have been abuse occurring in the family. However the victim had no known contact with any local domestic abuse agencies. The review will consider whether more could be done in Sheffield to raise awareness of services available to victims of domestic abuse, particularly in BME communities and / or whether there are barriers to accessing services that need to be addressed.

2. The review will consider whether agencies fully considered child safeguarding issues in relation to the family and whether appropriate action was taken.

3. The perpetrator had been released from prison five weeks prior to the incident and has an offending history which includes violent offences. The

review will consider whether his offending behaviour was managed appropriately.

4. The perpetrator had a history of drug misuse. The review will consider whether his substance misuse was managed appropriately.

5. Was there appropriate information sharing between agencies?

6. There are similarities with other domestic homicides in Sheffield: three previous DHRs and one Serious Incident Review involved people from BME backgrounds. This is the second death in 2014 in the same area of the City.

7. The Review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent child and the perpetrator's father.

8. The first language within the family is not English. Although the perpetrator and the sons are fluent in English, the victim was taking ESOL JCP lessons around 2011 - 2012. (English for Speakers of Other Languages) (Job Centre Plus)

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

## 3. DEFINITIONS

3.1 The experiences of H fell within the Government definition of domestic violence which can be found at Appendix A. (Hereinafter referred to as domestic abuse). The structure and governance of domestic abuse services within Sheffield First Safer and Sustainable Communities Partnership is described at Appendix B.

## 4. BACKGROUND - H and her husband

Note: The information in this section is drawn from chronologies, IMRs, family members and friends. Some of it is based upon a voluntary interview David Hunter and Paul Cheeseman had with the perpetrator in a prison. This took place on 08.04.2015 in the presence of his offender manager and offender supervisor from NPS. Information provided by the perpetrator is attributed to him at the appropriate place in the report and is presented unverified unless otherwise stated.

### 4.1 Victim Adult H

4.1.1 H was born in the Punjab region of Pakistan and was the eldest of seven siblings. She came to the UK in 1992 after marrying the perpetrator in Pakistan. English was not her first language and at the time of her entry into the UK GP records describe her use of English as very limited.

4.1.2 The sister of the perpetrator is married to the brother of H and they live in the south east of England. It is known that H travelled to their home with her children and spent extended periods of time there. From analysis of agency records it appears she was resident with these relatives in the home-counties for the following periods;

- 10.2000 to 2.2001
- 1.2002 to 12.2002
- 7.2003 to 9.2008

4.1.3 The victim never reported allegations of domestic abuse to the police. However, there is credible independent evidence that H suffered domestic abuse at the hands of the perpetrator.

**Family Contribution-From the Brothers and Sister of H**

4.1.4 "H was a loving and affectionate mother, sister and daughter. She had the ability to put a smile on everyone's face and a warmth in their heart. She cared passionately for the happiness of others and above all the happiness of her two sons. She was the backbone of our entire family and would guide us all when we were lost or troubled. There could be no situation in life in which the conversation of our dear sister would not administer comfort to our hearts. Wise beyond her years, she taught us to put family before everything, to respect our elders and to love endlessly.

4.1.5 She had so much to look forward to in life – she was enjoying watching her two sons grow into incredible young men and dreamt to see HS1 complete his university education, stand on his own two feet and eventually marry. She was proud of the person HS2 was becoming – wise, caring, respectful and would often call us with details of HS2's latest exam results or school report. She was proud of her sons and dedicated her life to them.

4.1.6 H was just a girl when she married and moved to this country. When our father gave her away 21 years ago, it was on the promise of protection, happiness and a better life. The people we put our faith in broke that promise and ended up so cruelly taking away her life. She suffered abuse in silence for many years, being the eldest she felt a sense of responsibility and never wanted to burden anyone of

us with her sorrows. She tried to break free many times, but would always end up going back for the sake of her two sons and because she would always give everyone the benefit of the doubt, second, third and fourth chances which turned out to be her biggest downfall.

4.1.7 She spent many years of her life living with us in (Place-name redacted), but throughout those years, she felt as though she was a burden on us. Our beloved H, you were a blessing, never a burden - if only you'd have known. If only we'd have done more to stop you returning to South Yorkshire, returning to those who are now responsible for your death.

4.1.8 Words cannot describe the grief and sorrow that took over our world the day she was so cruelly murdered. H was innocent, she wasn't in the wrong place at the wrong time. She was in her own bedroom, in the home she shared with her father in law and her sons.

4.1.9 When we learnt of the way her life was taken, the brutality of her murder, we felt enraged yet helpless. We have been unable to sleep peacefully since the day she was killed. The constant worry and heart ache has changed the whole dynamic of our family. We feel H's loss every single day, but more so at family gatherings or celebrations, which do not feel the same without her. For weeks after she died, I suffered from panic attacks and could not be home alone. I lost trust in everyone and everything. I didn't feel as though I should have the right to continue with my life when my sisters was so cruelly taken. Even now I feel physically sick, emotionally drained and keep wondering how something so terrible could happen to someone so kind. Why is it that despite knowing how dangerous, evil and twisted that murderer was, despite knowing his character, knowing about his violent and criminal past, nobody spoke out. Maybe if they had, H would still be with us today".

4.1.10 The Panel recognised that families often know when a member is subject of domestic abuse; they are told and/or witness the injuries. It is often difficult for family members to report their concerns to the police because they face the same barriers as the victim. Sometimes these barriers may be personal or sometimes they may be systemic. A recent report into the way the police tackle domestic abuse[1] found the reasons those surveyed gave for not reporting domestic abuse were: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent).

## 4.2 Perpetrator

4.2.1 The perpetrator was born in the UK and his parents originate from the Punjab area of Pakistan. He was educated in the South Yorkshire area. The perpetrator said he started missing days at school in his last year there. While he was in the top set for some subjects he said he 'messed up'. He started working as a waiter in restaurants in the city.

4.2.2 His record of work was patchy because of imprisonment. He found that he had an aptitude for poker and became very good at it. He won a number of prestigious tournaments in the UK, Europe and the USA earning sums of money. He travelled

[1] Everyone's Business: Improving the Police Response to Domestic Abuse. Her Majesty's Inspector of Constabulary 2014

to Pakistan in 1991 to enter into an arranged marriage with H and they returned to the UK where they set up home at address 1. The perpetrator said he wanted his wife to be remembered as a person who was kind and had good qualities.

4.2.3 He had a significant history of offending. The offences for which he was convicted are set out in Table One, below, at paragraph 4.2.6. As well as offending the perpetrator was known to have a history of substance misuse. The perpetrator was able to pinpoint the start of his misuse of drugs to a period when his mother was dying in 1993. He said he needed to get his mind off things and he could not eat or sleep. He became addicted to heroin and he also tried other drugs. The perpetrator said he had a really bad habit and described himself as 'messed up' until 2001.

4.2.4 This is supported by the earliest records from 1994 when he disclosed to his GP that he was using heroin. He also disclosed he used cannabis. From the GP records it appears that he started misusing drugs as a young man and continued using them up until the time he murdered H. There is evidence that others knew about his misuse of drugs and also suspected that he supplied drugs to other people. The perpetrator said he did not take drugs after 2001 although he acknowledged he then had a relapse in 2009.

4.2.5 The perpetrator couldn't remember what help he sought for his addiction to heroin in the 1990's. He returned to using the drug in 2009 when he was knocked out of a poker game. However he said he used much less of the drug than he did during his earlier period of addiction. The perpetrator said H was unhappy with his misuse of drugs and he sought help from his GP who prescribed methadone; he said he didn't seek help from any specialist services.

4.2.6 The perpetrator felt he had probably been depressed for a number of years although he did not acknowledge it at the time. Withdrawing from heroin addiction also made him depressed. He said he was given tablets by his GP for the depression he suffered.

| Date | Event | Action |
|---|---|---|
| 27.09.1994 | Possession of Controlled Drug | Sentenced: Fined £50 |
| 14.10.1994 | (1) Burglary Dwelling and (2) Handling Stolen Goods | Sentenced: (1) Community Service Order 80 Hours, and (2) CSO 40 Hours (concurrent) |
| 01.05.1995 | (1) Possessing Class A Controlled Drug with Intent to Supply, and (2) Breach of above CSO | Sentenced: (1) Imprisonment 3 Years, and (2) Resentenced for breach - 6 Months Consecutive Total term 3.5 years |
| 21.06.1996 | Affray | Sentenced: Imprisonment 6 Months (Concurrent to sentence immediately |

| Date | Event | Action |
|---|---|---|
| | | above). |
| 22.05.1998 | (1) Possess Controlled Drug;<br>(2) Handling Stolen Goods;<br>(3) Threatening Behaviour;<br>(4) Assault Occasioning Actual Bodily harm;<br>(5) Breach of Licence | Sentenced: (1) Imprisonment 1 Month (concurrent); (2) Imprisonment 2 Months (Consecutive) ; (3) Imprisonment 2 Months (concurrent); (4) Imprisonment 4 Months (Consecutive); (5) Imprisonment 180 Days<br>Total term 180 Days followed by 6 Months (app. 12 Months) |
| 24.07.1998 | Appeal against the sentence listed immediately above. | Appeal partially successful: Sentence varied to Imprisonment for 6 Months (total term 6 Months) |
| 19.07.2001 | (1) Pervert Course of Justice;<br>(2) Failing to Surrender;<br>(3) Disorderly Behaviour | Sentenced:<br>(1) Imprisonment 8 Months;<br>(2) Imprisonment 1 Month (Consecutive);<br>(3) Imprisonment 3 Months (concurrent)<br>Total term 9 Months |
| 18.03.2011 | (1) Possession of a Firearm with Intent to Endanger Life (13.03.2011), and<br>(2) Possession of a Firearm Without Lawful Authority (13.03.2011). | Outcome of Hearing:<br>Sent for Trial to Sheffield Crown Court on 25.03.2011.<br>Remanded into Custody |
| 14.09.2011 | the perpetrator appears in person for Case Management Hearing. | Outcome of Hearing:<br>Arrangements for trial.<br>Remanded on Bail |
| 05.12.2011 | the perpetrator appears in person for Case Management Hearing. | Outcome of Hearing:<br>Change of Plea.<br>Guilty on Count 1.<br>Remanded on Bail for PSR towards sentencing hearing |
| 09.02.2012 | the perpetrator appears in person for Sentencing Hearing. There is a basis of | Outcome of Hearing:<br>Count 1 - Possession of a Prohibited Weapon (13.03.2011) - Imprisonment |

| Date | Event | Action |
|---|---|---|
| | plea. | 6 Years.<br>221 Days already served to take into account.<br>Second charge of Possession of Imitation Firearm to remain on file. |

**Table One-Recorded Convictions perpetrator -Source HMCS**

## 4.3 H and the perpetrator's Relationship

4.3.1 The information in the following paragraphs was obtained from an interview between the DHR Chair and the perpetrator after his conviction and from material gathered by South Yorkshire Police in connection with the homicide enquiry. The identity of those family members providing that information has been protected.

4.3.2 In 1992 a relative of H was asked to travel to South Yorkshire to make enquiries regarding the background of the perpetrator to see if he was suitable to be married to H who at that time still lived in Pakistan. From enquiries he made in a Mosque he decided that the perpetrator was not of good character. However a decision had already been taken that the marriage should go ahead. After her arrival in the UK this relative would visit H often, but only saw the perpetrator on a few occasions. They were aware H was not happily married, although they say she had a good relationship with her father in law HHF.

4.3.3 This relative saw H with bruises on her face and once with a black eye and they were told by H on more than one occasion that the perpetrator had hit her and caused the injuries. Prior to 2003, H moved to a town in the south east of England to live with relatives on at least two occasions for 2 to 3 months because her life with the perpetrator was so difficult.

