safe & sound
Dudley's Community Safety Partnership

DUDLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'Nezha' IN MARCH 2022

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2017 to MARCH 2022

EXECUTIVE SUMMARY

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Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of Nezha for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

The circumstances leading to the murder were that, on a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that: "he was being intoxicated by a female from Syria." A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had "got her." He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha was seen to have a gunshot wound and Ahmad also had a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were nearby.

The working hypothesis of the West Midlands Police was that that Ahmad murdered Nezha before taking his own life.

There was no recorded history of domestic abuse with Nezha. There were allegations of domestic abuse from previous partners – but these were not substantiated no prosecuted. Ahmad was a licensed firearms holder.

The Panel recognised, of course, that this Review concerned a homicide and a suicide. The precise circumstances leading to the deaths of Nezha and Ahmad were determined by the Office of the Coroner in July 2022. In these circumstances, and when the Community Safety Partnership decided that a DHR will be completed, it would be usual to work with the specialist Family Liaison Officer (FLO) so that contact could be made with the family, friends and/or colleagues of the subject of the case and also with the family of the Perpetrator.

The Chair/Author and the Panel formed an excellent working relationship with the Family Liaison Officer (FLO) and they supported the Panel to complete its work.

However, due to the circumstances surrounding the investigation, the independent Author, the Commissioning Officer (from Dudley MBC), the FLO and a representative from the Professional Standards Department (PSD) of the West Midlands Police met in December 2022 to decide upon the best course of action regarding contact with the family of Nezha and the family of the Perpetrator, Ahmad. Taking account of the contact between the families of Nezha and Ahmad, the Family Liaison Officer and the PSD, it was decided – and confirmed in discussion with the Panel – that the Review should not make contact with any member, friend or associate of the family. Additionally, it was agreed by the Panel that any contact made by the family and/or friend(s) of Nezha and/or Ahmad must be facilitated via the FLO and their colleague from the Professional Standards Department (PSD) of the West Midlands Police Service.

It should be stressed that both the FLO and the PSD provided support to the Panel and, as efficiently and effectively as they could, provided answers to any of the questions raised by the Panel. The FLO and PSD also provided some context to the circumstances leading to the critical incident.

Further details of the work of the PSD are described in the section addressing 'parallel reviews'.

Section One
The Review Process

1.1 Incident leading to the Domestic Homicide Review

On a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that:
"he was being intoxicated by a female from Syria."

1.1.1 A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had 'got her.' He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

1.1.2 Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha presented with a gunshot wound and Ahmad with a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were also nearby. The working hypothesis is that Ahmad murdered Nezha before taking his own life.

1.1.3 There was no recorded history of domestic abuse with Nezha, but there were incidents of alleged domestic abuse with previous partners. Ahmad had 4 passports (UK, Ukrainian, Turkish, USA) and was a licensed firearms holder.

1.1.4 Ahmad was the sole tenant of the property, but there were suggestions that Nezha also stayed at the address.

1.1.5 There were no recorded convictions for assault and/or common assault.

1.2 The time period under Review

1.2.1 At the initial meeting of the Domestic Homicide Review Panel, held virtually in September 2022, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2017 to the date of the incident in March 2022. The panel decided on this time frame because this is the date that Nezha moved to the address where the incident occurred. However, the Panel was very clear in their communication with the agencies involved in the Review and requested that if any agency had any relevant information outside of this period, then this information should be included in the individual management review and chronology.

1.2.2 The parameters of the formal scope were effectively removed because a number of agencies did hold records from 2010-2014 concerning a number of subjects of this Review.

1.3 The Proposed timescale

1.3.1 The first meeting of the DHR Panel was held on the 1st of September 2022. The Panel met again in November 2022, January 2023, March 2023, April 2023 and in May 2023.

1.3.2 At the first meeting in September 2022, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and

the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

1.3.3 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies. The Panel also discussed the involvement of the family.

1.3.4 At the third meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies; the draft integrated chronology, the abridged chronology, the responses to the key lines of enquiry, the combined narrative, etc.

1.3.5 At the fourth meeting, the Panel considered a first crude draft of the Overview Report – a composite of the submissions structured in a format close to that required by the Home Office to ensure that all members of the Panel had a copy of all of the information submitted. The Panel also considered a number of emerging themes, and a number of the lessons learnt identified by the Agencies involved.

1.3.6 At the fifth meeting of the Panel, held in April 2023, the Panel considered a number of clarifications submitted by Agencies invited to submit and considered the first full draft of the Overview Report.

1.3.7 At the sixth meeting of the Panel, held in May 2023, the Panel considered the second draft of the Overview Report and committed to making comments and amendments by the beginning of July. The final draft was then submitted for consideration by the Community Safety Partnership and Domestic Abuse Boards.

1.4 The use of pseudonyms and involvement of the family of Nezha

1.4.1 As noted in the Preface, the Chair/Author and the Panel formed an excellent working relationship with the FLO and they supported the Panel to complete its work. Due to the circumstances surrounding the investigation, the Panel was advised that any contact with any member, friend or associate of the family, must be facilitated by the FLO and the Professional Standards Department (PSD) of the West Midlands Police Service.

1.4.2 Both the FLO and the PSD provided support to the Panel and provided answers, where they could, to any of the questions raised by the Panel and provided context to the circumstances leading to the critical incident.

1.4.3 Consequently, the Review Panel decided to use pseudonyms for the subjects of this case and these were all chosen by the Panel.

1.4.4 The pseudonyms chosen by the Panel – and used throughout the Overview Report – are described in the table below:

Name (Pseudonym)	**Relationship**
Nezha	Partner of the Perpetrator

Ahmad (Perpetrator)	Partner of Nezha at the time of the critical incident
Faisal	Child of Ahmad and Ayesha
Ayesha	Previous Partner to Ahmad and Mother of Faisal
Jameela	Previous Partner to Ahmad

Section two
Background information – the facts

2.1 A pen picture of Nezha and Ahmad – the focus of this DHR

2.1.1 Taking account of the nature of the contact with the families of Nezha and Ahmad – described in the Preface and parallel review sections of this Report – the Panel garnered as much information about Nezha as it could, whilst being cognisant of these necessary constraints.

2.1.2 We know that Nezha was born in Syria – in the city of Aleppo – in April 1982.

2.1.3 The Syrian civil war is an ongoing multi-sided civil war in Syria fought between the Syrian Arab Republic (which is led by the Syrian president Bashar al-Assad and he is supported by a number of domestic and foreign allies) and various domestic and foreign forces that oppose both the Syrian government and, in a variety of combinations, each other.

2.1.4 Unrest in Syria began in March 2011, as part of the wider 2011 "Arab Spring" protests that arose from discontent with the Syrian government. This escalated to an armed conflict after protests calling for Assad's removal were violently suppressed. The war is currently being fought by several factions: the Syrian Armed Forces and its domestic and international allies represent the "Syrian Arab Republic" and the Assad regime; opposed to it is the "Syrian Interim Government", which is a 'big-tent' alliance of pro-democratic, nationalist opposition groups whose defence forces consist of the Syrian National Army and the Free Syrian Army.

2.1.5 From this conflict, in 2011, Nezha made a visa application from Aleppo and later in 2011 Nezha arrived in Staffordshire in the UK.

2.1.6 We know that Nezha has two siblings – a younger Sister (born in May 1986) and a Brother – though his date of birth is not known. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. However, during the process of the Review, Nezha's Sister changed her address and has not yet informed the FLO of her new address. Subsequently, communication has been maintained with Nezha's Brother, who lives in Germany.

2.1.7 The FLO confirmed that Nezha's Sister has received contact details for the Independent Author of this Review – though no contact has been made (information has been shared with Nezha's Sister that Arabic interpreters can be made available).

2.1.8 Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

2.1.9 The Panel was told that, following the incident, Nezha's Sister and Brother informed the FLO (and the Office of the Coroner) that a friend of the family – who, at the time, was living in Swansea, Wales – was acting as the next-of-kin for Nezha. The family friend was invited by the family to assist with all necessary arrangements in the UK, including the collection of Nezha's body and the burial. However, as time moved

on the FLO was informed that the relationship between Nezha's Sister and Brother and the friend of the family broke down and all communication between them ceased after the burial of Nezha's body. Contact between the FLO and the friend of the family has also ceased – at the request of Nezha's Sister and Brother.

2.1.10 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences.

2.1.11 The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

2.1.12 During her studies at the University in the UK, the Panel learnt that Nezha engaged with the University – on a contractual basis – to undertake a variety of work, including as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

2.1.13 In August 2015, Nezha was renting a property in Newcastle-under-Lyme. Nezha was registered as a sole occupant of the Property. Nezha's studies at the University in the UK were progressing very well. She had passed 6 (out of 9) modules concerning the study of English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. This was awarded to her in October 2016.

2.1.14 In November 2018, Nezha's status as a refugee ceased, but she had received 'leave to remain' as resident in the UK.

2.1.15 When Nezha left the University in the United Kingdom – in 2021 – after completing her studies, it is likely that her income reduced significantly and this may explain why she was residing (in September 2021) in a House of Multiple Occupation (HMO).

2.1.16 Ahmad was born in February 1982 in Khorramabad, the city of the Lorestan Province in Iran. In 2009 – or thereabouts – Ahmad met his future wife (referred to in this Report as Ayesha). They married in 2009 in Istanbul, Turkey.

2.1.17 The Panel learnt that Ayesha sponsored Ahmad's visa application and they both moved to the UK in early 2010.

2.1.18 Ahmad commenced his post-graduate studies at the University in the United Kingdom in September 2015.

2.1.19 Ahmad had received his first degree from a University in Iran in 2005. From the application he made to the University in the United Kingdom, the Panel learnt that Ahmad had spent time working at three Hospitals in Tehran (between 2004 and 2010) – as an under-graduate and also when he received his first degree in biochemistry.

2.1.20 Ahmad then received his Masters Degree from a University in the United Kingdom (different to the one he attended with Nezha). He studied there between September 2014 and September 2015. Following his post-graduate qualification, Ahmad submitted to the University in the United Kingdom that he had worked in the

NHS as a biochemist and as a senior biochemical scientist. This information has not been confirmed for the Panel.

2.1.21 Whilst at the University in the UK, Ahmad received a quarterly stipend and worked for the University as a laboratory demonstrator and a senior laboratory demonstrator. It is assumed by the Panel that Ahmad and Nezha met whilst at the University in the United Kingdom.

2.1.22 Ahmad's PhD programme was in clinical biochemistry. Ahmad's PhD career was not entirely successful. He pursued a programme of 'English for Academic Purposes' but did not pass the one module that he commenced in 2016 and he did not complete his MA in Learning and Teaching in Higher Education module that he commenced in September 2017. Ahmad did not complete his PhD prior to the critical incident.

2.1.23 In contrast, as noted, Nezha's academic career was more successful. Aside from the completion of her PhD and the modules listed above, Nezha commenced a MA in 'Learning and Teaching in Higher Education' and was awarded Post-Graduate credits by the Senate in October 2018 (though not the full MA) and she commenced a MA in 'Higher Education Practice' in September 2018 and was awarded Post-Graduate credits by the Senate in October 2020 (though not the full MA).

2.2 Contributors to the Review

2.2.1 The agencies invited to make submissions to the Review are listed below:

Agency	Submission
Staffordshire and Stoke-on-Trent ICB	Individual Management Review and Chronology
Staffordshire Police	Individual Management Review and Chronology
University in the United Kingdom	Individual Management Review and Chronology
Black Country Healthcare NHS Trust	Individual Management Review and Chronology
Dudley Children's Services	Individual Management Review and Chronology
University Hospitals of North Midlands NHS Trust	Individual Management Review and Chronology
Black Country ICB	Individual Management Review and Chronology
Dudley Integrated Health and Care NHS Trust (DIHC)	Individual Management Review and Chronology
West Midlands Police	Individual Management Review and Chronology
West Midlands Ambulance Service	Individual Management Review and Chronology

2.3 Review Panel Members

2.3.1 Following the notification of the death of Nezha and Ahmad, the Dudley Community Safety Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of Dudley Council.

2.3.2 The Panel received reports from agencies and dealt with any associated matters such as media management and liaison with the Office of the Coroner.

2.3.3 The Commissioning Authority (Dudley Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

2.3.4 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations.