4.3.4 In 2003 H telephoned a relative saying that the perpetrator had beaten her badly and that she didn't want to live in South Yorkshire any longer. This relative collected her and HS1 and HS2 from address 1. They recall she had bruises all over her face and was crying. She travelled to the home-counties and remained there until 2009. The periods of time H resided in the home-counties with relatives can be estimated from the gaps in the GP records (see paragraph 4.2.2)

4.3.5 When seen in prison the perpetrator denied abusing H and said he had only pushed her on one occasion about 2003. He said they had argued after he had been to Pakistan as H was not happy as he failed to visit her parents while he was there. The perpetrator said they shouted abuse at each other and he pushed her and she fell and hit her lip. He said it was after this that H called her father and then she left and went to the home-counties. The perpetrator said he had never been oppressive towards H and never stopped her going out. He denied any other reports that he had used violence towards H and blamed some of his family for making things look bad for him. The panel note that the comments the perpetrator made, in which he minimised his abuse of H, were unsubstantiated. In the experience of the panel chair it is common for those convicted of domestic homicide to minimise their abusive behaviour towards their victims.

4.3.6 Although H was domiciled in the UK she maintained regular contact with her family. Another relative describes how she used to speak to tell her family about the perpetrator hitting her, verbally abusing her and treating her as a slave as opposed to a wife. Although there is evidence to show H contemplated divorce from the perpetrator and sought, what she believed to be independent advice, she was eventually persuaded to return from the south east of England to live in South Yorkshire in 2009.

4.3.7 For a period of time in 2011 when the perpetrator was on bail in relation to firearms offences he lived with a relative in the home-counties. During this time H told another relative that the perpetrator had made a threat over the telephone to kill her. He said that he was going to divorce her and told her to leave the house. Shortly after this threat he received a term of 6 years imprisonment in relation to the firearms offence.

4.3.8 When relatives of H visited her and the perpetrator at address 1 after his release from custody and shortly before she was killed, they believed the perpetrator seemed to have calmed down. At that time H told these relatives that she had given HS1, who by that time was a student, an amount of money to buy food and pay rent. The relative believed the perpetrator might become angry and violent if he found out. Another relative says that H had told them the perpetrator had threatened to teach the people responsible for putting him in prison a lesson. H said she told the perpetrator that if he did so she would tell the police. She also said that she would leave him and the UK.

4.3.9 When asked by the Chair what might have been done to help him and prevent the homicide he said he did not know if anything could have been. He felt that when he killed H he was depressed and admitted that he was smoking 'spice'[2] up until the time he came out of prison[3]. He said he and H were getting on well after his release. Following his release he said he used cannabis and drank small amounts of alcohol.

4.3.10 The perpetrator said he and H argued immediately before he killed her. He claimed he could not remember the whole of the incident. The perpetrator said that H had accused him of using drugs and doing nothing for the children. He said he just 'flipped', he said this had never happened to him before.

[2] Spice is the name for synthetic cannabis. It is reportedly a growing problem in UK prisons with serious physical and mental health consequences the chief inspector of prisons Nick Hardwick has said. Its popularity with inmates has surged because the psychoactive designer drug can be passed off as a tobacco roll-up, has no distinctive smell and it evades current drug testing capabilities in prisons. Source: Guardian 15.05.2014

[3] The DHR panel were concerned about the perpetrator's reference to the use of 'Spice' and raised the issue with the DACT Criminal Justice Manager who provided background information that appears at Appendix D establishment.

## 5. THE FACTS BY AGENCY

### 5.1 Introduction

5.1.1 The agencies who submitted IMRs are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

### 5.2 Events Pre-01.01.1993

5.2.1 No information of any relevance has come to light concerning events prior to this date and it appears that H did not enter the UK until 1994.

### 5.3 South Yorkshire Police (SYP) and Her Majesty's Court Service (HMCS)

5.3.1 Table One, above, at paragraph 4.2.6 sets out the convictions that are recorded against the perpetrator. It is not felt relevant to analyse each of these in detail as some do not relate to offences of violence. In addition to his convictions there are other offences he was involved in either as a victim or suspect that are felt to have some relevance and help portray the antecedents of the perpetrator as a man who used and experienced violence.

#### *Affray 21.06.1996 (Date of Conviction)*

5.3.2 On 15.07.1994 Derbyshire Police attended an address in Derby where it was reported that five males, including the perpetrator, had entered a house and argued with the occupant before assaulting him. It is believed that the sister of one of the males was in a relationship with the occupant. H was not convicted of the offence until 1996 (See Table 1) by which time he was already serving a custodial sentence imposed on 01.05.1995 for possession of a controlled drug with intent to supply.

5.3.3 Because of the passage of time detailed records no longer exist and it is therefore not possible to determine whether this may have been a case of so called honour based violence. However, given the circumstances, the possibility must be considered. Contemporary practice in relation to the way in which honour based violence is now identified, recorded and dealt with has changed significantly in the last twenty years. It was therefore not felt appropriate to make a recommendation in respect of this incident.

#### *Assault, Possession of Controlled Drugs and Handling Stolen Goods 22.05.1998*

5.3.4 On 19.09.1997 the perpetrator, with other males, was involved in a disturbance involving door staff at a night club. The victim was punched in the face and received a slight cut. The perpetrator was arrested, interviewed and charged with the offence. On 22.10.1997 the perpetrator was arrested for handing stolen energy tokens and was found in possession of cannabis; it is believed this was a relatively small amount he had on his person while at home. He appeared before the Magistrates' Court on 22.05.1998 and was sentenced to a total of 12 months imprisonment. This was later reduced on appeal.

5.3.5 It has been identified that on the occasion of his arrest on 22.10.1997 a separate report was not submitted by police officers in relation to the fact there were children present in the house. Procedures have now changed within SYP and similar

circumstances would now require the submission of a report (Gen 117) that would be shared with Social Care.

***Foul and Abusive Language 17.02.2011***

5.3.6 On this date the perpetrator was arrested for using foul and abusive language towards police officers at the scene of a road traffic collision. He was not charged with the offence, however he did receive a fixed penalty notice as an alternative. While this is a relatively minor offence it tends to show that the perpetrator could be aggressive even when dealing with persons in authority.

***Possessing a Prohibited Weapon 09.02.2012***

5.3.7 On 13.03.2011 SYP attended a hotel following reports of a person waving a handgun around at a wedding. Police officers attended and enquiries disclosed there had been a verbal altercation during which the perpetrator had produced a gun and threatened guests with it. Another male took the gun from the perpetrator and discharged a round into the ceiling.

5.3.8 The perpetrator was arrested and charged with possession of a firearm with intent to endanger life and possession of a firearm without authority. He appeared before a Magistrates' Court on 18.03.2011 and was sent for trial at the Crown Court and remanded in custody. At some point after this he was granted bail with conditions that he wore a tag and resided in Milton Keynes. He breached the conditions of bail and was remanded into custody again between 16.05.2011 and 20.05.2011 when he was again released on bail. On 14.12.2011 he was arrested by police officers in Milton Keynes for breaching his bail although it is not clear whether he was remanded in custody again. He appeared before the Crown Court and pleaded guilty to possession of a prohibited weapon on 15.12.2011 and was granted bail until he was sentenced for this offence on 09.02.2012.

5.3.9 Again, analysis of this event by the police IMR author, has disclosed that a Gen 117 report was not submitted in respect of this incident. The perpetrator was the father of children and many children were present when a firearm was discharged at the wedding. Consequently Social Care did not have the opportunity to carry out an assessment of the circumstances and the risk to children. Being able to procure ammunition and a handgun capable of firing live rounds is a significant risk factor.

***Suspected Assault by the perpetrator 21.09.2012***

5.3.10 While serving part of his custodial sentence a call was received by SYP from HMP stating that an inmate had been slashed across the face and the perpetrator was suspected of this offence. He was arrested and interviewed by SYP officers and denied responsibility. The perpetrator was not charged with an offence as the victim was uncooperative.

***Assault on the perpetrator 09.12.2012***

5.3.11 A call was received from the same prison, this time stating that the perpetrator had been attacked and had sustained minor cuts to the face. Police officers attended however the perpetrator was uncooperative and no action was taken. The identity of the assailant is unknown however it was suspected by prison staff that the attack may have been retribution for the assault thought to have been perpetrated by the perpetrator on a fellow prisoner 21.09.2012.

***Suspected Supply of Controlled Drugs 19.03.2014***

5.3.12 A call was received by SYP from a person who believed a group of Asian males were involved in supplying drugs outside a hospital. Police officers attended and carried out checks on a vehicle that was involved and established it was registered to H. A search was conducted however the vehicle was not located. Significantly this incident occurred while the perpetrator was on home leave from prison.

**Adult's H, HS1, HHF and Child HS2**

5.3.13 There are no matters recorded by SYP or HMCTS in respect of H, her children or father in law either as offenders or victims of crime.

## 5.4 National Probation Service (NPS) and Her Majesty's Prisons (HMP)

Note: On 31.05.2014 NPS took over from South Yorkshire Probation Trust and references to NPS before this date denote South Yorkshire Probation Trust.

5.4.1 The perpetrator served a number of terms of imprisonment in HMP establishments and had periods of time under the supervision of NPS (formally South Yorkshire Probation Trust). He was therefore known to both agencies. They hold a significant amount of information on him, however only that material felt relevant to this review is set out below.

5.4.2 The Criminal Justice Act 2003 (CJA 2003) provided for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. They are designed to protect the public from serious harm by sexual and violent offenders. MAPPA is not a statutory body and is a mechanism through which agencies operate so as to protect the public. The Secretary of State for Justice issued guidance to help agencies deal with MAPPA offenders and reference to this guidance is made within this report (MAPPA Guidance 2012 Version 4). Any offender subjected to MAPPA arrangements will be assigned to one of three MAPPA management levels. Level One cases are managed by a single agency (also known as ordinary agency management), Level Two by active multi-agency management and Level Three by active enhanced multi-agency management. Section 7.9 of the Guidance reads.

*"The central question in determining the correct MAPPA level is: 'What is the lowest level of case management that provides a defensible risk management plan'."*

5.4.3 The role of HMP is to ensure all MAPPA offenders sentenced to custody are identified following reception and are monitored while in custody through the local interdepartmental risk management team. Amongst other things HMP exchange information, assess the level of risk and manage the risk. They do not allocate a MAPPA management level. This is done by NPS who work with high risk of harm and MAPPA cases that are subject to either a community sentence or sentenced to over 12 months in custody. This includes the management of any period the offender spends on licence after release from custody. Each case is managed in accordance with the level of risk and need presented.

5.4.4 Prior to his conviction for possession of a prohibited weapon on 09.02.2012, NPS only had one other contact with the perpetrator and that related to his conviction in 1995 when he received 3.5 years in custody. All records relating to that matter have now been destroyed. Although he had a number of convictions in between

these dates because of their nature and the length of sentence NPS would not have been responsible for supervising the perpetrator.

5.4.5 A Probation Officer working for NPS prepared a pre-sentence report on the perpetrator and also completed a risk assessment. The perpetrator told the Probation Officer he was separated from H and lived with HHF, HS1 and HS2 at address one. He was assessed as posing medium risk of serious harm to the public and low risk to known adults. The latter included family members, children, staff and prisoners.

5.4.6 The respective definitions are;

Medium- "*There are identifiable indicators of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse."*

Low- *"Current evidence does not indicate likelihood of serious harm"*

5.4.7 Following his conviction and sentence on 09.02.2012 his case was allocated to a Probation Officer who became the Offender Manager (OM) and was based in South Yorkshire. The perpetrator served the early part of his sentence in South Yorkshire prisons. Medium risk cases are allocated an Offender Supervisor (OS) who works in the prison where the offender is based, in this case the OS was a Probation Officer. The OS is the person responsible for completing assessments and referrals while the offender is serving the custodial part of their sentence. Assessments done in the prison identified the perpetrator as a medium risk to the public and low risk to known adult, children, staff and prisoners.

5.4.8 HMP records show that he was assaulted by another prisoner on 09.03.2012. He received no injuries and this matter does not appear to have been reported to SYP. Prison records show he allegedly assaulted another prisoner on 21.09.2012 as a result of which he was placed in the Care and Separation Unit. On 03.10.2012 a bully alert was made active in respect of the perpetrator and an alert was raised in relation to his assessment as at medium risk of causing serious harm. Between 15.10.2012 and 17.10.2012 the perpetrator was moved to an establishment in another part of Yorkshire before returning to the prison in South Yorkshire; positive comments were made regarding his behaviour.

5.4.9 On 09.12.2012 a call was received from HMP stating that the perpetrator had been attacked and had sustained numerous cuts to the face. He attended hospital for treatment however he was uncooperative with any attempt to investigate the matter. Prison staff believed this may have been in retribution for the incident on 21.09.2012. There are no records to indicate that the information about the assaults upon, and by the perpetrator, were shared by either HMP or SYP with the OM from NPS. The perpetrator was transferred to a prison in Hertfordshire on 16.01.2013 and on 15.01.2014 finally to a prison in Suffolk. While there no physical or mental health concerns were noted and he scored 0 on the depression assessment tool. He remained at this prison until his release on licence.

5.4.10 In February 2014 a request was made for the perpetrator to be considered for Release on Temporary Licence (ROTL). Such arrangements are generally put in place when offenders are reaching the point at which they can make a gradual return to the community. They are a means of assessing their capability to comply

with conditions. On 01.02.2014 the prison carried out a risk assessment that showed the perpetrator was a low risk to children, known adults and staff and a medium risk to the public. This was the last risk assessment conducted while he was in custody.

5.4.11 The request for ROTL named H as the contact person at his home address. Until that time the perpetrator maintained he was separated and it is unclear when H returned to address one. The OM wrote to H and on 26.02.2014 visited address one and met her, HHF and HS2. The ROTL process was outlined and the family assured the OM they had no concerns about the perpetrator returning to address one. In the OM's opinion, Adult H seemed to fully understand the discussion despite English not being her first language. An interpreter was not used.

5.4.12 The panel discussed with the IMR author whether, had the OM been aware there was domestic abuse in the relationship, they would have asked to see H alone or used an independent interpreter. The view of the author was that the visit in relation to the ROTL was a standard one to check on the address and not to conduct a risk assessment. The OM could have requested an interpreter if the thought it necessary and they do ask questions about domestic abuse if they are aware of it as a risk. However in relation to this case they were not aware of the domestic abuse.

5.4.13 The perpetrator was ROTL from prison between 17.03.2014 and 21.03.2014. During that time he met his OM at the probation office and said he was *'feeling happy to be home and felt he had settled in well'*. On returning to the prison he was found to have breached the ROTL rules by returning late and being in possession of additional training shoes he hadn't taken out with him. Further ROTLs were therefore cancelled. Neither HMP nor NPS appear to have a record about the incident on 19.03.2014 when it is suspected the perpetrator may have been engaged in drug dealing while in possession of a vehicle registered to H. Neither does it appear SYP shared this information with either HMP or NPS.

5.4.14 During his time in custody the perpetrator did not present any indicators of domestic abuse nor was he assessed for them. He completed courses in victim awareness and assertiveness and decision making. HMP state there was no evidence that he used or was involved in dealing drugs. However he was known to have a substance misuse habit as he was prescribed methadone in prison although he would not engage with any substance misuse services while he was in custody.

5.4.15 The perpetrator was eventually released on licence from prison on 02.07.2014 which was to run until 02.07.2017. He was seen by his OM on the day of his release and a risk assessment was completed. The assessment concluded he presented a medium risk of serious harm to the public and a medium risk to known adults; these being the victims of the offence for which he was imprisoned. He was assessed as low risk to children, staff and prisoners. He was not managed through MAPPA as he was not considered to present a high risk of serious harm. Standard licence conditions were attached and in addition conditions not to contact the victims of the index offence and to attend the Thinking Skills Group Programme. The perpetrator stated he was '*happy to be back in the community and he was looking forward to spending time with his family*.'

5.4.16 The perpetrator reported to his OM on four further occasions before he killed H. These interviews focused on exploration of his index offence (possessing a prohibited weapon- firearm), and how he had settled back in to the family home.

Although he described things as 'good' he did disclose that he was thinking about taking a second wife. Although the details of this discussion are not documented the OM recorded that he had *'discriminatory attitudes'* towards women. He was also said to be in denial in relation to the index offence.

5.4.17 The perpetrator was considered at the time to be someone who did not pose a risk to females but was a medium risk to known adults following the incident when he discharged a firearm at a family wedding. The DHR panel discussed whether NPS should have attributed more risk to the perpetrator than they did, especially as it was felt he showed discriminatory attitudes towards women. The panel were advised that a Serious Further Offences (SFO) review had been conducted by NPS and the author of that identified that these attitudes alone would not be sufficient to raise the level of risk the perpetrator posed to known females.

5.4.18 The panel accepted the professional view of the NPS SFO author and felt the decision not to raise the risk was a reasonable one to make. They then considered whether it would have been good practice to ask both H and the perpetrator if there was any domestic abuse taking place either currently or previously. The panel agreed this question should have been asked.

5.4.19 The NPS panel member said the offender manager did make an appointment to see H. It was felt during this appointment that each family member had the opportunity to discuss any issues. As nothing was disclosed the offender manager was satisfied with the situation. The panel noted that the appointment was made with Adult H and it was Adult H that arranged for other family members to be present. At that time there were no concerns around domestic abuse in Adult H's relationship with the perpetrator.

5.4.20 The panel also considered whether, questions should have been asked when Adult H suddenly returned to Sheffield especially as the perpetrator was in prison and they had been separated for a number of years. The panel felt an opportunity was missed to gain information on why the couple were separated for so long, why Adult H moved back to the city and why the relationship broke down in the first place.

5.4.21 The panel agreed it would have been good practice to see Adult H alone without family members present and with the use of an interpreter to directly ask about domestic abuse. The NPS representative on the DHR panel advised that direct discussions are usually carried out successfully in the home though discussions around domestic abuse may be easier in situations where females are generally seen alone. The DHR panel felt the lesson to be learnt here is that individuals do not routinely disclose information but rather share what they want to, or what they think the interviewer wants to hear. They were assured by the NPS member that lessons and circumstances from this DHR would be planned into future NPS training sessions.

5.4.22 At the final meeting between the perpetrator and his OM they discussed employment. The perpetrator described feeling '*down'* because he had not managed to secure employment. He also expressed a desire to move to London in order to avoid any future contact with the families of his victims.

## 5.5 Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)

### Adult H

5.5.1 STHFT comprises five acute hospitals and adult community services. H was seen by seven separate clinical specialities or subspecialties during the period of this review and therefore only those most relevant are considered.

5.5.2 H made three presentations to Accident and Emergency (A&E). The first of these was on 10.04.1998 when she reported pain in her coccyx following a fall from the arm of a sofa. She was prescribed medication and discharged. On 02.01.2009 she presented with earache and was diagnosed with a viral infection.

5.5.3 The most recent presentation at A&E was on 17.06.2010 when H injured her left wrist stating she had fallen the previous day. Agency records indicate the perpetrator was not in custody at this time. She said she had put her hand out to break the fall. She was examined and a "flake fracture triquetral" diagnosed (the collective name for the eight small carpal bones of the wrist). A plaster of paris back slab was applied and she attended a number of follow up appointments. Records show she was not working and was being helped by her sister-in-law.

5.5.4 H attended the General Practitioner Cooperative on one occasion (13.01.2002) which at that time was based at one of the STHFT sites. She telephoned at 22.04hrs and complained of chest pains. She was transported to the site and gave a history of pain on the right side of her chest for the past two days associated with a cough. She was diagnosed with muscular chest pain, given medication and discharged with no follow up. The records show the perpetrator was not in custody at this time and had been released from prison in 11.2001.

5.5.5 In 1998/1999, Adult H attended a number of appointments with the obstetric service situated at the Northern General Hospital in connection with her pre and postnatal care. She gave birth to Child HS2 and was described as "a confident mother". No cause for concern was identified in relation to her social or domestic circumstances.

5.5.6 H made further presentations to this and other Departments within STHFT during the period under review the details of which are not considered relevant to this report. On one significant gynaecological presentation in 2003 it is recorded that she was supported by her husband (the perpetrator) who acted as her interpreter.

5.5.7 The panel member representing STHFT was asked about the use of the perpetrator as an interpreter. He explained that this clinical intervention took place at the Central Health Clinic which was then managed by The South East Sheffield Primary Care Trust, not STHFT. He is not aware of what this service's practice was in relation to the use of interpreters at this time. He reports however, that whilst professional interpreter services were available and widely used within STHFT, it would have been more common to use family members as interpreters. This was because the interpreter services were less accessible than they are today and clinical staff were less aware of the importance of this issue. However, professional practice has moved on significantly and this would definitely not happen now. The panel agreed that it needed to be careful not to apply the standards of 2003 to 2015.

**The perpetrator**

5.5.8 The perpetrator made nine presentations to A&E. Again only those felt to be of most relevance are discussed in detail. On 29.03.1999 he presented with superficial injuries and a human bite to the left side of his trunk following an alleged assault.

The wound was cleaned and dressed and he was given medication. There is no indication the police were involved in this incident.

5.5.9 On 05.03.2003 the perpetrator was referred by his GP with an abscess in the right groin which was incised and drained under local anaesthetic. The IMR author reflects that, with hindsight, this injury could have been evidence of intravenous injection of drugs. Finally the perpetrator made two presentations following road traffic collisions on 13.11.2003 and 22.10.2010. Neither of these disclosed significant injury and on both occasions he was discharged the same day. The perpetrator was referred by his GP to two other Departments within STHFT neither of which are relevant to this review.

**Adults HS1 and HHF**

5.5.10 STHFT are satisfied they have no information relating to HS1 or HHF that is relevant to this review.

## 5.6 Milton Keynes Hospital NHS Foundation Trust

5.6.1 Enquires here disclosed that only H had contact with the hospital and had two appointments following referral by her GP. These were on 20.06.2008 and 08.08.2008 for matters unconnected with this review and nothing of relevance was disclosed. Neither the perpetrator, HS1, HS2 nor HHF had any contact with this hospital during the period under review.

## 5.7 NHS Primary Care (GP and Addaction)

**Adult H**

5.7.1 All of the subjects within this review were registered at a GP practice in South Yorkshire. H registered when she arrived in the UK in 1994. Since then she attended on a number of occasion which are described by the reviewing GP as unremarkable and she notes that H attended with vague symptoms and minor viral illness although not at an excessive rate. Therefore only matters of any relevance to this review are included.

5.7.2 In March 2003 she was referred by her GP to STHFT for a significant gynaecology procedure (see paragraph 5.5.6). This episode is analysed in more detail within section 6. Later that year she was noted as travelling to Pakistan with the perpetrator. She told her GP in 2006 that she had been separated from the perpetrator for two years and she spent periods of time registered with another GP practice in the south east of England.

5.7.3 In 06.2010 H suffered a left wrist fracture which is recorded as being from a fall in the park. This corresponds with a visit she made to STHFT for a similar injury (see paragraph 5.5.3). She attended the surgery two months later with wrist pain and her hair falling out during which she was recorded as being accompanied by her sister in law who interpreted for her. The GP who saw her noted that stress could have been the cause of these symptoms. In 01.2011 she attended with hip and lower back pain following an unspecified fall. There is no corresponding entry within A&E records relating to this injury nor is the cause known.

5.7.4 In 01.2012 H attended her GP surgery with a friend complaining of depression for several months and stated that her husband had been in an altercation and was due in court. It is presumed this related to the discharge of the firearm on

13.03.2011. She was prescribed anti-depressants and reviewed two weeks later when her mood was described as OK. On these occasions she told the GP she was not living with the perpetrator and on a routine visit in 2013 said he was in prison. There are no further references to mental health after this time and she was not prescribed further medication. Her final GP attendance was on 22.05.2014 when she attended complaining of sore gums, hay fever and a lump on her leg.