2.3.5 The views and conclusions contained within this overview report are based on findings from documentary submissions and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

2.3.6 The members of the Panel are described in the table below:

Role	**Agency**
Community Safety Officer	Dudley MBC Community Safety Team Representing Safe and Sound, Dudley's Community Safety Partnership
Head of Safeguarding	Black Country Healthcare NHS Trust
Director of Student Services and Success	University in the United Kingdom attended by Nezha and Ahmad.
Temporary Chief Inspector (at the time of the Review).	Public Protection Department, West Midlands Police
Detective Sergeant, Force Review Team	West Midlands Police
Director of Community Services	Black Country Women's Aid
Assistant Designated Nurse for Safeguarding, Black Country Integrated Care Board (Dudley)	Black Country Integrated Care Board (Dudley)
Chief Executive Officer	Churches Housing Association of Dudley District (CHADD)
Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Head of Safeguarding, Practice and Quality Assurance	DMBC Children's & Young People Safeguarding & Review
Professional Standards Investigator	West Midlands Police (PSD)
Deputy Designated Nurse for Safeguarding Adults	Staffordshire and Stoke-on-Trent ICB
Lead for Safeguarding in Education	Children's & Young People Safeguarding & Review

Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Designated Nurse for Safeguarding Adults	Black Country Integrated Care Board
Team Manager	Dudley MBC Children's & Young People Safeguarding & Review - Professional Practice
Lead Nurse for Vulnerable People	North Midlands Partnership NHS Foundation Trust
Head of Adult Safeguarding & Principal Social Worker	Dudley MBC Adult Safeguarding / Adult Social Care
	Independent Author

2.4 The Author of the Overview Report

2.4.1 The Commissioning Authority, Dudley Metropolitan Borough Council (MBC), appointed an independent Author, John Doyle, to oversee and compile the Review, in accordance with the Home Office Guidance. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs and had no connection with the case or with any of the agencies involved in the review.

Section three

3.1 The Terms of Reference

3.1.1 The Panel approved these specific terms of reference and key lines of enquiry at its initial meeting and agreed to keep them under review as the process evolved. This was to ensure that they could be amended in order to capture any additional information revealed as a part of the Review process.

3.1.2 The Panel also noted that the over-arching purpose of a Domestic Homicide Review (DHR) which is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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 homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

3.1.3 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

3.2 The Key Lines of Enquiry

3.2.1 In order to undertake a critical analysis of the submissions made, the Panel approved these key lines of enquiry:

a. To establish what contact agencies had with Nezha and/or Ahmad

This required agencies to consider these issues:

1. What contact did your agency have with Nezha and/or Ahmad? Please describe these contacts for each subject of the Review
2. Did any agency know or have reason to suspect that Nezha and/or Ahmad were subject to any form of domestic abuse at any time during the period under review?
3. Had any mental health issues been disclosed by Nezha or Ahmad, or any mental illness diagnosed by an agency in contact with them?
4. Were there any complexities of care and support required by Nezha or Ahmad and were these considered by the agencies in contact with them?

5. Were assessments of risk and, where necessary, referrals to other appropriate care pathways considered by the agencies in contact with Nezha and Ahmad?
6. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with Nezha and Ahmad?

b. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Nezha and Ahmad.

This required agencies to consider these issues:

7. What actions were taken to safeguard Nezha and were the actions appropriate, timely and effective?
8. What happened as a result of these actions?
9. What actions were taken to reduce the risks presented to Nezha (and/or Ahmad) and were the actions you took appropriate, timely and effective?
10. What happened as a result of these actions?

c. To establish whether there were other risks or protective factors present in the lives of Nezha or Ahmad.

This required agencies to consider these issues:

11. Were there any other issues that may have increased the risks and vulnerabilities of Nezha or Ahmad?
12. Were there any matters relating to the safeguarding of other adults at risk, or children that the review should take account of?
13. Do you know if Nezha disclosed any domestic abuse to their family or friends? If so, do you know what action they took?
14. Did Ahmad make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

d. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

This required agencies to consider these issues:

15. Were effective whistleblowing procedures in place within agencies to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures. Briefly describe these procedures.

e. To identify clearly what the lessons to learn are and how they will be acted upon.

This required agencies to consider:

16.

What, (if anything), in your view should change as a result of the themes that are emerging from this Review and the production of a multi-agency action plan

f. To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

g. Events and incidents may have occurred during the attempts to manage the COVID Pandemic. We would like to understand the impact of the COVID-19 Pandemic and address any improvements to service delivery.

This required agencies to consider:

17. What impact did the management of the COVID-19 pandemic – including the restrictions associated with it – have on the planned delivery and provision of the services offered to Nezha and Ahmad by the agencies in touch with them

18. What impact did the COVID-19 pandemic – including the restrictions associated with it – have on both Nezha and Ahmad individually, and as a couple.

h. The Perpetrator was a licensed shotgun holder and his certificate was registered with the West Midlands Police. The Panel is not aware of any information to suggest that the Perpetrator's ownership of a shotgun was anything other than lawful. He was granted a license to own and use a shotgun because of the nature of his hobby and pass-time.

This required agencies to consider:

19. Was your agency involved in the assessment for, or granting of, the license for Ahmad to have a shotgun? If so, can you briefly describe the nature of your responsibility in this respect?

20. Is your agency aware of any prior information or intelligence to suggest that the ownership of a shotgun posed a particular risk to Nezha and/or Ahmad?

21. If so, please describe this information and/or your perspective on the risk.

Section four
Summary chronology

4.1 Outside the formal scope of the Review, but pertinent

Outside scope

Between **2010** and **2017**, a number of events and incidents occurred and these were considered by the Panel. In brief, these events included:

In 2010, Ayesha reported that bruising and scratches to her upper body were caused by her husband, Ahmad. They also informed West Midlands Police that they had not been allowed to leave the home address for the last eighteen months. Officers arrested Ahmad. Ayesha told officers that Ahmad had punched her to the head, face, arms and upper body resulting in bruising. The investigation did not yield the evidence to pursue a prosecution and, coupled with this, Ayesha withdrew her complaint.

In August 2011 Nezha took a break from her studies. The Panel presumed this may correspond with the death of her parent.

In November 2012, Ayesha filed for divorce and cited 'due to violence'.

In May 2014, a family court report was made whereby Ayesha made numerous allegations of violence perpetrated by Ahmad. The Judge concluded that Ayesha had fabricated the allegations to prevent Ahmad from having contact with their child.

In May 2015, Ayesha called WMP and reported that Ahmad had assaulted their child. During her call, Ayesha divulged that Ahmad had made threats to her over the previous five months but she had not reported these to police. Ayesha advised that she and C1 were uninjured and safe at a family address not known to Ahmad but was 'traumatised' by his behaviour. A statement was obtained from Ayesha and enquiries conducted. A DASH was completed. Ahmad was voluntarily interviewed and he denied the allegations, suggesting that Ayesha was making false claims in order to assist her in the on-going family court case. The investigation was conducted on a 'single agency' basis by WMP. A harassment offence was recorded in relation to the comments made by Ahmad to Ayesha.

A short time later, Ahmad commenced a programme of post-graduate study (a PhD programme) at the University in the United Kingdom.

In mid-January 2016, in the early hours of the morning, Ahmad called West Midlands Police via 999 and reported that he had been assaulted outside a nightclub in Birmingham. West Midlands Ambulance Service attended the scene. Enquiries were conducted at the scene and these enquiries suggested that Ahmad had inappropriately touched a woman. Ahmad could not point out the offenders. Ahmad was transported to the QE II Hospital in Birmingham.

In February 2016**,** Ahmad called 999 reporting that his ex-girlfriend (W2) was outside his property making threats to kill him. They had recently separated and W2 had left some of her belongings at Ahmad's flat. She had attended to collect them and when Ahmad refused, an argument ensued. Ahmad stated W2 had not actually threatened

to kill him. Ahmad agreed to allow W2 inside to collect her things whilst officers stayed and supervised.

In March 2016, Ahmad's GP noted that he was 'argumentative' in a consultation.

In June, Nezha's GP recorded that Nezha was not fit for work. A statement was issued referring to depression, and hearing loss. This was the first documented incident that Nezha attended an appointment with her partner, Ahmad.

In late July, Nezha's GP recorded low mood during a consultation. The GP also noted that:
"Father died suddenly in Syrian war; has had counselling in the past. Not wanting further counselling but clear she wants further medication. Feels unable to work. Combination of mood and also ongoing left sided hearing loss. Seen with partner".

In August 2016, West Midlands Ambulance Service (WMAS) attended an incident whereby Ahmad has called reporting chest pain. WMAS transported Ahmad to the Royal Stoke Hospital.

In October, the Senate (at the University in the UK) conferred the award of PhD on Nezha.

In mid-December 2016, the MASH Team Manager recorded that Ahmad alleged that Ayesha had attended his place of work with their child (at the University in the UK). Ayesha reportedly said they were homeless and under financial pressure, and therefore she was seeking reconciliation with Ahmad.

Within scope
2017

On the 9th of January, Nezha's GP recorded a consultation with Nezha and her partner. The review concerned deteriorating hearing (after effects of a road traffic accident the year before). The GP noted in the consultation that:

'*patient attended with partner, who did most of the talking'.*

An MRI and CT scan was arranged, along with a referral to audiology for a hearing assessment and hearing therapy. The information discussed was included in a letter to Nezha's GP including Nezha experiencing depression as a result of hearing loss.

In mid-August, Staffordshire Police recorded an incident concerning Ahmad. It was reported that a neighbour had kicked the door, thrown a bottle at Ahmad's head and made threats. The neighbour was arrested, interviewed and issued with a Conditional Caution (S4 Public Order Act).

In mid-October, Ahmad attended his GP. He wished to lose weight, but declined a referral to weight management service. Ahmad reported insomnia. It was noted that Nezha attended on the same date, also requesting weight advice. The GP recorded that they advised that Nezha was not overweight .

In early November, Staffordshire Police recorded an incident involving Ahmad. It was alleged that a neighbour was shining a laser through the window as Ahmad drove away in his car and had shone it into his eye. Personal Nuisance was recorded.

2018

In late January, Ahmad visited his GP and reported insomnia; anxiety at night and stress with work/PhD. It was noted that Ahmad enquired about medication for Nezha in his consultation.

In mid-March, Staffordshire Police recorded an incident concerning Ahmad. It was alleged that a male had broken the CCTV camera owned by Ahmad. Criminal Damage was recorded; the incident was Cross Referenced as a repeat victim of ASB. Intelligence checks were conducted on the suspect. Ahmad Declined to Prosecute

In early April, Ahmad attended the Urgent Treatment Centre Out of Hours Service (OOH) and requested anti-depressants and an opioid because he stated he had run out of medication. Medication was not issued by the OOH.

In early May, Staffordshire Police recorded an incident whereby Ahmad reported an issue with a friend of the neighbour who had nearly reversed into his wife (Nezha). The purpose of the call was to log the incident. The Police recorded Personal Nuisance. An ASB TAG was added to the Incident Report for Local Policing. It was also noted that Ahmad was a repeat victim of ASB.

In mid-July, the Black Country ICB recorded that Nezha requested co-codamol (opioid) and noted that 100 tablets had been issued only 6 days ago.

In October, Ahmad requested a break in his studies from the University in the UK. The break lasted until August 2019. Ahmad cited 'health reasons' for the request.

At the end of November, NHS 111 received a call from Ahmad on behalf of Nezha. Ahmad reported breathlessness, which was worsening. Nezha made her own way to A&E. Nezha was diagnosed with a lower respiratory tract infection and was discharged the same day with a course of antibiotics.

On the 1st of December, NHS 111 received a call from a person calling themselves XX (this was Ahmad using an alias) stating that Nezha had shortness of breath. It was recorded that the patient was with her husband, and her condition was worsening. An Ambulance was despatched. It was documented that Nezha had an anxiety disorder. Nezha was 'left in the care of her partner with advice for any future episodes'. A letter was sent to her GP.

2019

Towards the end of March, Staffordshire Police note an Incident Report. Ahmad stated that his car windows had been smashed. The crime was recorded as Criminal Damage. An investigation commenced. It was recorded that the Complainant Declined to Prosecute.

In early June, the GP received a letter from the Dudley out of hours (OOH) service. Ahmad had attended with his partner and stated that he was due a GP appointment

on that day but an accident on the M6 had caused a delay and he missed the appointment. Ahmad requested opioid and anti-depressant medication. It was good practice from the OOH to check Ahmad's appointment, liaise with the Practice in order to limit prescribing.

In Mid June, Ahmad's GP was asked to review a 'not fit for work' letter. Ahmad reported back problems. The duration of the letter was set for the 1st of October 2018 to the 21st of June 2019. Nezha had a GP consultation on the same day. The GP recorded panic attacks, a prolapsed disc, and knee pain.

2020

At the end of January**,** WMP received an application for a firearms and shotgun licence from Ahmad. Ahmad stated that he wished to shoot clay pigeons at a Midlands rifle club. He recorded on his application that he had previously held a firearms certificate in Iran between 2002 and 2006 and had two years military service**.** Two referees were listed – one a colleague and the other a neighbour and friend of six years from the Staffordshire area. The required checks were initiated and forms sent out to Ahmad's GP.