**The perpetrator**

5.7.5 Most of the perpetrator's relevant history relates to substance misuse. On 24.10.1994 he admitted to his GP that he had been using heroin for 4-5 months and he was started on methadone. He was then seen regularly over the following two months. On 14.12.1994 it was noted that he was *'getting addicted to methadone'.* However he was not seen at the South Yorkshire practice again until 13.03.1997 when he informed the GP who saw him that he had been given antibiotics while in prison.

5.7.6 Between then and 19.04.2002 there were no obvious gaps or significant attendances. However he disclosed to his GP on that visit that he was smoking £50 to £100 of heroin per day. He was referred to substance misuse services. However he did not engage with these services and instead continued to receive treatment for his addiction from his GP. On 05.11.2002 he told his GP that he had been using heroin and cannabis for around eleven years although he denied injecting it. This explanation is questionable given the groin injury he presented with (see paragraph 5.5.8). He claimed to have been 'clean' and said he wanted to stay off drugs. On 28.11.2003 he was noted as having sworn and been rude to the receptionist at his GP practice and again admitted using cannabis but not any other drugs.

5.7.7 On 15.10.2009 the perpetrator admitted he was smoking heroin again and he was prescribed suboxone, this caused side effects and he was then prescribed methadone. Although the GP records show he claimed to have spent a short time in prison in 2009 this is not borne out in the criminal justice records. The GP records show that he was seen upon on 8.12.2009 at which time he was still using methadone.

5.7.8 On 22.12.2009 his attendance notes indicate that he is *"not doing well"* although there is nothing to explain what this means. His GP records show that he was still smoking heroin in addition to the methadone that his GP was prescribing. He was also diagnosed with a depressive disorder on 02.02.2010 and it was noted that he did not appear to be looking after himself. He was prescribed the antidepressant drug sertraline and this was changed to mirtazapine in 05.2010. Illicit use on top of his prescription with co-morbid mental health indicates he had needs beyond those which the GP could meet and as such should have been referred to specialist substance misuse services.

5.7.9 He was still being prescribed methadone and mirtazapine when he was remanded in custody as the notes record a call from prison on 18.03.2011 regarding his methadone use. When he was released on bail on 23.05.2011 the records show that he was being prescribed supervised methadone of 10ml.

5.7.10 Addaction Drug Intervention Programme is commissioned by the LA to enable offenders to address their drug misuse and facilitates treatment for adults completing a statutory order or on a voluntary programme. They received a fax from the South Yorkshire Prison Counselling, Assessment, Referral, Advice and

Through Care services team (CARAT) on 22.03.2011 outlining that the perpetrator declined to use their services and instead was accessing substitute prescribing from the clinical team in the prison. The perpetrator declined the services of CARAT for a second and final occasion on 27.04.2011.

5.7.11 Addaction records show that on 08.09.2011 the perpetrator completed a referral at their centre in the community in order to facilitate continued prescribing if released from custody. Although on bail from the Crown Court the perpetrator then failed to attend appointments with Addaction and despite numerous attempts he did not engage and was discharged from their service on 30.09.2011. This would seem to indicate that, when not in custody, the perpetrator preferred to address his drug misuse directly with his GP. This was not necessarily the most clinically appropriate route for the perpetrator and agencies should use specialist commissioned pathways when addressing substance misuse with clients.

5.7.12 The last entry on his GP record relates to an A&E attendance in 12.12.2012 with lacerations to the face. As he was serving a term of imprisonment at this time it is highly likely this related to the assault on him by another inmate described earlier.

5.7.13 The perpetrator only mentioned his children on a couple of occasions when he saw his GP and there are no specific records to show that safeguarding issues were considered. However on the notes of HS2 there is a reference to 'Safeguarding concern-dad, drug user? There is no record within the perpetrator's GP notes that domestic abuse, or the signs of it, has ever been discussed or considered.

**Adult HHF and Child HS1**

5.7.14 Although HHF and HS1 were included in the original Terms of Reference they are not included in the GP IMR because there are no consultations relevant to this review.

## 5.8 Sheffield Children's Hospitals NHS Foundation Trust (SCHNHSFT)

5.8.1 HS1 was known to SCHNHSFT, however because of archiving no detail relating to contact he had is now available. HS2 was known to SCHNHSFT and was presented there on four separate occasions at their Emergency Department. The panel has looked at these presentations and, in light of the terms of reference, is satisfied there is nothing of significance to this DHR.

## 5.9 Education

5.9.1 HS1 and HS2 had been registered at Primary and Secondary Schools in both South Yorkshire and the south east of England since 1998. Movement between the areas corresponded with H moving between the two locations. No safeguarding information was transferred between the two respective authorities. There is no information of relevance relating to HS2.

5.9.2 Three months prior to the homicide of his mother HS2 received a fixed term exclusion from school for four days for a physical assault on another pupil. This occurred just over 2 weeks following the perpetrator release from prison. The school have been asked whether they considered this when excluding HS2. They

stated they had no knowledge at that time that the perpetrator had been serving a prison sentence or that he had been released, and therefore could not consider it a factor in his behaviour or their response. An agency recommendation has been made in relation to this issue.

## 6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in **bold** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one terms and where that happens a best fit approach has been taken.

### 6.1 There are indications that there may have been abuse occurring in the family. However the victim had no known contact with any local domestic abuse agencies. The review will consider whether more could be done in Sheffield to raise awareness of services available to victims of domestic abuse, particularly in BME communities and / or whether there are barriers to accessing services that need to be addressed.

6.1.1 There is independent evidence that H was the victim of domestic abuse at the hands of the perpetrator over a number of years. This information was known to members of both families. The perpetrator had a long history of offending and had a reputation that caused fear amongst some members within his community. It maybe that the domestic abuse H suffered at the hands of the perpetrator was known outside the families and in the community.

6.1.2 The panel was assisted with expert support from Apna Haq, a charity that provides confidential one to one support for Asian women and their children who are experiencing violence in the home. The panel discussed the relationship between H and the perpetrator. It was explained to them that if a family are poor they might accept any offer of marriage for a daughter. This may explain why the advice the relative in the UK gave, that the perpetrator was not suitable, was not taken up by the family in Pakistan.

6.1.3 The panel also considered why H was persuaded to return to her abusive relationship with the perpetrator. It was explained that the role of a woman is often seen as keeping the family together. Pressure to return to an abusive spouse can be intense and can go on for many years. The panel recognises that these issues are not confined to Asian or Muslim families.

6.1.4 The panel also consider that a significant issue behind the reason H chose to return to the perpetrator maybe that she received advice from within her community, from leaders or specialists in law that was not wholly independent. Rather than having the safety and well-being of H at the forefront, which commissioned independent domestic abuse providers would consider, the advice H actually received may have misguidedly been based upon the traditional role of the woman in her community and issues of respect, shame and honour.

6.1.5 In relation to the perpetrator his history of offending and drug misuse was well documented in official records and also probably well known in the community. This may have been one of the reasons why he was not considered suitable to marry H in 1992. The panel also discussed this issue and received advice that, in some families there may be a view that getting married and having children will calm someone down and make them change their ways. Such a misguided view may again have given precedence to traditional views before the more importance issue of the risks to the woman who is about to enter into that marriage.

6.1.6 The panel also considered the role of the community and agreed that, if there was information or a suspicion that H was the victim of domestic abuse, they have a responsibility to do something. While this review has considered families from a

Pakistani background, such a responsibility applies to all communities within the UK.

### 6.2 The review will consider whether agencies fully considered child safeguarding issues in relation to the family and whether appropriate action was taken.

6.2.1 The panel has looked carefully at the circumstances in relation to HS2 presentation at the Emergency Department with injuries. They are satisfied there was nothing significant in these presentations in relation to this DHR and that contemporary practice was applied. The panel has no concerns about the way in which they were dealt with although it recognises that the way in which safeguarding is considered in respect of such injuries has changed significantly since then.

6.2.2 In 1997 SYP held information that the perpetrator misused and kept controlled drugs at address one as he was arrested there while in possession of cannabis. A referral was not made by the officers in respect of HS1 who at that time was the couple's only child and was living at the address. This was a shortcoming however it is accepted that much has changed in the intervening years and procedures now exist to ensure there is more certainty that such information is captured.

6.2.3 The events of 13.03.2011 when the perpetrator had possession of a loaded firearm that was then discharged in a public place, were much more serious than any of the other offences he had been involved in before. By that time the procedures for capturing and sharing information around safeguarding were much more robust. It is therefore a shortcoming that a Gen 117 was not submitted immediately after this incident. The officer concerned should have recognised the possible impact that having a parent involved in such criminality had on a child. Had this form been completed, it would have been shared with Social Care and an assessment or multi-agency conference convened. This was a missed opportunity to intervene with the family and possibly an opening to speak with Adult H to enquire about her experiences.

6.2.4 While criminal justice agencies knew something about the perpetrator's misuse of drugs his GP had by far the most comprehensive information and records. As mentioned earlier there was an entry in HS2's records from 2009 about the perpetrator being a drug user which is an example of good practice in cross referencing. However as the IMR author opines *'the combination of heroin and cannabis use, methadone prescribing (especially when not on supervised ingestion), his forensic history and antidepressant prescriptions should have triggered an enhanced awareness of potential adult and children safeguarding issues in the rest of the family members'.* The fact this did not happen and that the perpetrator was also not referred into more suitable treatment for his drug misuse was a missed opportunity and similarly displays a lack of professional curiosity.

6.2.5 The GP who prepared the IMR is not able to tell from the records she saw how seriously children safeguarding issues were considered at the practice. She was told that it is routine to code the children of methadone users however it is not known whether the notes of the children and spouses' are reviewed for possible past incidents or consultations which might trigger further investigation into risk. In 2010 for example H fractured her wrist and complained of back, hip and arm pains. At the same time the perpetrator was prescribed antidepressants, had possible financial pressures and had been described as unkempt. However there is nothing

to indicate that the GP involved sought to establish whether or not these matters were connected and therefore rule in or out the possibility of domestic abuse.

**6.3 The perpetrator had been released from prison five weeks prior to the incident and has an offending history which includes violent offences. The review will consider whether his offending behaviour was managed appropriately.**

6.3.1 A Serious Further Offences Review (SFO) is being undertaken by NPS in relation to the release of the perpetrator and his commission of a murder. This will review in much more detail the way in which NPS and HMP managed the perpetrator. However, based upon the information that this DHR review has been provided with, it appears that both NPS and HMP largely followed policies and guidelines in respect of the management of the perpetrator although there are some shortcomings.

6.3.2 The perpetrator was allocated both an OM and an OS from the point at which he started his sentence. An initial assessment done in the prison by the OS identified the perpetrator as a medium risk to the public and low risk to known adults, children, staff and prisoners. When the perpetrator was being considered for ROTL in 02.2014 the OM made enquiries and visited the family home and spoke to H, HHF and HS2 to establish how they felt about his release and no concerns were raised. When the perpetrator was finally released on licence on 02.07.2014 a full assessment of risk was completed that concluded he was medium risk to the public, medium risk to known adults (the known adults being the victims of the original offence) and low risk to children, staff and prisoners. Appropriate conditions were attached to his licence to protect those victims of the index offence. The perpetrator was seen at regular intervals by his OM between release and the commission of the murder of H and there was no information disclosed by him that appeared to alter the risk he posed.

6.3.3 The DHR panel has discussed whether other information that was available, relating to the perpetrator, should have been considered in reaching the assessment as to the risk he posed. The first piece of relevant information concerns an assault he allegedly committed on another prisoner on 21.09.2012. It does not appear that this incident, nor the assault on the perpetrator that was believed to be a retribution attack on 09.12.2012 were known to the OM. They did not therefore inform the risk assessment. Had this information been known then its impact would most likely to have been in respect of the risk he posed to other prisoners rather than his wife and family or prompted enquiry as to domestic abuse at home.