In early February, Ahmad's GP received a request for Consent to Release Medical Information. The request was from the Staffordshire & West Midlands Police Firearms Licensing Unit and it was asking for information regarding medical history. A letter was sent to Ahmad requesting consent to release, with an invoice for the fee (for private work, payable to the GP). There was no further record of this on EMIS system and no consent to disclose was received.

Note: Following a discussion with the GP, there was no further contact from Ahmad for consent to release information and no contact from the Police around this. No medical information was shared. Hence, Ahmad's GP Practice were unaware that a firearms licence had been granted. Therefore, there was no documentation or safeguarding oversight of this request on EMIS

In late February, Ahmad requested a break in his studies from the University in the UK. The break lasted until October 2020. Ahmad cited COVID as the reason for the request.

On the 10th of February, Staffordshire Police recorded an Incident whereby Ahmad was arrested at his home address regarding an incident involving Controlled Drugs (an allegation of illegal importation). Ahmad was arrested and held in custody under his alias name. His registered property and linked property were searched.

'Special Branch' noted that there was no relevant intelligence to share from their point of view and remarked that from the details in the (Staffordshire) log, there was nothing to support any 'CT-LASIT[1] ideology which may lead to any activity at this time'.

Staffordshire Police provided the custody reference number under the name of the alias used. There was no direct contact between WMP and Ahmad. It could not be

[1] Counter-Terrorism Left-wing Anarchist Single Issue Terrorism

proven that Ahmad had imported Heroin. Ahmad was released with no further action for that offence.

Later in May, Nezha attended her GP for a medication review. It was noted that Nezha was still taking anti-depressants; taking co-codamol daily for knee and back pains. The GP recorded a 'shortness of breath'. Nezha's Partner stated that Nezha almost chokes in her sleep at night.

On the 1st of June, Ahmad attended his GP for a telephone consultation. Ahmad requested an opioid prescription. A short time later, Ahmad called the Practice to enquire about the the prescription for the opioid medication. The issue was refused by the GP – they were awaiting Ahmad's regular GP to return. It was recorded that Ahmad:
'wasn't happy. Took my name. Said it was neglect and to remember this conversation in case someone rings back to pursue it.'

This was good prescribing practice.

At the end of July, Ahmad met with the Firearms Licensing Officer (FO1) to consider the firearms application. The rifle club confirmed that Ahmad was a member and had passed a probationary period. FO1 recorded that in their opinion, Ahmad could 'be permitted to possess a firearm without danger to public safety or the peace'.

On the 12th of August, Staffordshire Police noted an Incident where Ahmad called to state that his Partner had been assaulted by a neighbour and was bleeding and needed an Ambulance. On investigation, it was recorded that the incident was an assault between neighbours. Both parties had been aggressive toward each other. A Community Resolution and advice was given to both parties. The incident was recorded as 'Violence Against the Person'. WMAS attended the scene and noted that Nezha did not wish to go to A&E. Nezha's partner was happy to look after Nezha.

2021

In mid-January, West Midlands Ambulance Service were called. Ahmad advised the call handler that they had muscular pain in left side. Ahmad was not conveyed to Hospital. Ahmad stated that they would visit their GP. A short time later, Ahmad called stating that the chest pain had worsened. Ahmad was deemed to have capacity and refused transport to hospital. Ahmad was left in the care of his partner who was recorded as next of kin.

A little later in January, Ahmad called for an Ambulance and reported ongoing chest pain for 8 days, which was gradually worsening. Once again, after the attendance, Ahmad was left in the care of his partner.

On the 13th of February, West Midlands Ambulance Service were called by Ahmad who advised that he had:
"….gone into fridge that morning to get a bottle of Pepsi. A friend had put approximately 30-30ml of methadone in the fridge and he had accidentally consumed it".

There was no evidence of analysis around who the methadone belonged to, or if there were other residents in household.

Towards the end of February, Staffordshire Police noted an incident involving Nezha. It was reported that Nezha had suffered the loss of £9,351.65. The incident was recorded as a complaint of theft. Nezha named a suspect as an Egyptian National who, over the last four months, had lived at the address and had now left. An appointment was made for a Police Officer to attend Nezha's home address. Nezha was recorded as having COVID symptoms and was awaiting an appointment for a test and requested the Police call when she was better. Over the following 3-4 weeks, several attempts were made to confirm appointment times and dates. The matter was reviewed and a short time later filed as 'Nezha declined to engage'.

On the 5th of May, Ahmad requested an urgent appointment with his GP. Ahmad reported that since having the AstraZeneca vaccine, he had chest pain, oedema (swelling), and inflammation. The GP reviewed the matter and noted:

"Looking back patient was having these pains before the vaccine, spoke to him in January about this and that he Did Not Attend two double appointments with the GP. Ahmad stated that he had blood samples taken 2 days after speaking to the GP in January, but there were no results on the system".

On the 14th of June, Staffordshire Police received an anonymous call concerning Ahmad and Nezha's property. The Housing Association had changed the locks on the property following the previous Police visit. The caller stated that a man had returned to the property, called the Housing Association who did not give them keys or codes to the key safe. The man returned with a woman (presumed to be his partner and presumed to be Nezha). The call was made to the Police because they think they have broken into the property and were not sure if the Police needed to know.

Police Officers attended and spoke to Ahmad and Nezha outside the property. They had been away for 30 days in Birmingham and returned to find the door to the flat had been forced open due to the council forcing entry after serving a notice on the property.[2]

On the 8th of September**,** Nezha reported she had returned to her room within a Home of Multi-Occupancy at which she was residing, to find an unknown person had entered by unknown means and stolen jewellery and mobile phones.

The incident log was later passed to an officer within the Initial Investigation Team to make further contact with Nezha and on the 11th of September, they attempted to speak with her on the phone. Nezha did not answer. Three further calls were made over the next two days but Nezha did not answer or respond to texts sent asking for a call back. Nezha failed to return any messages and the matter was filed on the 14th of September pending any further information coming to light.

[2] The Panel noted that Nezha's employment at the University in the UK ceased in 2021. She had reported the theft of approximately £10,000 and could not pay her rent to the Housing Association. The Housing Association issued notice to vacate the property and were operating under the assumption that Nezha had returned to Syria (the reasons for this were not clarified for the Panel)

Towards the end of September, the University in the United Kingdom agreed (via appeal) another extension to Ahmad's PhD submission deadline (6 months).

2022

On the 7th of January, Ahmad reported an incident (an offence of taking without consent – TWOC) that actually occurred on the 26th of August 2021. Ahmad reported this offence using an alias. When asked why he did not report the matter at the time, he informed he was unaware that he had to do so. His insurance company had since advised him to contact the police. Ahmad was advised to contact his insurance company and the log was closed.

Three days later, Ahmad contacted WMP. He requested the log number and explained that the offender had collided with a parked car prior to returning the vehicle to his address.

Ahmad was advised that an officer would contact him within approximately twenty four hours for further details. The second log reference was generated and provided to Ahmad. Contact staff called Ahmad for further information

The matter was recorded as a crime and the reference number sent to Ahmad along with notification that the matter would be sent to the Investigation Hub to progress. An officer from the hub attempted to contact Ahmad several times and after the third failed attempt, the report was filed.

Towards the end of March, there was a text message exchange between the Social Worker and Ahmad (the Social Worker was appointed for the Child of Ahmad and Ayesha). Ahmad sent a text message back to the Social Worker, requesting that Ayesha (mother of their child) to contact him due to a "very urgent matter."

A little later, the University approved a final extension to the deadline for Ahmad's PhD submission.

Later in March, the Social Worker confirmed with the school Safeguarding Lead that they had passed Ayesha's number to Ahmad, and Ahmad's number to Ayesha.

A short time later, the critical incident occurred.

Section five
Key issues arising from the Review

5.1 The incidence of traumatic events in adolescence and early adulthood
5.1.1 The 'pen-picture' generated by the Panel from the submissions made by the agencies in contact with Nezha and Ahmad and from the information provided by the Family Liaison Officer, indicated that Nezha arrived in the UK seeking asylum and fleeing conflict in her country of birth. For Nezha, the Panel believes that she left Syria in 2010, or thereabouts.

5.2 Was there a formal recognition of disability
5.2.1 The Panel received submissions concerning the gradual loss of hearing endured by Nezha. There was no evidence to suggest that Nezha was formally registered as being disabled.

5.2.2 The Panel noted that, on reviewing the records from the Black Country ICB, there appeared to be a little inconsistency. In 2017, the GP Practice noted that Nezha's 'husband' said Nezha was unable to work. On the 29th of September 2017 at Nezha's new patient health check with her new Practice, Nezha said that she spent most of her time at work standing or walking. It was noted, however, that in 2019, a GP from the same Practice wrote a supporting letter to the Department for Work and Pensions for a home visit assessment due to Nezha's back pain, stating that she was spending most of the day lying down and needed a wheelchair.

5.2.3 The Panel did not receive any information to suggest that Ahmad was formally registered as disabled. He did not access the services offered to him by his employer when he referred to his disability (this is clear from the submission received from the University in the UK).

5.3 Hearing the voice of Nezha
5.3.1 In 2017, Nezha's new patient health check referred to a statement made in correspondence from the University Hospitals of the North Midlands NHS Trust that Nezha's main language was English and that Nezha's English was: "reasonable when she engages".

5.3.2 There were occasions when – in a literal sense – Nezha's voice was not heard. The Panel received submissions noting that Ahmad would 'do most of the talking' when joint visits to the GP were made. It is noteworthy, of course, that joint visits to the GP were the most frequent mode of contact for Nezha.

8.3.3 The Panel noted that – as time moved on – Nezha's voice became less obvious. The opportunities available to her to, perhaps express concern and to 'tell her story' diminished significantly. At the same time, it appears from the accounts received (particularly from healthcare providers and from Staffordshire Police) that Ahmad became more visible and more dominant.

5.4 Knowing the full history of Ahmad
5.4.1 There was a history of notifications for Ahmad, including detail of Domestic Violence with his ex-partner, Ayesha.

5.4.2 The Staffordshire Police arrested a person (who was in fact Ahmad, using an alias) on suspicion of importing heroin. For evidential reasons, no prosecution occurred – but the use of the alias had implications.

5.4.3 Medicines Management records for Ahmad noted that he was over-ordering an opioid medication. The Panel noted that Ahmad's attempt to order repeat prescriptions for pain-relief medication – including a request at a NHS Walk-In Centre – were clearly identified by his GP Practice and the requests were denied. The Panel worked on the assumption that Ahmad may have been preoccupied with attempting to receive this form of medication, but that his behaviour did not demonstrate a dependency on opioid medication and none of the submissions indicated that Ahmad was addicted to any prescribed or illicit substances.

5.4.4 The consideration and management of potential opioid dependency would have been applicable for Ahmad and also for Nezha.

5.5 The Taking With-Out Consent incident reported in January 2022.

5.5.1 In light of Ahmad's apparent reluctance to engage, the lack of available information about the offender and loss of potential CCTV, the decision was taken that there was insufficient information for WMP to pursue the investigation any further and the matter would be filed pending any future contact from Ahmad. The author of the submission from WMP noted that, because the TWOC was aggravated by the fact the offender crashed the vehicle, the matter required further investigation.

5.5.2 Ahmad was not home when his vehicle was taken but did provide details about what happened. It is not recorded how he knew the offender was indeed responsible. It is fair to suspect this information was provided to him by his partner who was therefore a key witness in the case. What the Panel could garner from the chronology was that, whilst the incident was reported in January 2022, it actually occurred in August 2021. In February 2021, Nezha reported the theft of approximately £9,400 and on the 8th of September 2021, Nezha reported that she had returned to her room within an HMO to find that an unknown person had entered her room and stolen property.

5.6 Subtle signs of coercion and control

5.6.1 As noted, a frequent mode of contact with General Practice was for Nezha and Ahmad to make joint visits. The GP noted that Ahmad would often lead the conversation and speak on behalf of Nezha.

6.6.2 While in isolation, the softer signs of potential safeguarding risk are less visible, but when domestic abuse and safeguarding concerns are viewed as a whole, they can provide a picture that may otherwise go unseen. Identification of these subtle signs is key.

5.7 Transferring abuse from one partner onto another

5.7.1 There was a period when Ayesha (who made allegations of abuse) would make contact with Ahmad – frequently this concerned the care and welfare of their child. Ahmad would often refer to this contact as harassment and it appeared to cause considerable distress and distraction for him.

5.8 Anti-social behaviour and discrimination from neighbours

5.8.1 Ahmad and Nezha both endured episodes of discrimination and disputes with their neighbour(s). It is not clear whether this constituted a 'hate crime'. The Panel learnt that counter allegations were made by the neighbour about Ahmad.