6.3.4 The panel discussed the fact that, while it was believed that the perpetrator had assaulted another prisoner while in custody and was assaulted himself, this did not appear to have influenced the level of risk he posed. The panel noted that information gathered in prison is not routinely shared with NPS. They concluded it was reasonable that these matters would not have impacted upon the risk assessment of the perpetrator; the incidents may have increased the risk to other prisoners but not the risk the perpetrator posed to the wider community on his release.

6.3.5 SYP did make information available to the OM on 20.08.2012 concerning the perpetrator criminal associations. It is not clear what bearing this had on the risk assessment that was carried out nearly two years later. This information did not relate to his family nor H. On its own it therefore did not appear to increase the risk

to H. However it was of some relevance in that it helped inform a broader picture of the perpetrator criminality and escalation beyond what had previously been low level offending.

6.3.6 The final piece of relevant information concerned the use of a car registered to H being used in alleged drug dealing on 19.03.2012. It does not appear this information was passed by SYP to NPS and SYP did not appear to know that the perpetrator was in the community and on a ROTL at the time. On its own this information did not appear to change the risk to H and because SYP did not know about the ROTL presumably the information about the incident was not passed back to OM.

6.3.7 While not affecting the specific risk to H this information would again help form a broader picture of the antecedents and behaviour of the perpetrator. However it would have needed much more development before it could have been specifically used to take formal action against the perpetrator either for a substantive criminal offence or in respect of his ROTL. Had SYP been aware at the time that the perpetrator was ROTL it might conceivably have escalated their response and the resources they committed to the information. For example they may have undertaken a home visit to see the perpetrator which could have led to his arrest.

6.3.8 The important issue is that all of this information might have helped present a different picture of the risk that the perpetrator posed. This in turn may have led to the perpetrator being made the subject of MAPPA arrangements. Such arrangements would have increased the knowledge base agencies had about him and to the tactical actions that could be taken to manage his risk. However, even if all the information that we now about the perpetrator was known to a MAPPA panel, considerably more would have been needed to reach a view that he presented a series  low, medium or high risk of causing serious harm to H. On the information that agencies held, and with no substantive information nor suspicion of domestic abuse, it is highly unlikely the case would have reached the threshold for a MARAC.

6.3.9 The Probation IMR author, who has expertise in this field, has questioned the assessment made by the OM that the perpetrator was low risk to children for two reasons; one of the victims of his index offence was under 18 years of age and also because of the perpetrator criminal antecedents. This, in the author's opinion, suggests potential for risk at the home address where HS2 lived.

6.3.10 Under these circumstances the IMR author believes it was reasonable to make a referral to a child safeguarding referral in this case. The OM visited address one on 26.02.2014 and spoke to the family and satisfied herself that they were prepared to have the perpetrator reside there on his release. The OM states that a referral was made and this resulted in a visit being made to the home address by the local authority. The IMR author has been unable to locate a copy of the referral within the NPS systems. There is no corresponding entry in the Children's Services IMR. Attempts were made to resolve this issue but with no success. Therefore it had to be assumed that the OM was mistaken and a referral was not made in this case.

6.3.11 Had concerns been raised about any risk that the perpetrator posed to children then again this may have resulted in him being subjected to MAPPA management. In turn this might have resulted in actions being taken to protect children such as licence conditions as to residence. However there does not appear to be any

information available at the time that it would have been reasonable to expect the OM to have known that would have increased the risk to H.

6.3.12 There were some anomalies in the way the offending behaviour of the perpetrator was managed. However the panel believe there is a significant gap between any oversight in the management of the perpetrator and the homicide of Adult H. It would therefore be unreasonable to believe the two were linked.

### 6.4 The perpetrator had a history of drug misuse. The review will consider whether his substance misuse was managed appropriately.

6.4.1 The perpetrator had a history of drug use that stretched back to when he was a young man. He had admitted to his GP on a number of occasions that he smoked cannabis and used heroin. While living in the community the perpetrator failed to engage with the agencies in the South Yorkshire area commissioned to treat substance misuse. While in custody he also declined to engage with the prison drugs treatment team (CARAT) or to attend appointments made for him when released. Instead he seemed to prefer to remain engaged with his GP.

6.4.2 The IMR author is satisfied there is nothing in the GP notes to suggest that the perpetrator's drug misuse was not handled appropriately. He seemed to have a good relationship with his GP which in the view of the author meant the GP was able to monitor his drug addiction and co-existing conditions in an environment that the perpetrator was comfortable attending. The author believes the consultations were recorded in a way that suggested the perpetrator was able to be honest about his misuse of drugs and his mood in a non-judgmental environment. He received regular reviews in relation to his misuse of drugs. He was prescribed methadone in prison and there appears to have been information shared between the prison prescribing service and the GP practice.

6.4.3 It is a concern that the perpetrator did not engage with drug treatment agencies. Such treatment offers effective maintenance with a recovery focus. However patients are not forced to take an abstinence recovery route. Engagement is a personal choice. However the panel believe it would have been appropriate for the GP to refer the perpetrator into the specialist service at the time which provided secondary care prescribing for individuals with dual diagnosis. Although we do not know directly from the perpetrator why he chose not to access these services, one reason might be that he was concerned about being seen by others he knew visiting a drugs treatment agency's premises. He requested to change his methadone collection arrangements from supervised consumption to collection from the pharmacy on the basis that he bumped into people in the pharmacy he did not want to see and there may have been a degree of shame. This was agreed by the GP.

6.4.4 An alternative view might be that the perpetrator was manipulative with both his GP and his pharmacist and deliberately did not engage with drug treatment agencies. He may have believed that a regime of maintenance, as opposed to recovery, allowed him continued access to prescribed methadone which has a street value and which he could then sell. Such behaviour is not unusual and clinicians and pharmacists are aware it happens. The fact a condition was attached to the change in prescribing, that his urine samples were clear for heroin, demonstrates that they were alive to this possibility.

6.4.5 In addition to the management of the perpetrator's drug misuse it is also felt important to consider the impact this may have had on his family. There is an entry on HS2 GP record that his father was a drug user. His GP said that this cross referencing is routine practice. However there is no cross reference to the records of H and the GP said the practice would never routinely create such cross references. In the opinion of the IMR author it is not really feasible to mark notes in this way as the spouse or partner may not be aware if the extent of the others drug use. None the less the IMR author believes '*the combination of heroin and cannabis use, methadone prescribing (especially when not on supervised ingestion), his forensic history and antidepressant prescriptions should have triggered an enhanced awareness of potential adult and children safeguarding issues in the rest of the family members'.*

6.4.6 This is particularly relevant in relation to some presentations H made to her GP and primary health care in respect of a fractured to her wrist (17.06.2010) and back, hip and arm pains (31.01.2011). While H provided an explanation for the fall, knowledge of the perpetrator's drug misuse should have triggered an enhanced awareness and more professional inquisitiveness about the ailments H presented with. Drug misuse, alcohol and mental health issues are well known factors in domestic abuse and are often referred to as the 'toxic trio'[4]. For this reason the IMR author makes a specific recommendation about GPs recording these factors on patient records.

## 6.5 Was there appropriate information sharing between agencies?

6.5.1 Much of this has already been explored elsewhere. In 1997 SYP did not notify Children's Services about the fact the perpetrator had controlled drugs at address one nor did they notify them about the discharge of the firearm in a public place (13.03.2011) There were also gaps in the way in which information was shared by health agencies relating to presentations by HS2 at A&E with head injuries (27.01.2013). Similar comment has also been made earlier (paragraph 6.3.3) about the fact that NPS did not seem to be aware of the alleged assault carried out by the perpetrator on another prisoner. Nor were they aware of the incident on 19.03.2012 when the perpetrator was ROTL and a vehicle registered to H was allegedly used in drug dealing.

6.5.2 Something that has not been considered so far is that the GP surgery that the perpetrator attended held a considerable amount of information about his misuse of drugs and other relevant presentations. However, while the GP was aware the perpetrator had been in custody (as he told them and the prison shared information on prescribing), his GP did not know the nature nor extent of his convictions. In the opinion of the IMR author the sharing of such information with GPs and other health professionals would give those more to consider when deciding the risk to the other members of the household.

## 6.6 There are similarities with other domestic homicides in Sheffield: three previous DHRs and one Serious Incident Review involved people from BME backgrounds. This is the second death in 2014 in the same area of the city.

[4] Dept. of Health, Health Visiting and School Nursing Programmes: supporting implementation of the new service model No.5: Domestic Violence and Abuse –Professional Guidance

6.6.1 The most recent domestic homicide in Sheffield involved the homicide of a female victim (Adult G) by her husband in early spring 2014. Adult G and her husband originated from Kuwait where they were stateless. They settled in the UK and brought three children with them. Several neighbours heard violent incidents occurring in the property on the two days prior to the discovery of the body of Adult G.

6.6.2 Both Adult G and Adult H were members of BME communities and moved to the UK with their husbands, although Adult H had been in the UK for much longer than Adult G. Adult H was limited in her use of English and required an interpreter for most consultations with agencies. Adult G required an in interpreter at all times.

6.6.3 The following similarities were identified between the cases;

- In both cases the GP did not ask either victim about domestic abuse;
- Adult G did not present with classic hallmarks of domestic abuse such as depression or unexplained injuries. Adult H did have some indicators of domestic abuse although these were not excessive in nature and there was a reasonably significant length of time between her presentation with them;
- The husband of Adult G, Adult H and the perpetrator all attended at various times with depression. A lesson arising from the review into the death of Adult H was that it is good practice to ask about domestic abuse when patients attend with depression;
- The case of Adult H suggests that staff need to be aware of potential cultural issues in migrant communities which may create a barrier to reporting domestic abuse and explain why she returned to an abusive spouse.
- The case of Adult G identified that it is good practice to record the use of interpreters and who is present in a consultation. It was recorded that an interpreter was present during Adult G's appointments. No other attendees were recorded and therefore no evidence that she was accompanied. The IMR author notes that it is likely that she was but there is no evidence of this and certainly no evidence of other male relatives accompanying her. The case of Adult H has highlighted issues in relation to the use of interpreters including the use of a spouse and family members acting in this role.
- In the case of Adult G it was found there could have been information sharing between the GP practice and the Health Visiting Service. The case of Adult H has highlighted the importance of cross referencing information in GP records when there is information that might suggest in the case of either party there are indicators of domestic abuse;
- The review into the death of Adult G found similarities with other domestic homicides in Sheffield: two previous DHRs and one Serious Incident Review involved people from BME backgrounds. Adult H was also from a BME background;
- Both the death of Adults G and H show some similarities with the death of Adult E 2013 in that this victim also presented to GPs although not with conditions that would prompt discussions regarding domestic abuse.

**6.7 The Review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent child and the perpetrator's father.**

6.7.1 While the perpetrator spent a considerable time in prison, it does not appear that agencies considered the impact his absence may have had on his children HS1 and HS2. Parental imprisonment can have a significant negative impact upon the lives and development of children. Routine information about custodial sentences is not passed onto other agencies by criminal justice agencies, although in some special cases it maybe (e.g. when assessing a risk to children or families through Multi-Agency Public Protection Arrangements (MAPPA)).

6.7.2 For a variety of reasons, such as shame or fear, families may choose to maintain a degree of confidence when a parent is imprisoned and therefore will not disclose this information to schools or other agencies. Families may not even tell their own children and may cover up the absence of a parent. If children are aware, for a variety of complex reasons, they may choose not to tell anyone at school. This makes it very difficult for agencies to routinely identify the needs of all children with imprisoned parents and to put support mechanisms in place.

6.7.3 Sheffield's Prevention and Early Intervention Strategy identifies families with a parent in prison as a priority group. The panel are reassured that, while it comes too late for HS1 and HS2, Sheffield City Council and Barnardo's are working together on developing a handbook for agencies and professionals who come into contact with children who have a parent in prison. This work will improve outcomes, provide a children's rights perspective, address intergenerational offending and develop a whole family approach maximising a range of outcomes. The panel feel this an important development that will benefit other children who have similar experiences as HS1 and HS2.