5.9 Nezha's accommodation and lived experience

5.9.1 Nezha was registered as a resident in one property that she shared with Ahmad. However, toward the end of the scope of the Review, there is reference to Nezha living in a house of multiple occupation. This occurred approximately six months after the reported theft of approximately £10,000.

5.9.2 The Panel noted that Nezha's employment with the University in the UK ceased in 2021. This, no doubt, had significant financial implications and the representative from the University did confirm that Nezha's income will have fallen notably from this point.

5.10 The incident of the Burglary on the 8th of September 2021.

5.10.1 It is unclear whether or not Forensic Services did eventually visit the address where the burglary occurred. There is nothing to suggest that they did and nothing relating to forensic evidence, or lack of, documented within the rationale for filing the case.

5.10.2 Despite there being an entry within the incident log that states Nezha was vulnerable (she had self-disclosed an undefined disability), this is not referenced anywhere within the crime investigation log.

5.10.3 It is subsequently not clear what Nezha's disability was or indeed her level of vulnerability. This may have been explored with Nezha on the 'phone had she answered one of the several calls made by WMP. However, because efforts to engage with Nezha failed, there is no way of knowing.

5.11 The licensing of the firearm

5.11.1 The Panel was informed that Ahmad's GP reported that they received a 'consent to disclose medical information form' and invited Ahmad to provide consent, along with a fee for payment. This was not received and the GP did not share any information about Ahmad with the Staffordshire and West Midlands Police (WMP) Firearms Licensing Unit.

5.11.2 The Enquiry Officer from the joint Firearms Licensing Unit did not identify that the incident concerning the arrest of Ahmad in February 2020 was the same Ahmad that was applying for a firearm. At the incident of the arrest in 2020, Ahmad was arrested by Staffordshire Police using one of his aliases. Had the link been made, the Enquiry Officer would have been prompted to conduct a check on the Police National Computer which would have revealed that he was actually arrested (under an alias) and was under investigation for allegedly importing heroin into the UK.

5.11.3 It was possible – though the Panel were acutely aware of the dangers associated with hindsight – that enquiries could have been made with Staffordshire officers, such as obtaining custody photos and information from the seized documents and this would have confirmed that the alias was in fact Ahmad. At the time, there was no rationale for doing so.

5.11.4 Had this been confirmed, and given the nature of the offence, WMP was clear that Ahmad would not have been granted a firearms licence.

5.11.5 The Panel also learned that the Licensing Department had – from March 2020 for around twelve months due to the management of the COVID Pandemic – frozen grant applications and this affected the application process. The application process was re-opened after intervention from both the Offices of Executives and Commissioners due to pressure from the public, the press and shooting associations. The enquiry was done by a restricted police officer as many of the licensing team were working from home under the COVID restrictions

5.11.6 As noted elsewhere in this Report, the guidance concerning the issuing of firearms licenses was amended in December 2021. If an individual has applied for a firearms license and is the subject of a PNC or PND check, it will show that they have applied for a license. The firearms licensing department are now informed if an applicant has been arrested and license holders are recorded on PNC and PND in accordance with this regulation. At least one referee must now be contacted as part of the application process. No one will be given a firearms licence unless the police have reviewed information from a registered doctor setting out whether or not the applicant has any relevant medical history – including mental health, neurological conditions or substance abuse issues. individuals are now required to provide a medical pro-forma alongside their application, filled out and signed by a registered doctor.

5.12 The effect of dominance.

5.12.1 The Panel learnt that the GP noted that Ahmad often arrived late for appointments, requested medication late, had poor compliance with medication, did not attend for some appointments and requested that his name was changed on EMIS to include the title 'Dr.' This may be seen as someone who wished to control their circumstances.

5.12.2 The Author of the submission made by the University Hospitals of the North Midlands considered the remark made by Ahmad during a consultation with them (that he felt that the Syrian conflict was what makes his wife: "virtually unresponsive") to be a curious remark to make about a woman who appeared, from other accounts, to be perfectly competent and confident.

5.12.3 There was no evidence on the EMIS records for Nezha that transferrable risk from Ahmad had been considered. This was disappointing in light of Ahmad's dominance at some appointments.

5.13 Nezha's healthcare history

5.13.1 As noted elsewhere in the Review, Nezha presented to her GP with a variety of healthcare needs. A number of these consultations concerned advice and prescribing to tackle pain relief. There were 33 prescriptions for pain relief issued during the scoping period, although there was no evidence to suggest that there was any over prescribing.

5.13.2 As noted, Ahmad was quite involved in Nezha's healthcare. The degree of intrusion into the healthcare record of a partner could be seen as a form of coercion and control. The recognition and response to these less subtle indicators is specified in current training provided to healthcare professionals.

5.14 Alerts and safeguarding oversight:

5.14.1 A visible chronology of safeguarding indicators could have made a difference in this case. Consideration should be given to what constitutes a 'safeguarding incident' and the difference between 'EMIS coding' and an 'alert'. It would be beneficial to code individual incidents so that on the patient's 'summary record', an overview of the frequency and timeline of events would be evident.

5.15 Ahmad's behaviour in the 12 months prior to the incident

8.15.1 The Panel concentrated upon just three specific examples.

- In 2021, Ahmad contacted the Ambulance Service when he accidentally consumed methadone when he mistook it for a soft-drink in his fridge. Critical thinking and safeguarding oversight on receipt of this notification could not be seen. Expectations would be to invite Ahmad to the surgery, establish who the person was that prescribed the methadone and whether there was transferrable risk or drug dependency issues for Ahmad.
- Ahmad was also prescribed pain relief initially in 2017 and again in 2022. This opioid analgesic painkiller is a highly effective medication for pain relief and is a controlled drug. Analysis around the ongoing use of anti-depressants and the 'accidental' methadone overdose could have initiated a GP consultation and onward referral to mental health services and substance misuse services.
- In 2021, Ahmad contacted his GP Practice on a number of occasions reporting that he was concerned about the possible effect of his Astra-Zeneca COVID vaccination. Ahmad stated that it was having an effect on his facial hair, that he was developing enlarged breast tissue and that – on a recent trip to Germany – he had received a testosterone test and told his GP at the Practice that it was low. None of these symptoms could be confirmed by his Practice.

5.16 The incident in Plymouth

5.16.1 The Panel set aside some time to discuss the tragic incidents that occurred in Plymouth in August 2021. The Office of the Coroner held an Inquest into those events and in February 2023 the Inquest Jury returned a verdict of unlawful killing of all of the victims.

5.16.2 The Panel noted, from the press release from the Plymouth Coroner, that a comprehensive Preventing Future Deaths Report had been completed and that recommendations had been made to the Home Office. Additionally, the Panel noted that the failings highlighted by the jury's findings, which contributed to the shootings and which will likely be used to make widespread changes to UK gun laws, included:

- That Devon & Cornwall Police [Firearms and Explosives Licensing Unit (or 'FELU') made serious errors in granting Jake Davison's application for a shotgun licence and by failing to revoke it in 2020;
- Following the assault on two children in 2020, the force made an unreasonable decision to charge the assault as one of battery and to properly investigate

whether it was safe to return the shotgun and certificate, after initially seizing them;
- The force did not have robust systems in place concerning the training of FELU staff, or to ensure decisions were made at the correct level;
- Sufficient medical information was not taken in respect of the initial shotgun licence application;
- FELU (Firearms and Explosives Licensing Unit) failed to properly obtain and consider all the relevant evidence before deciding whether to grant the licence;
- A lack of national accredited firearms licensing training failed to equip police staff to protect the public;
- There was a catastrophic failure in the management of the FELU, with a lack of managerial supervision, inadequate and ineffective leadership.

8.16.3 The Independent Office for Police Conduct (IOPC) has also stated that a criminal investigation into possible health and safety breaches by Devon and Cornwall Police was underway at the time of writing this Report.

8.16.4 The Senior Coroner in Plymouth noted in his Preventing Future Deaths Report that the Home Office, and each of the 43 Chief Constables in England and Wales, should respond to his detailed examination of gun laws by the 3rd of May 2023. The Home Office has applied to the Office of the Coroner for an extension to the deadline.

Section six
Conclusions

6.1 This Domestic Homicide Review concerns the death of Nezha, who died in March 2022, and of Ahmad – who died at the same incident. The working hypothesis of the West Midlands Police was that Ahmad murdered Nezha with a licensed firearm and then took his own life. This was confirmed by the Office of the Coroner at the Inquest held into the deaths. The Inquest was concluded in July 2022.

6.2 The Domestic Homicide Review Panel that completed this Review recognised that this was a murder, followed by a suicide.

6.3 As noted in the Preface, the circumstances surrounding the review being undertaken by the Professional Standards Department (PSD), meant that the Review Panel would not make direct contact with any member, friend or associate of the family of either Nezha or Ahmad and that all communication must go via the FLO and their colleague from the PSD. The information acquired by the Review to provide a 'pen-picture' of the subjects of the case was verified by the FLO and the Panel are grateful for their help and support.

6.4 The Panel noted that the agencies contacted in relation to this Review identified a specific diversity issue concerning Nezha. The agencies recorded and noted that Nezha was Syrian and had fled conflict in her country of birth and sought asylum in the UK. Nezha made a visa application to the UK from Aleppo and arrived in Staffordshire in 2011.

6.5 The Panel learnt that Nezha has two siblings – a Sister and a Brother. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

6.6 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences. The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

6.7 During her studies at the University in the UK, the Panel learnt that Nezha engaged with the University to undertake a variety of work. This included working as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

6.8 In August 2015, Nezha was living in a property in Newcastle-under-Lyme and she was registered as the sole occupant of the Property. The Panel learnt that, when Nezha and Ahmad formed their relationship (in approximately 2015), from time to time, Ahmad would also reside at the property.

6.9 During this period, Nezha's studies at the University in the United Kingdom were progressing very well. She had passed 6 (out of 9) modules concerning the study for a MA in English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. Nezha was awarded her PhD in October 2016.

6.10 The Panel learnt that in November 2018, Nezha's status as a refugee ceased. However, it was noted that Nezha received 'leave to remain' and so remained a resident in the UK.

6.11 Nezha left the University in the United Kingdom in 2021. She had completed her studies. The Panel worked on the assumption that, at this point, Nezha's income reduced significantly. This may explain why Nezha was residing (in September 2021) in a House of Multiple Occupation (HMO) and it may suggest that, to some degree, Nezha was becoming financially dependent upon Ahmad.

6.12 The Panel noted that the report of assault and harassment from Ayesha was handled promptly and relevant safeguarding procedures were undertaken. Relevant referrals were made with Children's Services in both the area in which Ayesha and her child had lived when the incident occurred and the area they moved to following the incident. Contact was maintained with Ayesha throughout the investigation and her expectations managed accordingly.

6.14 The Panel learnt that Ahmad applied to West Midlands Police (WMP) for a firearms license at the end of January 2020. At this time, the WMP were using an intelligence system called FLINTS. Following discussion of the application process, it became apparent that if an intelligence log had been submitted to include Ahmad's 'aliases', this would have shown up on FLINTS. However, of course, as noted by the author of the WMP submission, the enquiry officer was unaware that Ahmad was known in Staffordshire Police because he had been arrested under an alias and this alias was completely unknown to WMP.

6.15 As a part of the licensing procedure, a letter was sent to Ahmad requesting consent to release relevant medical information. The Panel received a copy of the licensing guidance in operation at the time of the application and this element of the procedure was in accordance with that guidance. Discussion between the GP and the author of the submission from the relevant ICB, outlined that no further communication was received from Ahmad or the Police. This suggested that Ahmad's medical history was not shared with the Police. in addition, the GP informed the Author of the submission that Practice X was unaware that a firearms license had been granted to Ahmad.

6.16 As noted above, the submissions received from the agencies in contact with Ahmad tend to generate an image whereby Ahmad's behaviour, in the 12 months prior to the critical incident, can be described as unusual or at least out of character. Whilst each individual feature did not generate a concern acute enough to consider a safeguarding referral, or discussion at a multi-agency arrangement, when taken together they portray a person experiencing some degree of trauma or mental distress, the precise causes of which are not entirely clear. There may have been a strong desire exercised by him to control those elements of his life that he could control – and that included Nezha.

6.17 Throughout this Review, the voice of Nezha has been very difficult to discern. The Panel valued the information provided via the Family Liaison Officer, which, in turn, came from Nezha's Siblings. This information, coupled with the submissions

received from the one or two agencies in contact with her prior to 2015, gave a clear impression of a woman strong enough and resilient enough to flee the trauma of violence in her country of birth and make a new life in the UK. However, when Nezha began her relationship with Ahmad in 2015, more agencies began to record contacts with her – including Staffordshire Police, the Ambulance Service and NHS primary and secondary care services. Nevertheless, it appeared to the Panel that as Nezha was becoming known to more services, simultaneously her presence was becoming less obvious to the extent that she seems to have lost her autonomy.

6.18 Nezha was murdered by Ahmad and the weapon used by him to kill her was a legally held licensed firearm. The Panel await the response of the Home Office to the request made by the Coroner in Plymouth to review the guidance concerning the issuing of firearms licenses.

6.19 The Panel extends its condolences to the family, friends and colleagues of Nezha.

Section seven
Lessons to be learned by the agencies submitting information.

7.1 Staffordshire Police

7.1.1 Predominantly, the response from Staffordshire Police was focused upon an ongoing dispute between Ahmad and/or Nezha with identified neighbours. As noted elsewhere in this Review, there was a mixture of attempted resolutions to these disputes but they were not entirely successful and the dispute continued.

7.1.2 The Panel did note that at least one incident involving the identified neighbours could have been coded as a 'hate crime' and that a lack of engagement with victims of such crimes can be countered by more direct (but sensitive) enquiry with them and a more assertive service directed towards the perpetrators of such crimes.

7.2 Dudley Children Services

7.2.1 Dudley Children's Services informed the Panel that there is learning in relation to the sharing of information, specifically contact numbers, between parents where domestic abuse is, has been, or may be a concern. Further, Dudley CSC noted that there is a learning opportunity in relation to the quality of support and intervention in relation to safeguarding C1. A number of referrals were received from family members, raising concerns about C1's safety. A more robust assessment of C1's care and Ayesha's parenting capacity may have led to more timely intervention.

7.3 Dudley Integrated Health and Care NHS Trust (DIHC)

7.3.1 The author of the submission questioned the decision made to issue a firearms licence to an individual who has been reported to have been the perpetrator of domestic abuse.

7.4 West Midlands Police

7.4.1 With regard to the response provided by WMP on the day of Ahmad and Nezha's deaths, the author of the submission was not in a position to comment at the time the Review was underway (due to the Review being undertaken by the Professional Standards Department).

7.4.2 At the time of publication of this Review (June 2024), the final report of the PSD case concerning the deaths of Nezha and Ahmad was being written. The lead reviewer from the PSD confirmed that 'recommendations were being made for the force' and that these recommendations will be considered by the Appropriate Authority in the PSD.

7.4.3 West Midlands Police did identify a number of learning opportunities from their involvement with the Review, concerning specifically Ahmad's application for a firearms license. These are set out below:

- Intelligence checks conducted when processing applications for a firearms license need to be more robust and repeated prior to being issued regardless of how long the process takes.
- It is evident that the missing of information meant that Ahmad was granted a firearms licence and held a shotgun.

- Had all available information been obtained, Ahmad would not have been granted the licence.
- Background checks for applicants must be repeated at the point the applicant is deemed suitable and before the supervisor grants the license. These must include checks with an applicant's GP so that any changes are noted and considered.

7.5 UK University

7.5.1 Details are provided within the five actions described in the single agency action plan, appended to this Report.

7.6 Black Country Integrated Care Board (Dudley Place)

7.6.1 From discussion with the GP, it is understood that Nezha and Ahmad often accompanied each other to their appointments. The GP described Ahmad as polite, rational, and educated and that there were no concerns noted by the GP about the relationship dynamics between Ahmad and Nezha. Nezha and Ahmad's joint attendance at appointments was not always recorded on EMIS, therefore was not identifiable by future professionals as a possible risk factor.

7.6.2 Nezha and Ahmad both had a history of physical and mental health difficulties for which they took medication including long term anti-depressants, opioid medications and the Panel considered that it may be possible that Nezha and Ahmad lived with a degree of opioid medication dependency.

7.6.3 Discussion with the GP around Ahmad's mental health raised that Ahmad had no formal mental health diagnoses. Ahmad requested Selective Serotonin Reuptake Inhibitors (SSRIs) and low dose antidepressants were prescribed to help Ahmad with the stresses and strains of everyday life, busy work, and study.

7.6.4 Previous domestic homicide reviews have highlighted a link for victims with attending A&E, patient stress and anxiety, unexplained pain (including allegedly from a car accident), concerns about weight, stress, urinary problems, and issues with digestion (IRIS, 2022), all of which Nezha experienced. Perpetrators presented with recurrent symptoms of anxiety and depression, attended the practice more than average, reported having problems with partners and children, had access to a weapon (IRIS, 2022), all of which could be applicable to Ahmad.

7.6.5 Safeguarding checks had been completed by BCHFT (Black Country Healthcare Foundation Trust) MASH Safeguarding Nurses and documented on EMIS. As noted, these safeguarding entries do not receive GP safeguarding lead oversight and can be missed amongst consultation text. Current alert systems on EMIS could be more effective in highlighting historic safeguarding concerns. Safeguarding checks are an essential information source to highlight potential risk to staff and transferrable risk to other adults and children. In historic domestic homicide reviews, General Practice was the main professional that both the victim and perpetrator were engaged with.

Recommendations from the Review

Set out below are the Recommendations made by the Panel, accompanied by the rationale for each Recommendation.

These Recommendations are **NOT** in any order of priority.

Recommendations

1. Sharing information concerning risk and vulnerability with Higher Education institutions.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Investigate the development of a 'disclosure form' which will require the agency making the submission to the MARAC (or other relevant multi-agency arrangement) to secure the consent of the client to disclose necessary information to other MARAC Partners prior to the MARAC submission being made. The disclosure form – with the relevant information – could then be shared securely with each Partner on the MARAC prior to the meeting taking place. This disclosure form may allow – where necessary – information to be shared with institutions of Higher Education;
- Consider whether safeguarding training could be shared across the interface with higher education services within the CSP area to help share knowledge of local agencies and their threshold for providing support;
- To consider forging links with the Staffordshire and Stoke-on Trent CSPs to share their training across the interface with the Universities within their organisational footprint.

2. Firearms Licensing

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the West Midlands Police that the DARA[3] is applied for first responders and the use of DASH is promoted as a dynamic assessment, specific to the client, used for conducting secondary risk assessments;
- Consider the development of a multi-agency assessment of firearms applications and invites the MARAC Governance Group to act as the assessing Panel;
- Invite the West Midlands Police to apply a resolution to any GDPR issues at the point of application by explicitly informing the applicant that their application will be referred to a multi-agency forum for assessment;
- Apply due diligence to a process whereby, as necessary, applications that may have potential for risk to transfer to children, colleagues, family members, etc. to be referred to the appropriate safeguarding authority and the employee alert system across Dudley MBC

[3] the Domestic Abuse Risk Assessment (DARA) has been identified by the College Professional Committee and the NPCC as the preferred risk tool for first responders to domestic abuse. The NPCC supports forces adopting the DARA for first responders to domestic abuse. The DARA has been designed and evaluated for use by first responders. Specialist police officers and staff conducting secondary risk assessment are expected to continue using the DASH. Similarly, as the DARA has been evaluated in a frontline policing setting, partner agencies are expected to continue to use the DASH.

3. Adverse experiences in early adulthood

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from partners that trauma informed practice is being embedded across the Borough
- Assess the development of trauma informed practice, specifically for people seeking asylum

4. Use of the Pathfinder Toolkit and NICE Guidance.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from all Partners that they have suitable and effective domestic abuse and safeguarding training which is available to their staff

5. Suicide and the impact on family and friends

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with the Black Country Healthcare NHS Foundation Trust and supports the Trust in its endeavour to secure 'real-time-surveillance' (RTS) data on suicide and supports the Trust to develop a plan to promptly deliver support to family and friends, as appropriate;
- Seek support and guidance from the Offices of HM Coroner to deliver the ambition to secure 'real-time surveillance' data and also to drive the delivery of the recommendations from the National Confidential Inquiry into Suicides and Mental Health (NCISH);
- Deliver these particular recommendations in tandem with the Recommendations made by the Panel for DHR-9, specifically:
    - To promote the connection between suicide and domestic abuse;
    - Include domestic abuse as an explicit priority within the suicide prevention strategy;
    - Ensure that the RTS system asks specific questions about domestic abuse.

6. Prescribing practice

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the Pharmacy Clinical Network that systems are in place to support safe and effective prescribing, particularly for drugs that can be abused and/or may lead to dependency

7. Hate Crime, Anti-Social Behaviour and Domestic Abuse

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seeks assurance that all officers – Police, the ASB Team, housing services and others – consider domestic abuse when receiving referrals concerning hate crime and/or anti-social behaviour and vice versa; and

- That there are clear routes into appropriate services when hate crime and/or anti-social behaviour coupled with domestic abuse is identified.

8. Placing 'alerts' onto EMIS

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with IRISi and seek clarification for the decision to step-down the use of certain READ codes, which results in them no longer being promoted on the IRIS training;
- Invites IRISi to consider supporting the re-introduction of key domestic abuse related READ codes into the training programme;
- Ensure IRISi continues to promote in its training programme specific codes for people subject to a history of domestic abuse (14XD, 14X3); domestic abuse in the household (13Wd); being a victim of domestic abuse (14XG).

9. Family Safeguarding

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Work with the Children's Social Care Service to support the ongoing work regarding 'Think Family' and other 'strength based' models;
- Offer particular support to the implementation of "Family Safeguarding", which commenced within the Borough from July 2023;
- Encourage partners to work together and with other Partnerships (including the Safeguarding Board) to promote and deliver a programme to support the adoption of the 'Think Family' ethos and model of delivery.

DUDLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'Nezha' IN MARCH 2022

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2017 to MARCH 2022

OVERVIEW REPORT

Independent Author: **John Doyle**

FINAL DRAFT **JUNE 2024**

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The Coronavirus-19 Pandemic

On the 31st of December 2019 the World Health Organisation (WHO) Office in the People's Republic of China picked up a media statement by the Wuhan Municipal Health Commission on cases of 'viral pneumonia' in Wuhan. The Country Office translated the media statement and passed it to the WHO Western Pacific Regional Office. At the same time, the WHO's Epidemic Intelligence Team picked up a media report about the same cluster of "pneumonia of unknown cause" in Wuhan.

On the 1st of January 2020 the WHO activated its Incident Management Support Team and on the 2nd of January informed the Global Outbreak Alert and Response Network (GOARN) about the cluster of pneumonia cases.

The UK Government issued a statement in Parliament on the 23rd of March 2020 stating that people 'must' stay at home, work from home, maintain social distance and that certain businesses must close. This has been described as the date when the first of a number 'lockdowns' and/or geographical tiered restrictions commenced in the UK.

The harm caused by the pandemic has been profound and distressing, and this has been exacerbated by the effect of the lockdown on usual social activity – socialising, schooling, shopping, going on holiday, and going to work. The effect on the public services has, at times, been almost overwhelming as the capacity to manage the impact of the pandemic has been tested to breaking point.

Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of Nezha for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

The circumstances leading to the murder were that, on a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that: "he was being intoxicated by a female from Syria." A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had "got her." He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha was seen to have a gunshot wound and Ahmad also had a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were nearby.

The working hypothesis of the West Midlands Police was that that Ahmad murdered Nezha before taking his own life.

There was no recorded history of domestic abuse with Nezha. There were allegations of domestic abuse from previous partners – but these were not substantiated no prosecuted. Ahmad was a licensed firearms holder.

The Panel recognised, of course, that this Review concerned a homicide and a suicide. The precise circumstances leading to the deaths of Nezha and Ahmad were determined by the Office of the Coroner in July 2022. In these circumstances, and when the Community Safety Partnership decided that a DHR will be completed, it would be usual to work with the specialist Family Liaison Officer (FLO) so that contact could be made with the family, friends and/or colleagues of the subject of the case and also with the family of the Perpetrator.

The Chair/Author and the Panel formed an excellent working relationship with the Family Liaison Officer (FLO) and they supported the Panel to complete its work.

However, due to the circumstances surrounding the investigation, the independent Author, the Commissioning Officer (from Dudley MBC), the FLO and a representative from the Professional Standards Department (PSD) of the West Midlands Police met in December 2022 to decide upon the best course of action regarding contact with the family of Nezha and the family of the Perpetrator, Ahmad. Taking account of the contact between the families of Nezha and Ahmad, the Family Liaison Officer and the PSD, it was decided – and confirmed in discussion with the Panel – that the Review should not make contact with any member, friend or associate of the family. Additionally, it was agreed by the Panel that any contact made by the family and/or friend(s) of Nezha and/or Ahmad must be facilitated via the FLO and their colleague from the Professional Standards Department (PSD) of the West Midlands Police Service.

It should be stressed that both the FLO and the PSD provided support to the Panel and, as efficiently and effectively as they could, provided answers to any of the questions raised by the Panel. The FLO and PSD also provided some context to the circumstances leading to the critical incident.

Further details of the work of the PSD are described in the section addressing 'parallel reviews'.