6.7.4 The difficulties of disclosure faced by BME victims of domestic abuse were commented on in paragraph 6.1 et al.

**6.8 The first language within the family is not English. Although the perpetrator and the sons are fluent in English, the victim was taking ESOL JCP lessons around 2011 - 2012.**

6.8.1 Within the GP records there seems to be some variance as to the extent of the victims understanding and use of English. When she first came to the UK in 1994 she was described as having limited use of the language. The GP from her practice who provided the information for the IMR said the fact that use of an interpreter was not read-coded into her records would imply that her English was very good. However other entries are at odds with this, for example on 28.07.1999 an entry says that a prescription was not given because there was no interpreter available. This seems to imply interpreters were used with her and there are entries which indicate her sister in law seems to have acted in this role on occasions. However it is not possible to know with certainty from the records when an interpreter was used and who it was.

6.8.2 The important issue for the purposes of this review is that if interpreters were not always used, this is likely to have had an impact on whether the GP that saw her was able to ascertain more subtle worries or problems. There is also the concern that if a family member such as one of her sons, husband or in-laws interpreted for her then she would not have been in a position to speak freely about domestic problems

6.8.3 In 1994 when H underwent routine health surveillance at STHFT she spoke no English at all. While there was no evidence of an interpreter being present the

record shows that Adult H was under the supervision of a health visitor. During the period in 1998 when she attended the hospital in connection with her pregnancy there is evidence to show that her language difficulties were identified and addressed by the use of interpreters.

6.8.4 An area of concern that has been identified in relation to the South East Sheffield Primary Care Trust (no longer in existence) when Adult H attended the Central Health Clinic in connection with a significant gynaecological issue. On this occasion it was recorded that the perpetrator supported the decision she had reached to go ahead with the procedure although it is also recorded that he was interpreting for her. The IMR author for STHFT considers this was poor practice, in that the health care professional could not be certain the decision to proceed had come from the patient. He does add there is no evidence to suggest that any member of staff had any reason to believe that Adult H may have been coerced into a course of action.

6.8.5 In 2010 H visited her GP following a wrist injury. It was noted in the records that her sister-in-law accompanied her as an interpreter.

6.8.6 The OM visited address one and saw H, HS2 and HHF on 26.02.2014. The OM felt H seemed to fully understand the discussion despite English not being her first language. However the NPS IMR author believes it is not clear how much English H spoke or understood. It is their view that in view of her recent return to the family home and English being a second language, the services of an interpreter should have been used.

6.8.7 The IMR author also believes there should have been more professional curiosity in relation to the relationship between H and the perpetrator. For example the reason as to why they had separated for such a long period, why she H had returned and about the care of the children. As family members were present when OM saw H such conversations would have been difficult and more so if H's use of English was poor and she either did not understand the questions or required a family member to act as interpreter.

6.8.8 In considering the use of interpreters the panel felt it was important to recognise the need to be realistic as to the limitations in their use. Most agencies in the earlier periods covered in this review would probably have used family or whoever the patient or client brought with them to interpret at an appointment. Now all agencies use professional interpreters although some GPs use other members of staff if available. While the use of such professionals is a welcome development there are still issues such as the fact that direct translation is not always possible and interpreters may not understand the sensitivities of some discussions for example would they be aware of domestic abuse issues and pick up on the more subtle signs.

6.8.9 Telephone interpretation, which is a service many agencies use for unscheduled contact, is always more difficult as body language is important to understanding the thoughts and feelings of patients or clients in relation to sensitive matters. In addition, in such situations, there has to be trust between the patient/client and the interpreter which it may be difficult to establish or assess. The panel therefore concluded that the problems associated with interpreters is much greater than the individual agencies have the ability to resolve and are beyond the scope of this review.

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

No additional information has been identified.

## 7. LESSONS IDENTIFIED

7.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix 'B'.

7.2 The DHR Lessons learned are listed below. Each lesson is preceded by a narrative.

### 1. Narrative:

Adult H suffered domestic abuse at the hands of the perpetrator over a period of years. Relatives knew that she had been subjected to abusive behaviour at his hands. At one point she left the perpetrator and moved to another part of the country to get away from him. She contemplated divorce and sought advice from people she may have believed to be independent. However she was persuaded to return to South Yorkshire and address 1.

**Lesson**:

The Sheffield DACT needs assessment identified that 26% of individuals receiving support from DACT commissioned providers were BME; this is in comparison to an overall BME population of 19.2% of the Sheffield population. Domestic abuse is under reported generally and members of some BME communities may face additional hurdles when disclosing domestic abuse[5]*. This includes language, access to interpretation and isolation to name a few. These hurdles may make it more difficult for them to disclose their experiences and then to access competent independent advice and support. These findings were also identified from a focus group held following the case of Adult G.

### 2. Narrative

Although the perpetrator did not access specialist drugs services and instead chose to be treated for his misuse by accessing his GP, this DHR has found there are lessons for substance misuse services[6]. Safeguarding children is high on the agenda for these services. The risk of domestic abuse, although addressed to a degree, is not necessarily given the same level of scrutiny.

**Lesson**

The 'toxic trio' (also referred to by organisations as the 'trilogy of risk' are three risk factors that increase the risk of child abuse; they are parental mental health issues, parental substance abuse (including alcohol) and

[5] Better Housing Briefing Paper 9: Gill, Aisha & Banga, Baljit October 2008

[6] The Home Office identified that nationally in a number of cases of domestic homicide the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, sexual abuse, alcohol, substance misuse and mental health illness. In some cases the domestic violence and abuse was not always identified because agencies were focusing on addressing, for example, the mental health or substance misuse. Suggestions from the Home Office for what can be done locally included that Drug and alcohol services should review, amend and make robust use of their risk assessment frameworks, which involve assessment of risk in relation to violence and abuse; Promotion of the AVA Complicated Matters toolkit and training with local practitioners; Promotion of the CAADA guidance on attendance of mental health and substance use services at MARAC. Home Office 2013: Domestic Homicide Reviews Common Themes Identified as Lessons to be Learned

domestic abuse. In this case the substance abuse was identified but unfortunately, although present, domestic abuse was not enquired about and so the second factor of the toxic trio was not identified. Specialist substance misuse services, and GPs if they are providing treatment for misuse, should always ask questions about home circumstances when assessing patients who present with issues of substance misuse. They should be alert for signs of domestic abuse and take action as required. Addressing domestic abuse needs to have the same profile amongst specialist substance misuse services as is given to safeguarding children.

## 3. Narrative

The perpetrator declined to engage with specialist drugs services both while living in the community and while serving terms of imprisonment. Instead he chose to seek support and treatment for his drugs misuse from his GP. Consequently his GP was not always aware of what treatment and prescribing had been undertaken while the perpetrator was in custody. Similarly prison health providers were not aware in relation to the treatment the perpetrator was receiving in the community. On most occasions the GP and prison health providers had to rely on what the perpetrator told them rather than patient notes.

### Lesson

The prison recording system is closed and as such there is no consent, agreement or system in place to share information gained while an individual are in prison. There is a need to develop ways in which GP notes can be shared with prison health providers and the DHR panel notes NHS England are currently undertaking work to address this.

## 8. CONCLUSIONS

8.1 The perpetrator had a history of offending that grew incrementally over the years. He used violence towards others and was also subjected to violence himself. His ability to obtain, and his willingness to then carry, a lethal weapon (a prohibited firearm capable of discharging live rounds) indicates his connections to serious criminality. Even if his hand was not on the weapon at the time it was fired the fact he was involved in bringing a weapon like this into a public place during which it was discharged indicates his preparedness to engage in an act which had the potential to result in serious, if not fatal, injuries to other persons.

8.2 H arrived in the UK when she was already married to the perpetrator. Little is known about her background in Pakistan or her life in the UK other than what has been gleaned from agency records. In contrast to the perpetrator she has no convictions and there is no evidence she was involved with him, or his associates, in any criminal activity. Neither is there any evidence she misused drugs or consumed alcohol. From the limited information that was available to the panel she appears to have been a good mother to both HS1 and HS2 ensuring they had access to medical care when required.

8.3 Accounts differ as to how well H understood and could converse in English. It appears she came to the UK following an arranged marriage and like other women in similar circumstances relied on the support of her husband and family members to help her access services. Her medical history was unremarkable however there were some presentations following injuries that begged more curiosity from her GP. While there was no direct evidence these were caused by the perpetrator there should have been more probing, particularly given the perpetrator's antecedent history of drug misuse. Her poor use of English may have created a barrier to such probing as may the absence of an interpreter or the use of a family member in this role. Consequently opportunities may have been lost to ask direct questions about domestic abuse. Similarly there may have been a lost opportunity for more professional curiosity when OM spoke to H in the presence of her family and without an interpreter.

8.4 In relation to child safeguarding there were lost opportunities for a multi-agency assessment of risk when SYP officers did not submit referrals in respect of HS1 and HS2 in 1997 and 2012 respectively. The fact that the perpetrator misused drugs for many years was an important factor that should have escalated the interest that was taken in safeguarding yet it was not until 2009 that this information was noted on HS2 record and it was never cross referenced to the record of H.

8.5 Risk assessments carried out on the perpetrator while he was in custody and upon his release concluded that he was medium risk to the public, medium risk to known adults (the known adults being the victims of the original offence), low risk to children, staff and prisoners. However there was more information available that appears not to have been shared with the OM by HMP and SYP. This related to the attack on the perpetrator in prison, the alleged revenge attack and the use of a car owned by H in alleged drug dealing during the short period the perpetrator was ROTL. The presence of such information may have altered the assessment of risk and led to the perpetrator being made the subject of MAPPA arrangements. Additionally the OM may not have placed insufficient weight on the fact that one of the victims in the index offence was under eighteen and in respect of the perpetrator's criminal associations. However the panel concluded that there was a

significant gulf between the possible understatement of this risk and the homicide of H.

## 9. PREDICTABILITY/PREVENTABILITY

9.1 Despite the perpetrator's criminal possession of a firearm, his criminal antecedents and his misuse of drugs agencies had no direct information about domestic abuse in the relationship between H and the perpetrator. While there may have been some, so called, 'soft signs' and some missed opportunities to exercise professional curiosity there were no precursor incidents that might have caused any agency to believe H was at risk of serious harm from the perpetrator.

9.2 When H attacked and killed the perpetrator it came without any visible or documented escalation in his behaviour towards her. The panel recognise that abusers do not always escalate their behaviour through a series of incremental levels of physical violence before killing. However on this occasion the panel believe no agency could have forecast what would happen to the perpetrator. The panel therefore conclude that her homicide was neither predictable nor preventable.

## 10. SUMMARY OF KEY FINDINGS

i. H was a caring woman who suffered in silence. She never reported what happened to her however her experiences meant she was a victim of domestic abuse at the hands of the perpetrator.
ii. The perpetrator had a significant history of offending including the use of violence. He also had a long history of misusing drugs.
iii. There should have been more curiosity shown by her GP when H presented with injuries.
iv. English was not the first language of H and this may have presented a barrier to her disclosing her experiences to professionals.
v. When professionals spoke to H in the presence of a family member who acted as an interpreter this may have created a barrier for H that prevented her disclosing information about the behaviour of the perpetrator.
vi. The misuse of drugs by the perpetrator should have escalated the interest professionals took in safeguarding issues.
vii. There was information known to HMP and SYP but not by NPS which might have affected the assessment of risk that was undertaken on the perpetrator when he was released on licence from prison.
viii. When assessing risk, greater weight could have been given by NPS to the fact that a victim involved in the index offence when a weapon was discharged was under 18 years of age at the time it was committed.
ix. While there were some 'soft signs' and missed opportunities to exercise more professional curiosity in relation to domestic abuse, no agency could have predicted or prevented the homicide of H.