Section 1. Background

This Domestic Homicide Review concerns the death of two people. In March 2022, Nezha died following an incident involving a firearm. The Perpetrator of her murder was her Partner, referred to in this Report as Ahmad. On the same day, Ahmad took his own life.

The West Midlands Police investigated the circumstances leading to the death of Nezha and referred the matter to the Dudley Community Safety Partnership to be considered as a domestic homicide review. The reason for this consideration is:

Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) states:

> *(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*
> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same household as himself,*
> *held with a view to identifying the lessons to be learnt from the death.*

A more complete description of the key components of the Domestic Abuse Act 2021 can be found in Appendix 1.

1.1 Incident leading to the Domestic Homicide Review

On a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that:

> "he was being intoxicated by a female from Syria."

1.1.1 A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had 'got her.' He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

1.1.2 Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha presented with a gunshot wound and Ahmad with a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were also nearby. The working hypothesis is that Ahmad murdered Nezha before taking his own life.

1.1.3 There was no recorded history of domestic abuse with Nezha, but there were incidents of alleged domestic abuse with previous partners. Ahmad had 4 passports (UK, Ukrainian, Turkish, USA) and was a licensed firearms holder.

1.1.4 Ahmad was the sole tenant of the property, but there were suggestions that Nezha also stayed at the address.

1.1.5 There were no recorded convictions for assault and/or common assault.

1.2 Significant people in this case

1.2.1 Both pseudonyms and the name for the subject in this case have been chosen by the DHR Panel. The significant people referred to within this Overview Report are described, in brief, below:

Name (Pseudonym)	Age when the incident occurred	Relationship
Nezha	39 years	Partner of the Perpetrator
Ahmad (Perpetrator)	40 years	Partner of Nezha at the time of the critical incident
The child		Child of Ahmad and Ayesha
Ayesha	Not Known	Previous Partner to Ahmad and Mother of the child
Jameela	Not Known	Previous Partner to Ahmad

1.3 The use of pseudonyms and involvement of the family of Nezha and Ahmad

1.3.1 As noted in the Preface, the Chair/Author and the Panel formed an excellent working relationship with the FLO and they supported the Panel to complete its work.

1.3.2 Due to the circumstances surrounding the investigation, the independent Author, the Commissioning Officer (from Dudley MBC), the FLO and a representative from the Professional Standards Department (PSD) of the West Midlands Police met in December 2022 to decide upon the best course of action regarding contact with the family of Nezha and the family of the Perpetrator, Ahmad. Taking account of the contact between the families of Nezha and Ahmad, the Family Liaison Officer and the PSD, it was decided – and confirmed in discussion with the Panel – that the Review should not make contact with any member, friend or associate of the family. Additionally, it was agreed by the Panel that any contact made by the family and/or friend(s) of Nezha and/or Ahmad must be facilitated via the FLO and their colleague from the Professional Standards Department (PSD) of the West Midlands Police Service.

1.3.3 It should be stressed that both the FLO and the PSD provided support to the Panel and, as efficiently and effectively as they could, provided answers to any of the questions raised by the Panel. The FLO and PSD also provided some context to the circumstances leading to the critical incident.

1.3.4 Consequently, the Review Panel decided to use pseudonyms for the subjects of this case and these were all chosen by the Panel.

1.3.5 Taking into account the discussions undertaken by the Panel – and briefly described in 1.3.2 – the Panel discussed whether Ayesha and Jameela would be contacted by the Review Panel and invited to make a contribution to the Review. A conversation was held with a representative from the Children's Social Care Service (CSC). The CSC had provided and continued to provide support to Ayesha and to the child. They informed the Panel that the case was relatively complex and this was magnified by Ayesha assuming some responsibility for caring for an older relative. On balance, taking into account

the advice from the FLO, the PSD and Children's Social Care, the Panel decided not to contact Ayesha.

1.3.6 Whilst it was likely that the same decision would have been reached with regard to contacting Jameela, this process was truncated because her current whereabouts and contact details were unknown.

1.4 Purpose and conduct of the review

1.4.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

1.4.2 This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the latest revisions of the guidance issued by the Home Office in 2016 to support the implementation of the Act.

1.4.3 As described above, this particular case was referred by the West Midlands Police for the consideration of a DHR in accordance with Section 2, Paragraph 18, of the DHR Guidance.

1.5 The time-period under review

1.5.1 At the initial meeting of the Domestic Homicide Review Panel, held virtually in September 2022, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2017 to the date of the incident in March 2022. The panel decided on this time frame because this is the date that Nezha moved to the address where the incident occurred. However, the Panel was very clear in their communication with the agencies involved in the Review and requested that if any agency had any relevant information outside of this period, then this information should be included in the individual management review and chronology.

1.5.2 The parameters of the formal scope were effectively removed because a number of agencies did hold records from 2010-2014 concerning a number of subjects of this Review.

1.6 Proposed timescale

1.6.1 The first meeting of the DHR Panel was held on the 1st of September 2022. The Panel met again in November 2022, January 2023, March 2023, April 2023 and in May 2023.

1.6.2 At the first meeting in September 2022, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

1.6.3 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies. The Panel also discussed the involvement of the family.

1.6.4 At the third meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies; the draft integrated chronology, the abridged chronology, the responses to the key lines of enquiry, the combined narrative, etc.

1.6.5 At the fourth meeting, the Panel considered a first crude draft of the Overview Report – a composite of the submissions structured in a format close to that required by the Home Office to ensure that all members of the Panel had a copy of all of the information submitted. The Panel also considered a number of emerging themes, and a number of the lessons learnt identified by the Agencies involved.

1.6.6 At the fifth meeting of the Panel, held in April 2023, the Panel considered a number of clarifications submitted by Agencies invited to submit and considered the first full draft of the Overview Report.

1.6.7 At the sixth meeting of the Panel, held in May 2023, the Panel considered the second draft of the Overview Report and committed to making comments and amendments by the beginning of July. The final draft was then submitted for consideration by the CSP Board.

1.7 Statement of Confidentiality

1.7.1 The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals outside the DHR process.

1.8 The Conduct of the Review and methodology

1.8.1 At its first meeting, the DHR Panel approved the use of an Individual Management Review (IMR) and Chronology template. The Commissioning Officer from the Dudley Metropolitan Borough Council, contacted each participating agency and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was excellent. The Panel, due to the COVID restrictions described earlier, made allowances for any minor delays in submission.

1.8.2 Together with the Commissioning Officer, the Chair/Author provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office, December 2016). The IMR Authors were not directly involved with the subjects of this case. IMR reports were quality assured by a senior manager from the participating agency and they countersigned the report.

1.8.3 Copies of IMRs were circulated to all the DHR Panel members prior to the scheduled meetings. The IMRs were then discussed and scrutinised by the Panel and significant events were cross referenced and any clarifications that

were considered necessary from the IMR author were invited via the independent author and Commissioning Officer of the Overview Report.

1.8.4 The Panel agreed that a DHR should not simply examine the submissions received, but that the Review should be professionally curious, and in so doing identify which agencies had contact with Nezha and Ahmad, and which agencies were in contact with each other.

1.9 The Conduct of the Review (contributors and Panel members)

1.9.1 Following the notification of the death of Nezha and Ahmad, the Dudley Community Safety Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of Dudley Council.

1.9.2 The Panel received reports from agencies and dealt with any associated matters such as media management and liaison with the Office of the Coroner.

1.9.3 The Commissioning Authority (Dudley Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

1.9.4 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations.

1.9.5 The views and conclusions contained within this overview report are based on findings from documentary submissions and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

1.9.6 The members of the Panel are described in the table below:

Role	**Agency**
Community Safety Officer	Dudley MBC Community Safety Team Representing Safe and Sound, Dudley's Community Safety Partnership
Head of Safeguarding	Black Country Healthcare NHS Trust
Director of Student Services and Success	Representative from a University in the United Kingdom attended by Nezha and Ahmad
Temporary Chief Inspector (at the time of the Review).	Public Protection Department, West Midlands Police
Detective Sergeant, Force Review Team	West Midlands Police
Director of Community Services	Black Country Women's Aid

Assistant Designated Nurse for Safeguarding, Black Country Integrated Care Board (Dudley)	Black Country Integrated Care Board (Dudley)
Chief Executive Officer	Churches Housing Association of Dudley District (CHADD)
Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Head of Safeguarding, Practice and Quality Assurance	DMBC Children's & Young People Safeguarding & Review
Professional Standards Investigator	West Midlands Police (PSD)
Deputy Designated Nurse for Safeguarding Adults	Staffordshire and Stoke-on-Trent ICB
Lead for Safeguarding in Education	Children's & Young People Safeguarding & Review
Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Designated Nurse for Safeguarding Adults	Black Country Integrated Care Board
Team Manager	Dudley MBC Children's & Young People Safeguarding & Review - Professional Practice
Lead Nurse for Vulnerable People	North Midlands Partnership NHS Foundation Trust
Head of Adult Safeguarding & Principal Social Worker	Dudley MBC Adult Safeguarding / Adult Social Care
	Independent Author

1.9.7 Contributors to the Review

Agency	**Submission**
Staffordshire and Stoke-on-Trent ICB	Individual Management Review and Chronology
Staffordshire Police	Individual Management Review and Chronology
University in the United Kingdom attended by Nezha and Ahmad	Individual Management Review and Chronology
Black Country Healthcare NHS Trust	Individual Management Review and Chronology
Dudley Children's Services	Individual Management Review and Chronology
University Hospitals of North Midlands NHS Trust	Individual Management Review and Chronology
Black Country ICB	Individual Management Review and Chronology
Dudley Integrated Health and Care NHS Trust (DIHC)	Individual Management Review and Chronology
West Midlands Police	Individual Management Review and Chronology
West Midlands Ambulance Service	Individual Management Review and Chronology

1.10 Parallel Reviews

1.10.1 Due to the circumstances concerning the investigation into the death of Nezha, West Midlands Police, during the conduct of this Review, commenced an internal Review into the management of the procedures they followed after the critical incident was first reported to them.

1.10.2 The remit for the Review, managed and delivered by the Professional Standards Department (PSD), includes an interrogation of the incident log and the response of the West Midlands Police to the call for service.

1.10.3 At the point of writing this Review, the Professional Standards Department is in the process of completing its review.

1.10.4 As noted in the Preface of this Review, because of the nature and scope of the PSD review, it was decided by the Author, the FLO, the PSD and the commissioning CSP – a decision approved by the Panel – that direct contact between the Panel and the members of the family of Nezha and Ahmad would not occur and any contact would be mediated by the FLO and approved by the PSD.

1.10.5 To add clarity to the decision taken by the Panel – a decision taken in conjunction with the PSD and FLO – and to reinforce the gravity of that decision, the lead officer from the PSD provided a brief outline of the conduct of the Review and its parameters.

1.10.6 In brief, the Review by the PSD intends to investigate why the West Midlands Police, in this case, did not achieve the fifteen minute response time set for an incident of this magnitude. The incident was graded as a 'P1' incident, hence the target of a fifteen minute response.

1.10.7 The fifteen minute response time is set from the point that the log is graded, and this was no more than 2 minutes from the telephone call being received by the WMP call room.

1.10.8 Sixteen minutes after the log was graded, resources (i.e., suitable police officers) were identified to be deployed to attend the incident and six minutes after that point, the deployment was confirmed. However, fourteen minutes later, the resources identified to be deployed were still in WMP premises.

1.10.9 The officers confirmed their attendance at the scene approximately thirty nine minutes later than the standard response time expected.

1.10.10 The PSD also noted that the address of the incident had a firearms license marker associated with it and, consequently, there should have been an assessment by the force duty inspector to consider the deployment of firearms officers. The force duty inspector was only made aware of this incident at 07:24 when unarmed officers were already on their way to the scene and due to arrive and at 07:30 the inspector deemed it suitable for unarmed officers to attend due to no mention of a firearm being used or seen.

1.10.11 The Panel considered the magnitude of the Review being conducted by the PSD and agreed that, due to its sensitive and serious nature, contact with the family must be conducted via the FLO and the approved by the PSD.

1.10.12 At the time of publication of this Review (June 2024), the final report of the PSD case concerning the deaths of Nezha and Ahmad was being written. The lead reviewer from the PSD confirmed that 'recommendations were being made for the force' and that these recommendations will be considered by the Appropriate Authority in the PSD.

1.11 Coronial matters

1.11.1 As a matter of courtesy, the Office of the Coroner was informed by letter (from the Author and commissioning authority) that the Domestic Homicide Review was taking place and the expected time frame of the Review.

1.11.2 The Inquest into the deaths of Nezha and Ahmad was held on the 7th of July 2022. This was a 'read-only' Inquest (which means the Coroner will read from the file of evidence and no witnesses will attend) and the outcome of the Inquest was:

- Nezha was unlawfully killed
- Ahmad took their own life
- The cause of death for both Nezha and Ahmad was 'shotgun wound'.

1.12 The Purpose of a Domestic Homicide Review

1.12.1 The Panel noted that the over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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 homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

1.12.2 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

1.13 Specific Terms of Reference and Key Lines of Enquiry for this Domestic Homicide Review

h. To establish what contact agencies had with Nezha and/or Ahmad

This required agencies to consider these issues:

16. What contact did your agency have with Nezha and/or Ahmad? Please describe these contacts for each subject of the Review
17. Did any agency know or have reason to suspect that Nezha and/or Ahmad were subject to any form of domestic abuse at any time during the period under review?
18. Had any mental health issues been disclosed by Nezha or Ahmad, or any mental illness diagnosed by an agency in contact with them?
19. Were there any complexities of care and support required by Nezha or Ahmad and were these considered by the agencies in contact with them?
20. Were assessments of risk and, where necessary, referrals to other appropriate care pathways considered by the agencies in contact with Nezha and Ahmad?
21. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with Nezha and Ahmad?

i. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Nezha and Ahmad.

This required agencies to consider these issues:

22. What actions were taken to safeguard Nezha and were the actions appropriate, timely and effective?
23. What happened as a result of these actions?
24. What actions were taken to reduce the risks presented to Nezha (and/or Ahmad) and were the actions you took appropriate, timely and effective?
25. What happened as a result of these actions?

j. To establish whether there were other risks or protective factors present in the lives of Nezha or Ahmad.

This required agencies to consider these issues:

26. Were there any other issues that may have increased the risks and vulnerabilities of Nezha or Ahmad?
27. Were there any matters relating to the safeguarding of other adults at risk, or children that the review should take account of?
28. Do you know if Nezha disclosed any domestic abuse to their family or friends? If so, do you know what action they took?
29. Did Ahmad make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

k. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

This required agencies to consider these issues:

30. Were effective whistleblowing procedures in place within agencies to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures. Briefly describe these procedures.

l. To identify clearly what the lessons to learn are and how they will be acted upon.

This required agencies to consider:

16. What, (if anything), in your view should change as a result of the themes that are emerging from this Review and the production of a multi-agency action plan

m. To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

n. Events and incidents may have occurred during the attempts to manage the COVID Pandemic. We would like to understand the impact of the COVID-19 Pandemic and address any improvements to service delivery.

This required agencies to consider:

17. What impact did the management of the COVID-19 pandemic – including the restrictions associated with it – have on the planned delivery and provision of the services offered to Nezha and Ahmad by the agencies in touch with them
18. What impact did the COVID-19 pandemic – including the restrictions associated with it – have on both Nezha and Ahmad individually, and as a couple.

h. The Perpetrator was a licensed shotgun holder and his certificate was registered with the West Midlands Police. The Panel is not aware of any information to suggest that the Perpetrator's ownership of a shotgun was anything other than lawful. He was granted a license to own and use a shotgun because of the nature of his hobby and pass-time.

This required agencies to consider:

19. Was your agency involved in the assessment for, or granting of, the license for Ahmad to have a shotgun? If so, can you briefly describe the nature of your responsibility in this respect?
20. Is your agency aware of any prior information or intelligence to suggest that the ownership of a shotgun posed a particular risk to Nezha and/or Ahmad?
21. If so, please describe this information and/or your perspective on the risk.

1.14 Equality and Diversity

1.14.1 The review panel was committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to Nezha, and her Partner, Ahmad (the Perpetrator of the murder).

1.14.2 There was no evidence that Nezha was <u>directly</u> discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

1.14.3 The Panel considered the implementation of the Equalities Act and discussed the impact of the legislation on the services that were in contact with Nezha. It was noted that equality law recognises that bringing about equality may mean

changing the way in which services are delivered. This is the 'duty to make reasonable adjustments' to the way things are done and the way services are provided in order to make them useable by everyone eligible to use them.

1.14.4 The Panel noted the guidance from the UK Government, stating that if an organisation providing facilities or services to the public or a section of the public, finds there are barriers to people in the way it does things, then it must consider making adjustments (in other words, changes). If those adjustments are reasonable for that organisation to make, then it must make them.

1.14.5 The Panel also noted that this duty is 'anticipatory', meaning that an organisation cannot wait until a person with a specific need covered by the legislation wants to use its services, but must think in advance (and on an ongoing basis) about what disabled people with a range of impairments, might reasonably need, such as people who have a visual impairment, a hearing impairment, a mobility impairment or a learning disability.

1.14.6 The question posed by the Panel for those agencies in contact with Nezha (and Ahmad) was whether:

- the way it operated
- the physical feature of its premises, or
- the absence of an auxiliary aid or service

created a barrier which would have placed Nezha (or Ahmad) at a substantial disadvantage compared with other people using the service.

1.14.7 It was noted that, at certain contacts with certain services (notably the Police and the Health Service), both Nezha and Ahmad reported that they were disabled. In both cases, the Panel did not receive any confirmation that this was accurate or true. Additionally, accounts of Nezha's disability (explored further later in the Report) were either inconsistent across agencies or were asserted on her behalf by Ahmad.

1.14.8 The Panel noted that sex (gender) is a protected characteristic under the terms of the Act and were cognisant of the fact that there is a disproportionate prevalence of women as victims of domestic abuse, coercion, control and violence. Please refer to Appendix 2 for further details concerning the prevalence of these incidents.

1.14.9 The Panel noted the analysis of the MARAC national dataset (described in more detail in Appendix 2), completed by SafeLives and this facilitated a discussion concerning some of the key elements in this case. The Panel did acknowledge that not all of the elements were pertinent in this case, but that a number were salient:

- **Gender:** Women are much more likely than men to be the victims of severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- **Low income:** women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000. The Panel noted that Nezha's income – when she ceased her

employment with the University in the United Kingdom – will have dropped significantly.

- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction (whether or not it is related to domestic abuse)

1.14.9 Setting aside the issue of gender, and the previous history of the Perpetrator, there had been allegations of domestic abuse from two previous partners – Ayesha and Jameela.

1.14.10 In July 2010, Ayesha reported that she had been assaulted by Ahmad and had injuries consistent with such. West Midlands Police (WMP) had received a call from a staff nurse at Russell's Hall Hospital reporting that Ayesha was in A&E with bruising and scratches to her upper body which, she had informed them, were caused by her husband, Ahmad. Officers attended the Hospital and arrested Ahmad and other officers went into the A&E Department to speak with Ayesha and photograph her injuries This was Ayesha and Ahmad's first contact with West Midlands Police (WMP). Ahmad was arrested and charged. However, Ayesha withdrew from the Criminal Justice process and the case was withdrawn.

1.14.11 In 2012, after the child had been born, Ayesha filed for divorce citing 'due to violence'.

1.14.12 February 2016 saw the first recorded domestic incident between Ahmad and Jameela. Counter-allegations were made by Ahmad and Jameela did not wish to pursue a prosecution.

1.14.13 With regard to Ayesha, these allegations had been dismissed as fabricated by a Judge in the Family Court and Jameela declined to support any process of investigation.

1.14.14 Nevertheless, it would be naive for the Panel to assume these allegations have no bearing on this Review. Additionally, the Panel was aware of the report published by the Domestic Abuse Commissioner concerning the impact of the Family Court on survivors of domestic abuse.[4]

1.14.15 The Panel also noted that Nezha had informed her GP that she felt depressed due to having had a car accident and stresses of working. Nezha also disclosed that her father had died in the Syrian war. She was subsequently prescribed a 'low dose' of Citalapram. Nezha had been prescribed Citalapram by a previous GP. Nezha was not deemed to have any acute illness and declined any onward referrals. A fuller account of Nezha's prescribing history is described within the Report.

1.14.16 Both Nezha and Ahmad were Muslims. There is no record that they were married – either in a Westernised ceremony nor an Islamic ceremony.

[4] https://domesticabusecommissioner.uk/wp-content/uploads/2023/10/DAC_Famliy-Court-Report_Oct-2023.pdf

1.14.17 Nezha was born in Syria and Ahmad was born in Iran. From the submissions received by the Panel, it is assumed that Nezha understood verbal English and written English. However, the Panel obviously assumed that English was not Nezha's first language.

1.14.18 This would, undoubtedly, be relevant when Nezha engaged with services, seeking their support.

1.14.19 The Panel also believed that immigration status may, potentially, be relevant. Both Nezha and Ahmad were immigrants to Britain from Syria and Iran respectively. Nezha entered Britain in 2011 and Ahmad entered in 2010. Both were granted settlement and indefinite leave to remain in the UK.

1.14.20 At the first review panel meeting, based on information available from initial information about agency involvement, the following protected characteristics were identified as requiring specific consideration:

- Sex – Nezha was a female and Ahmad was a male.
- Race – Nezha was Syrian and Ahmad was Iranian.
- Religion/belief – Nezha and Ahmad were of Muslim faith.
- Language – Nezha's first language was not English – it would have been Arabic

1.14.21 The panel considered how the characteristics above may have created a barrier to Nezha feeling able to disclose any form of abuse, control or coercion, speak about her health issues and ask for help from specialist services.

1.14.22 Intersectionality is an analytic framework for understanding how aspects of a person's identity may combine to create different modes of discrimination. In Nezha's case, her sex, race, religion, and perhaps her preferred first language intersected, or overlapped, and this may have formed an obstruction to her recognising Ahmad's behaviour, and feeling able to make a request to access and/or use available services.

1.15 Dissemination of the Overview Report

1.15.1 The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The Dudley Community Safety Partnership
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for the West Midlands
- All agencies involved in the review
- The Office of the Domestic Abuse Commissioner
- Members of the family of Nezha (to be determined)
- Office for Health Improvement and Disparities (for Suicide Lead Officers)
- Public Health England

Section 2. Background information – the facts

2.1 A pen picture of Nezha and Ahmad – the focus of this DHR

2.1.1 Taking account of the nature of the contact with the families of Nezha and Ahmad – described in the Preface and parallel review sections of this Report – the Panel garnered as much information about Nezha as it could, whilst being cognisant of these necessary constraints.

2.1.2 We know that Nezha was born in Syria – in the city of Aleppo – in April 1982.

2.1.3 The Syrian civil war is an ongoing multi-sided civil war in Syria fought between the Syrian Arab Republic (which is led by the Syrian president Bashar al-Assad and he is supported by a number of domestic and foreign allies) and various domestic and foreign forces that oppose both the Syrian government and, in a variety of combinations, each other.

2.1.4 Unrest in Syria began in March 2011, as part of the wider 2011 "Arab Spring" protests that arose from discontent with the Syrian government. This escalated to an armed conflict after protests calling for Assad's removal were violently suppressed. The war is currently being fought by several factions: the Syrian Armed Forces and its domestic and international allies represent the "Syrian Arab Republic" and the Assad regime; opposed to it is the "Syrian Interim Government", which is a 'big-tent' alliance of pro-democratic, nationalist opposition groups whose defence forces consist of the Syrian National Army and the Free Syrian Army.

2.1.5 From this conflict, in 2011, Nezha made a visa application from Aleppo and later in 2011 Nezha arrived in Staffordshire in the UK.

2.1.6 We know that Nezha has two siblings – a younger Sister (born in May 1986) and a Brother – though his date of birth is not known. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. However, during the process of the Review, Nezha's Sister changed her address and has not yet informed the FLO of her new address. Subsequently, communication has been maintained with Nezha's Brother, who lives in Germany.

2.1.7 The FLO confirmed that Nezha's Sister has received contact details for the Independent Author of this Review – though no contact has been made (information has been shared with Nezha's Sister that Arabic interpreters can be made available).

2.1.8 Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

2.1.9 The Panel was told that, following the incident, Nezha's Sister and Brother informed the FLO (and the Office of the Coroner) that a friend of the family – who, at the time, was living in Swansea, Wales – was acting as the next-of-kin for Nezha. The family friend was invited by the family to assist with all necessary

arrangements in the UK, including the collection of Nezha's body and the burial. However, as time moved on the FLO was informed that the relationship between Nezha's Sister and Brother and the friend of the family broke down and all communication between them ceased after the burial of Nezha's body. Contact between the FLO and the friend of the family has also ceased – at the request of Nezha's Sister and Brother.

2.1.10 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences.

2.1.11 The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

2.1.12 During her studies at the University in the United Kingdom – on a contractual basis – to undertake a variety of work, including as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

2.1.13 In August 2015, Nezha was renting a property in Newcastle-under-Lyme. Nezha was registered as a sole occupant of the Property. Nezha's studies at University were progressing very well. She had passed 6 (out of 9) modules concerning the study of English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. This was awarded to her in October 2016.

2.1.14 In November 2018, Nezha's status as a refugee ceased, but she had received 'leave to remain' as resident in the UK.