## 11. RECOMMENDATIONS

11.1 The Agencies recommendations appear in the Action Plan at Appendix 'B'. The panel consider that a number of the agency recommendations also embody their discussions and thoughts. They have not therefore duplicated these as separate panel recommendations. As Appendix B contains both panel and agency recommendations grouped by agency. The relevant action number as it appears in Appendix B is therefore shown in bold below.

11.2 The DHR panel recommends that;

A. DACT commissions work to identify the barriers that may be present within some Asian and Muslim communities that prevent victims from reporting domestic abuse to their families and agencies and develop an action plan to address any identified gaps. **(Action 1)**;

B. DACT commissioners work with current domestic and sexual abuse service providers to undertake consultation with service users and community groups and ensure that staff are trained in cultural issues and barriers. **(Action 2)**;

C. DACT alerts NHS England and the National Offender Management Service (NOMS) to the issues identified in this report in relation to the sharing of patient information between GPs and prison health providers and requests they consider to what extent national policies and procedures can be improved **(Action 3)**;

D. Specialist substance misuse services commissioned within the Sheffield area should ensure that addressing domestic abuse is given the same profile as safeguarding children. Questions about home circumstances and alertness for signs of domestic abuse should be a routine part of assessment processes. If there are indications of domestic abuse, appropriate action should be taken. When new services are commissioned the contract should include this as a requirement of the service **(Action 4)**;

E. DACT should continue to translate publicity materials and work with community organisations to ensure that support services are publicised appropriately. When material signposts victims to interpreting services these should be interpreters that are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to. **(Action 5)**;

F. When domestic abuse is disclosed, GPs should be encouraged to enquire about other significant risk factors causing vulnerability to children such as substance misuse and parental mental health concerns in all other household members and regular contact with a child. **(Action 8)**;

G. When a significant risk factor is disclosed GPs should be encouraged to enquire about other vulnerable people in their household and consider appropriate safeguarding referrals. **(Action 9)**

H. NHS Sheffield CCG suggests that the practice lead GP for Safeguarding Adults reminds clinicians to enquire about domestic abuse if possible when patients discuss their drug or alcohol issues **(Action 10)**;

I. The issue of interpreters is not exclusive to Sheffield. However those who commission interpreters within the Sheffield area, and were part of this review, need to be alerted to the issues that have emerged within this review. Commissioners should ensure that interpreters are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to. **(Action 16)**.

J. South Yorkshire Strategic Management Board (MAPPA) to remind the Responsible Authorities and Duty to Cooperate Agencies the importance and value in sharing information to assist the management of offenders. **(Action 24).**

K. Reinforce the need for professionals in all agencies to gather information from all likely sources when formulating and managing risk, thereby ensuring that all risk factors are identified and assessed. **(Action 6)**

L. DACT reviews the process for making and receiving third party reports of domestic abuse and considers ways in which this may be improved. **(Action 7)**

## Terms

### *Domestic Violence*

1. The Government definition of domestic violence against both men and women (agreed in 2004) was:

   "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

   *Controlling behaviour is:* a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

   *Coercive behaviour is:* an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

3. Therefore, the experiences of AV fell within the various descriptions of domestic violence and abuse.

### *DASH risk assessment model*

4. Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently by SFSSCP

5. DASH is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC].

6. There are three parts to the DASH risk assessment model:

   i. Risk identification by first response police staff

ii. The full risk assessment review by specialist domestic abuse staff

iii. Risk management and intervention plan by specialist domestic abuse staff

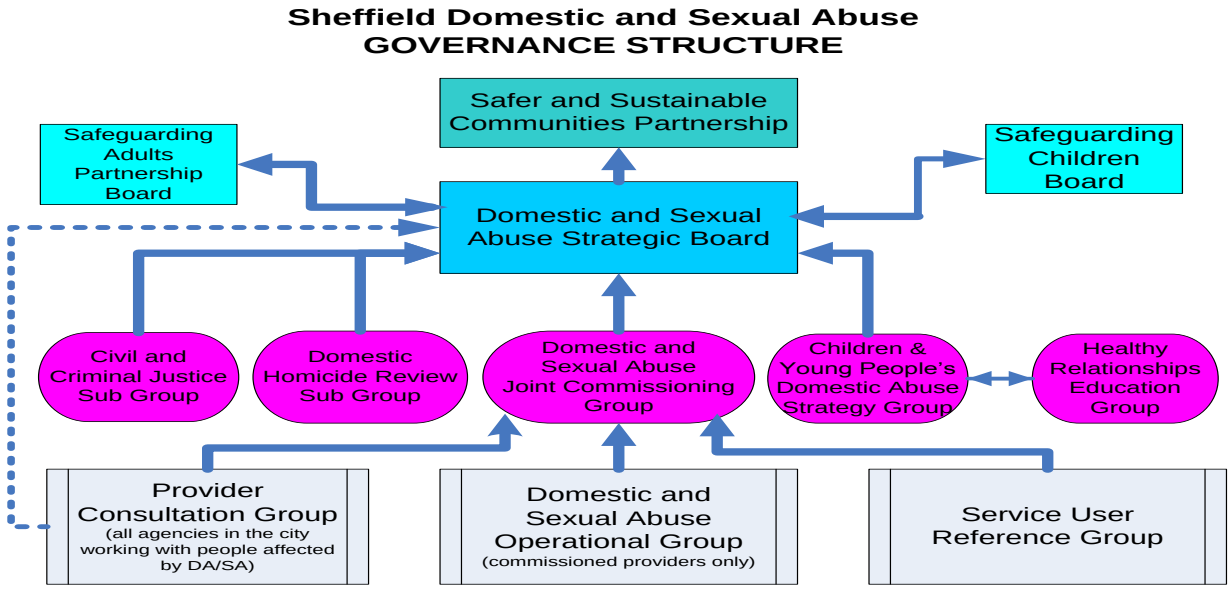
7. The definitions of risk used by Sheffield Safer and Sustainable Communities Partnership are:

- Standard: Current evidence does NOT indicate likelihood of causing serious harm
- Medium: Identifiable indicators of risk of serious harm. Offender has potential to cause serious harm but unlikely unless change in circumstances
- High: Identifiable indicators of risk of imminent serious harm. Could happen at any time and impact would be serious

All High risk cases go to MARAC.

**Appendix B**

## SUMMARY OF LOCAL PROVISION - SHEFFIELD SERVICES




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[7] DASH[8] 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 Incident Reviews, and one to oversee the multi-agency work in relation to civil and criminal justice including the MARAC.

[7] Association of Chief Police Officers

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

## 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:

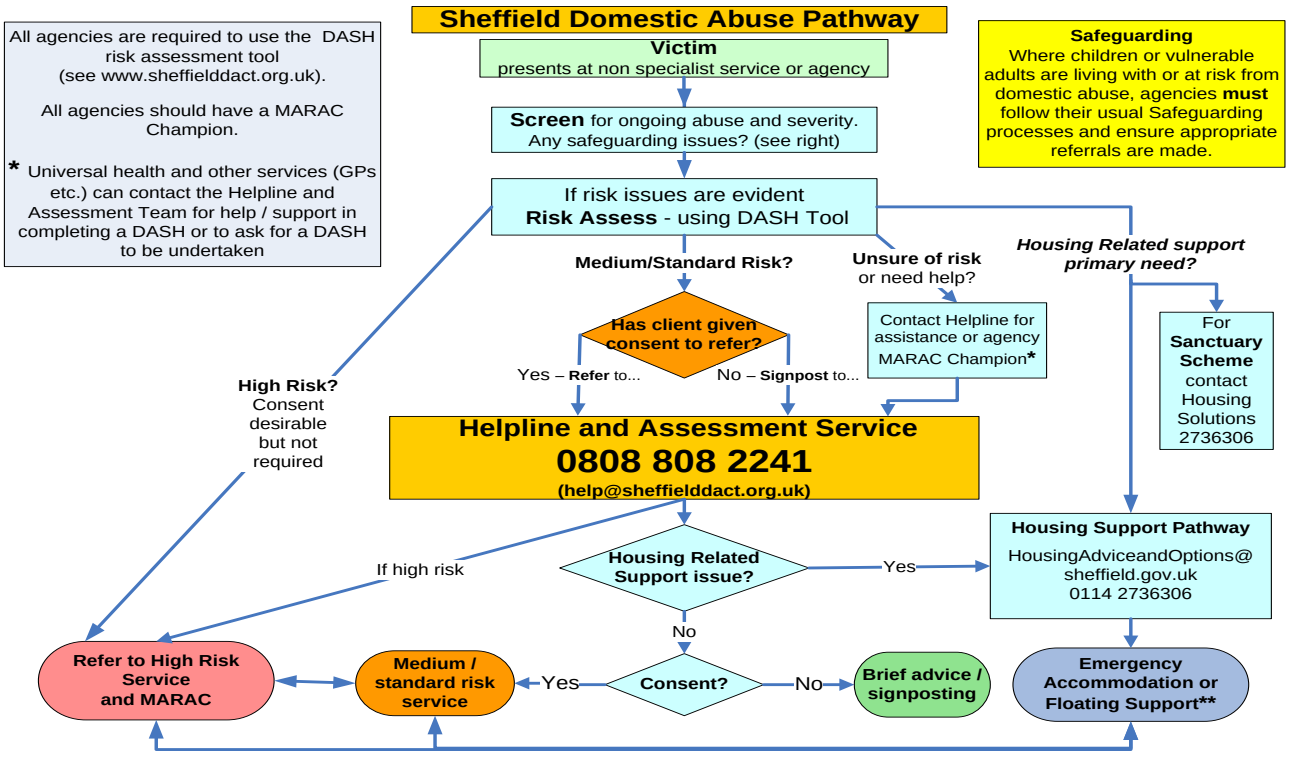
- To save lives through early risk identification, intervention and prevention.
- To create one standardised practical tool to refer cases to the Multi-Agency Risk Assessment Conference (MARAC), to share information and manage risk effectively.

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.



**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.*

## Action Plan

**Appendix C**

| Rec. No. | Recommendation | Milestones / actions taken | Lead person | Target date | Status Aug -15 | Status Oct-15 | Stataus Jan 2016 | Evidence of outcome |
|---|---|---|---|---|---|---|---|---|
| **Sheffield DACT updated 04/02/2016** | | | | | | | | |
| 1 | Commission work to identify the barriers that may be present within some Asian and Muslim communities that prevent victims from reporting domestic abuse to their families and agencies and develop an action plan to address any identified gaps. **(Recommendation A)** | Sheffield DACT to work with local providers to interview current service users re. barriers to reporting but also to interview users at community based / non DA services and liaise with community leaders including councillors. To be discussed with providers at DASA Operational Group in early December. Report to go to DAS Board in May 2016 identifying gaps and an action plan to address them. Report identifying gaps produced. | Alison Higgins | May-16 | **RED** | **AMBER** | **GREEN** | |
| 2 | DACT commissioners work with current domestic and sexual abuse service providers to undertake consultation with service users and community groups and ensure that staff are trained in cultural issues and barriers. **(Recommendation B)** | DACT to raise issues relating to this review, staff training and cultural issues and barriers in performance monitoring meetings for Q2 2015.Providers will be asked to provide information re. proportion of Asian and Muslim service users taking up support compared to the numbers referred and outcomes by year end. And this work will be linked with community consultations in action 1 and reported to the DAS Board in May 16. Report produced identifying gaps. | Alison Higgins | May-16 | **RED** | **AMBER** | **GREEN** | |

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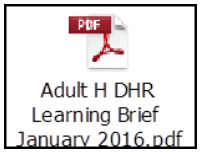
| 3 | Alert NHS England and the National Offender Management Service (NOMS) to the issues identified in this report in relation to the sharing of patient information between GPs and prison health providers and requests they consider to what extent national policies and procedures can be improved. **(Recommendation C)** | Letter to be written to NHS England and NOMS | Alison Higgins | Nov-15 | RED | AMBER | AMBER | |
| 4 | Specialist substance misuse services commissioned within the Sheffield area should ensure that addressing domestic abuse is given the same profile as safeguarding children. Questions about home circumstances and alertness for signs of domestic abuse should be a routine part of assessment processes. If there are indications of domestic abuse, appropriate action should be taken. When new services are commissioned the contract should include this as a requirement of the service. **(Recommendation D)** | This has been included in the Adult H Learning Brief and recent training (5 workshops for DA and Subs Misuse workforces) has addressed the links and the Adult H case. There is also a joint project to build on this work and develop a training pack covering the issues that will be conducted between January and March 2016. | | | RED | AMBER | COMPLETE |   |

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| 5 | Continue to translate publicity materials and work with community organisations to ensure that support services are publicised appropriately. When material signposts victims to interpreting services these should be interpreters that are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to. (Recommendation E) | Publicity available on DACT website in a range of community languages and wesbite has google translate function. Training of interpreters is an issue also being looked at in Adult G review action plan - guidance on preparing and using interpreters in domestic abuse inquiries, is in development including ensuring the gender of the interpreter is the same gender as the service user. Consultation to take place with commissioners to establish whethter training requirement to be built into contract arrangments | Alison Higgins | Mar-16 | RED | AMBER | AMBER | |
| 6 | Reinforce the need for professionals in all agencies to gather information from all likely sources when formulating and managing risk, thereby ensuring that all risk factors are identified and assessed. **(Recommendation K)** | Learning in relation to this review to be included in a learning brief and circulated to all relevant agencies | Alison Higgins | Jan-16 | RED | RED | COMPLETE | Learning brief produced sav 4 above. |
| 7 | Review the process for making and receiving third party reports of domestic abuse and considers ways in which this may be improved. **(Recommendation L)** | To be discussed at next Civil and Criminal Justice Sub Group in April 2016 | Alisom Higgins | Jun-16 | RED | RED | RED | |
| **NHS Sheffield CCG updated 19/01/216** | | | | | | | | |

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| 8 | When domestic abuse is disclosed, GPs should be encouraged to enquire about other significant risk factors causing vulnerability to children such as substance misuse and parental mental health concerns in all other household members and regular contact with a child. **(Recommendation F)** | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| 9 | When a significant risk factor is disclosed GPs should be encouraged to enquire about other vulnerable people in their household and consider appropriate safeguarding referrals. **(Recommendation G)** | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| 10 | NHS Sheffield CCG suggests that the practice lead GP for Safeguarding Adults reminds clinicians to enquire about domestic abuse if possible when patients discuss their drug or alcohol issues. **(Recommendation H)** | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| 11 | Each Practice Lead GP for Safeguarding Adults recommends that when using an interpreter, this should be documented in the patient's GP notes by the member of staff using the interpreter. | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |

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| 12 | Encourage all Practice Lead GPs for Safeguarding Adults to remind staff within their practice to appropriately read code records of children where there are safeguarding concerns or domestic abuse in the household. | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| 13 | Recommend to all practices via Practice Lead GPs for safeguarding adults, that all practices should undertake appropriate training as detailed in the training strategy for safeguarding vulnerable people. | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| 13 | Recommend to all practices via Practice Lead GPs for Safeguarding Adults, that the possibility of domestic abuse should be considered by the GP when women present requesting a significant gynaecology procedure | | Amy Lampard | Dec-15 | RED | GREEN | COMPLETE | Communication to be sent t |
| 14 | Recommend to all practices via Practice Lead GPs for Safeguarding Adults, that information about domestic abuse should be displayed in the local languages of prevalent populations attending GP Practices if resources available. | | Amy Lampard | | RED | COMPLETE | | Communication sent to GPs |
| **All Commissioners of Interpreting Services that took part in the review** | | | | | | | | |

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| 15 | The issue of interpreters is not exclusive to Sheffield. However those who commission interpreters within the Sheffield area, and were part of this review, need to be alerted to the issues that have emerged within this review. Commissioners should to ensure that interpreters are trained and educated in respect of the vulnerability of victims and the domestic abuse risk factors they may be exposed to. **(Recommendation I)** | | | | | | | |
| | **SCC** | | | | RED | RED | AMBER | |
| | **South Yorkshire Police** | | | | RED | | COMPLETE | See SYP actions adult G |
| | **Addaction** | | | | RED | | | |
| | **Sheffield CCG** | contract for interpreter services being reviewed | | | RED | AMBER | AMBER | |
| | **Sheffield childrens NHS FT** | To be discussed at next Trust Safegaurding meeting on 15.02.2016 | Sally Shearer | | RED | RED | RED | |
| | **Sheffield Teaching Hospitals** | | | | RED | AMBER | COMPLETE | For the majority of the hosp community services STH us face to face or telephone int provided by a company calle Language Line. We have a (together with Sheffield City this company and as such w customer supplier relationsh them. Training for the interp be the role of their employin organisation. |
| | **National Probation Service** | | | | RED | RED | AMBER | National Training needs ass underway for the NPS, inclu provision of domestic violen |
| **National Probation Service updated 01/02/2016** | | | | | | | | |

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| 16 | The Services policy in terms of file retention are reviewed in light of this case. | Due to the NPS being a national organisation there is a national policy with regard to retention of case files. This recommendation can however be fed back via the Senior Leadership Teams to the central policy team. | Max Lanfranchi | 3 months from date of publication | RED | AMBER | AMBER | Recommendation still under central policy team. |
| 17 | Protocols for use of interpreters are reviewed and redistributed, including evaluation of a SPOC within each division. | New process for booking of interperters has been introduced. SPOC to be identified | Max Lanfranchi | 3 months from date of publication | RED | AMBER | GREEN | Process for booking of intep embedded in the service. |
| 18 | The concept of professional curiosity is promoted throughout the service | | Max Lanfranchi | 3 months from date of publication | RED | RED | AMBER | Development of Performanc Quailty Committee and Prof Practice Forum to promote a encourage professional dev SFO and DHR learning is in into these forums and feedb LDUs. |
| 19 | Learning points from the DHR are distributed throughout the service | Until such time as the DHR is published learning points cannot be distributed. | Max Lanfranchi | 3 months from date of publication | RED | RED | AMBER | Process for process of learn underway. Fedback via Mar meetings and then down to from managers. |
| **South Yorkshire Police updated 27/01/2016** | | | | | | | | |
| 20 | Disseminate reminder to all officers of the requirement to submit a GEN117 referral when a parent / carer is involved in activities which could significantly impact on the welfare of their children | Numerous reminders have been placed on the Intranet for officers attending at incidents where children are present in the household. The referral form (Gen 117) was changed to reflect the Voice of The Child on 28.10.2015 | Louise Houghton | 31.05.15 | AMBER | AMBER | COMPLETE | \Evidence Adult H Copy of Intranet Page re Gen |
| **Addaction** | | | | | | | | |

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| 21 | Reiterate importance of recording case notes and directed all staff members to read our 'record keeping policy'. Measures in place to speak with the practitioner concerned, to revisit expectations surrounding record keeping and the responsibilities and accountability of Addaction staff in ensuring that record keeping is accurate, contemporaneous and complete. | b) Staff member has left organisation. Record keeping had not been satisfactory and formed part of performance management prior to departure. | a) Quentin Marris, Service Manager<br>b) Keeley Ward, Operations Manager | a) June 2015<br>b) N/A | RED | | | |
| **CYPF MAST - Education** | | | | | | | | |
| 22 | CYPF and the SSCB to provide 'Hidden Sentence 'Training and guidance and make this available to all workers in the children's workforce, including schools. | | | | RED | | | |
| **South Yorkshire Strategic Management Board (MAPPA)** | | | | | | | | |
| 23 | Remind the Responsible Authorities and Duty to Cooperate Agencies the importance and value in sharing information to assist the management of offenders. | | | | RED | | | |

**Appendix D**

## Commentary from DACT Criminal Justice Manager on the use of 'Spice'

New Psychoactive Substance use in prisons is known to be a substantial and increasing problem. Anecdotal reports from Prisons, the Drug Interventions Programme and the Police all confirm the increasing use of NPS in prisons, particularly synthetic cannabinoids. 'Spice' is one of a number of similar products currently available legally from 'Head Shops' and on the internet.

DIP staff are trained and competent in dealing with NPS use and would routinely assess NPS use with all offenders they have contact with including prison leavers. The response to these assessment questions and the subsequent work undertaken would depend on what type of NPS use that was disclosed, with advice, support or treatment following the same lines as for the illegal drugs the NPS is made to mimic. For synthetic cannabinoid use this would be the same as for illegal cannabis use, which would be harm reduction advice, health information and potential referral to Psychosocial Interventions. However the criminal justice to drug treatment pathway is predominantly designed to deal with Class A drug users, although the system will work with the users of any substances; but this requires voluntary identification and engagement from the individual concerned. Many NPS users do not see their drug use as problematic or even as 'proper' drug use. There are very few people in structured drug treatment reporting a problem with a NPS whether they are referred from a CJ route, self-refer or come via any other referral route. Anecdotally many offenders will return to the illegal and original versions of the drugs rather than the NPS version designed to mimic the drug after their release from custody.

Because these substances are so difficult to trace, agencies including prison health, drug and recovery services would be reliant on prisoners disclosing their NPS use in custody (or prior to custody) before they could be offered any help or support. Currently these drugs would be very hard to detect through conventional means. For example drug sniffer dogs would not detect the drugs being smuggled into prisons and there are no simple ways of drug screening individuals to detect the presence of the substances. This is a rapidly changing field with new and altered drugs being manufactured every week. A test to detect substance 'X' this week would not detect substance 'Y' next week. There is also no quality control with these products, so aside from strength varying from batch to batch, what is purchased in a packet of 'Spice' one day may be a different substance to that purchased in a packet of 'Spice' the next day. Following some recent laboratory analysis of samples seized in Sheffield we discovered that some products have no psychoactive contents.

The Public Health England publication 'New Psychoactive Substances, a toolkit for substance misuse commissioners' produced in November 2014 provides a series of questions/suggestions relating to a broad strategic approach to NPS use and the commissioning of good quality services to deal with the problem. These questions are divided into seven broad areas of work. The final area relates to 'NPS' in prisons and the children's and young people's secure estate'. Our NPS Multi-Agency Group has audited our current practice and commissioning agreements against these questions and whether they are included in our local NPS Strategy. Because there are no adult prisons in Sheffield and prison health care and recovery services are commissioned regionally by NHS England, we are currently still seeking answers to

this group of questions from the local Youth Justice Service for Sheffield's one secure estate for young people and from NHS England for the Doncaster cluster of prisons for men and HMP Newhall for women.

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Domestic Abuse Strategy Manager
Sheffield City Council
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Sheffield S1 4LP

14 December 2015

Dear Ms Higgins

Thank you for submitting the Domestic Homicide Review report for Sheffield to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 18 November 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found the report contained a good representation of analysis with evidence that the review panel had probed the IMRs, drawn its own conclusions and identified useful lessons. The Panel also noted there was good representation of family views in the report and found the family tributes particularly powerful.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider before you publish the final report:

- The Panel felt the layout of report would be improved by including a section summarising all the key findings;
- The executive summary would benefit from contextual information, such as timescales, panel membership etc, to allow it to be read in isolation;
- It would be helpful if the report could clarify whether information from relatives set out in paragraphs 4.3.1 to 4.3.7 was obtained by the chair through interviews or from trial records. It would also be helpful to have clarification on who these relatives are;
- Additionally please clarify whether the family have been given an opportunity to see the draft report;

- The Panel felt the reference in paragraph 1.2 (in both reports) allows the perpetrator to speak for the victim (in relation to her designated ethnicity) and should be removed and replaced with the ethnicity simply stated;
- The Panel recommended checking the wording in paragraphs 6.1.3 to 6.1.5 to ensure the victim's children do not consider the comments to be targeted at them;
- The action plan requires milestones, outcomes and progress to be included;
- Additionally, the Panel suggested the review panel may wish to consider including a recommendation in the action plan on how third party reporting could be improved safely.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

**Christian Papaleontiou**
Chair of the Home Office DHR Quality Assruance Panel

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