2.1.15 When Nezha left the University in the United Kingdom – in 2021 – after completing her studies, it is likely that her income reduced significantly and this may explain why she was residing (in September 2021) in a House of Multiple Occupation (HMO).

2.1.16 Ahmad was born in February 1982 in Khorramabad, the city of the Lorestan Province in Iran. In 2009 – or thereabouts – Ahmad met his future wife (referred to in this Report as Ayesha). They married in 2009 in Istanbul, Turkey.

2.1.17 The Panel learnt that Ayesha sponsored Ahmad's visa application and they both moved to the UK in early 2010.

2.1.18 Ahmad commenced his post-graduate studies at the University in the United Kingdom in September 2015.

2.1.19 Ahmad had received his first degree from a University in Iran in 2005. From the application he made to the University in the United Kingdom, the Panel learnt that Ahmad had spent time working at three Hospitals in Tehran (between 2004 and 2010) – as an under-graduate and also when he received his first degree in biochemistry.

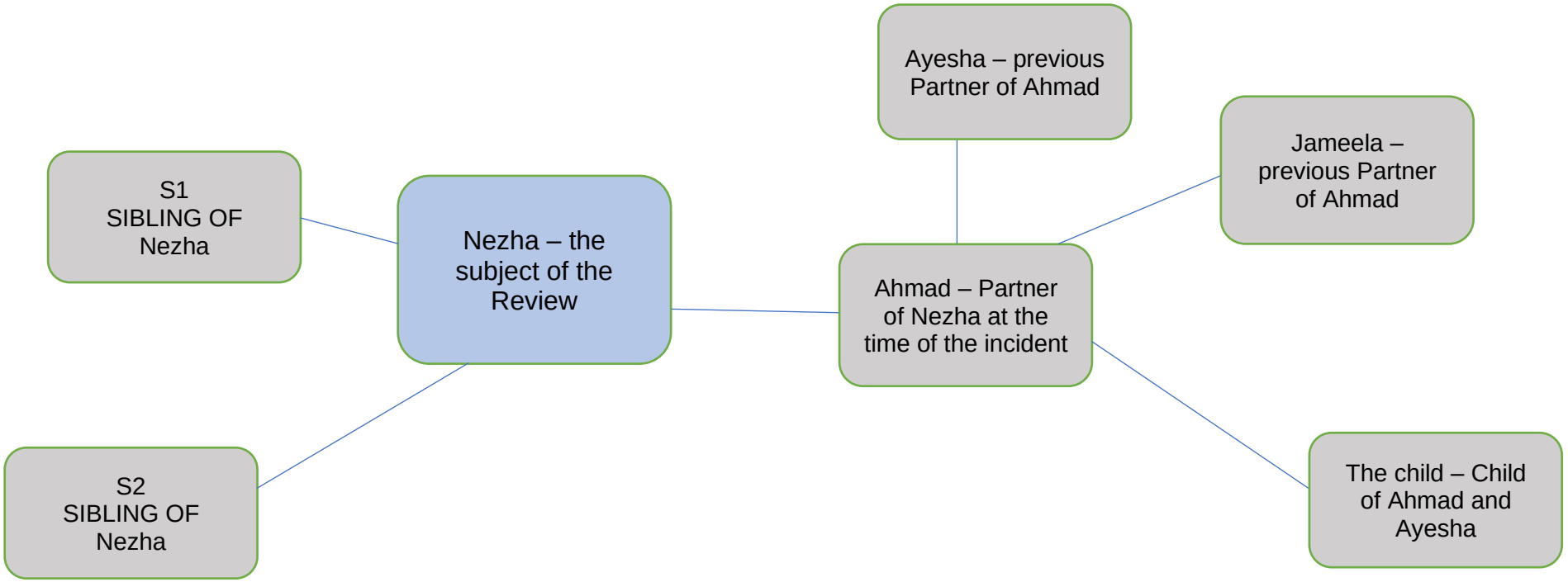
2.1.20 Ahmad then received his Masters Degree from a University in the United Kingdom (different to the University to the one attended with Nezha). He studied there between September 2014 and September 2015. Following his post-graduate qualification, Ahmad submitted to the University in the United Kingdom that he had worked in the NHS as a biochemist and as a senior biochemical scientist. This information has not been confirmed for the Panel.

2.1.21 Whilst at the University in the United Kingdom, Ahmad received a quarterly stipend and worked for the University as a laboratory demonstrator and a senior laboratory demonstrator. It is assumed by the Panel that Ahmad and Nezha met whilst at the University in the United Kingdom.

2.1.22 Ahmad's PhD programme was in clinical biochemistry. Ahmad's PhD career was not entirely successful. He pursued a programme of 'English for Academic Purposes' but did not pass the one module that he commenced in 2016 and he did not complete his MA in Learning and Teaching in Higher Education module that he commenced in September 2017. Ahmad did not complete his PhD prior to the critical incident.

2.1.23 In contrast, as noted, Nezha's academic career was more successful. Aside from the completion of her PhD and the modules listed above, Nezha commenced a MA in 'Learning and Teaching in Higher Education' and was awarded Post-Graduate credits by the Senate in October 2018 (though not the full MA) and she commenced a MA in 'Higher Education Practice' in September 2018 and was awarded Post-Graduate credits by the Senate in October 2020 (though not the full MA).

2.2 A Genogram of the subjects referred to in this Review



3. Abridged chronology

Outside scope

2010
At the beginning of July, West Midlands Police (WMP) received a call from a staff nurse at Russell's Hall Hospital reporting that Ayesha was in A&E with bruising and scratches to her upper body which, she had informed them, were caused by her husband, Ahmad. They also informed WMP that Ayesha had not been allowed to leave the home address for the last eighteen months. The nurse stated that Ayesha was ready to be discharged but wished to keep her at hospital until police attended to speak with her. Staff had asked Ahmad to leave but he was still outside with security officers. Officers attended and arrested Ahmad from the location and others were dispatched to A&E to speak with Ayesha and photograph her injuries. Ayesha told officers that Ahmad had punched her to the head, face, arms and upper body resulting in bruising. The investigation did not yield the evidence to pursue a prosecution and, coupled with this, Ayesha withdrew her complaint.

2011
In June, Nezha commenced her post-graduate PhD programme at the University in the United Kingdom.

In August, Nezha commenced a module of study – 'English for Academic Purposes' – at the University in the United Kingdom. From mid-October to December, Nezha took a break from her studies (the Panel presumes this may correspond with the death of her parent.

2012
The child was born.

In November, Ayesha filed for divorce and cited 'due to violence'. Ayesha had previously reported an assault (see the incident in 2010). Ayesha stated that she was also concerned that Ahmad would attempt to remove the child from the UK. Police Officers made a successful request for relevant markers to be placed on the Police National Computer (PNC) should an incident occur and a flag to be placed on the Passport of each subject for a period of six months.

A short time later, Ayesha attended the local Police station to inform WMP there was now a court order in place which prohibited Ahmad from removing the child out of the country.

2014
In January, Ahmad's General Practitioner recorded that Ahmad had expressed 'depressed mood'. He stated that he had a child and his ex-partner would not allow access to them.

In May, a court report was made whereby Ayesha made numerous allegations of violence perpetrated by Ahmad. The Judge concluded that Ayesha had fabricated the allegations to prevent Ahmad from having contact with the child.[5]

In November, Ahmad attended his GP. It was noted that there was some loss of hearing to the left side due to an explosion when Ahmad was doing military training. Ahmad was referred to Audiology.

2015

On the evening of the 17th of May, Ayesha called WMP and reported that Ahmad had assaulted on the 16th of May. During her call Ayesha divulged that Ahmad had made threats to her over the previous five months but she had not reported these to police. Ayesha advised that she and the child were uninjured and safe at a family address not known to Ahmad but was 'traumatised' by his behaviour.

Officers visited Ayesha at home that same evening where she told them that she had been in a car park outside a shopping centre having met Ahmad for a child contact arrangement set by the Family Court. An argument ensued and Ahmad became aggressive and had thrown the child into the trolley causing them to cry. That night, the child was crying and complained of having a sore shoulder, though Ayesha could not see any injuries.

A statement was obtained from Ayesha and CCTV enquiries conducted. Whilst there was footage recorded by cameras at the location, it did not assist in identifying what happened. The incident was referred to Children's Services and following a MASH discussion and review, via the Barnardo's Screening Tool, no role was identified for them and the investigation was run 'single agency' by WMP. A harassment offence was recorded in relation to the comments made by Ahmad to Ayesha.

A DASH was completed and Ayesha was deemed to be 'standard risk'. Ahmad was voluntarily interviewed and he denied the allegations, suggesting that Ayesha was making false claims in order to assist her in the on-going family court case. Ahmad confirmed that when he met Ayesha, he had been with a female, namely Jameela, who was also with her five year old child, and stated that the argument started when Ayesha realised this.

Ayesha was updated following the interview and the investigation remained open whilst further checks were conducted with Children's Services.

In early June, whilst the aforementioned incident was under investigation, Ahmad reported that he was being harassed by Ayesha. He stated that Ayesha had obtained private photographs of him and his new partner and sent them to his family. He explained that he was from Iran and the pictures could result in "big problems within his culture".

An appointment was made for officers to meet with Ahmad and obtain further information. A short time later, Ahmad called WMP again advising that his parents had received a letter that day which stated he was going to "pay with his life", obviously

[5] Op. cit. footnote 1, above.

causing him concern. He requested to be seen as soon as possible due to the threats to his life. Ahmad explained that Ayesha once lived with him and was unsure whether she still had keys to the property which he stated was a concern because of her ”unbalanced” behaviour. He believed this behaviour had escalated due to the fact the case regarding the child was under review and ‘in his favour’. A visit was agreed and officers attended Ahmad’s home address that evening

During the visit, Ahmad explained that Ayesha had copied images from his Facebook account of him kissing Jameela and sent them to his parents in Iran. He explained that he believed that the Iranian Government was aware of the images because they open packages sent there and would hand them to his parents and question them about the content.

Ahmad informed the attending officers that his parents were aware of his relationship with Jameela and accepted it. It was recorded that that there was no supporting evidence for Ahmad’s allegation and that it was a standard risk domestic abuse non-crime matter only. The incident was listed for joint screening and intelligence checks. The screening identified no role for any other agencies and the investigation was closed.

It was not recorded how Ahmad became aware that the pictures had been taken and posted. There was no detailed explanation of why Ahmad suspected the Iranian Government would intercept a package addressed to his family and then visit them and ask questions about it. There was no record of any questions being asked or information provided by Ahmad about the letter in which the comments were made about paying with his life.

Whilst Ahmad suggested that Ayesha sent the images to cause trouble and assist her case at court, there is no recorded explanation as to why Ahmad thought doing so would actually achieve this. This also applied to his comment regarding Ayesha’s ”unbalanced” behaviour.

With regard to the pictures, when Ahmad made his initial call to the police, he referred to the images as being ‘indecent’. During the visit, he informed officers that they were of him kissing his new partner, likely to have been Jameela. There is nothing recorded to suggest why Ahmad told the call handler that the matter could cause ‘big problems’ within his culture. However, when visited by officers, Ahmad stated that his family were accepting of his new relationship.

A short time later, Ahmad commenced a programme of post-graduate study (a PhD programme) at the University in the United Kingdom.

2016

In mid-January, in the early hours of the morning, Ahmad called West Midlands Police via 999 and reported that he was in Birmingham and had been assaulted by several people and was bleeding from his nose. WMP requested an ambulance. A response unit was dispatched. Officers met with Ahmad who was described as being heavily intoxicated. Ahmad stated that a female inside a night-club had bumped into him and that he’d been ejected by security, before then being set upon by a number of men.

Enquiries were conducted at the scene and these enquiries suggested that Ahmad had inappropriately touched a woman. Ahmad could not point out the offenders. WMAS attended the incident and Ahmad was transported to the QE II Hospital in Birmingham.

A face-to-face appointment was made to visit Ahmad when he was discharged. He explained he had been with his then partner Jameela, when he was assaulted. He confirmed he also sustained a broken tooth and swelling to his eyes. He denied being drunk at the time of the incident. He recalled being accused of touching the woman but denied doing so.

Footage viewed at the club showed Ahmad being pushed by a group of females who he then attempted to punch prior to then being escorted out by security. The quality of the footage did not assist in identifying those involved. No further reports were made by any other party about the incident. Jameela was not spoken to about this incident. The matter was filed on the 4th of February.

In February, Ahmad called 999 reporting that his ex-girlfriend was outside his property making threats to kill him. Officers attended the location where both Ahmad and Jameela were both present. They had recently separated and Jameela had left some of her belongings at Ahmad's flat. She had attended to collect them and when Ahmad refused, an argument ensued. Ahmad stated he had refused Jameela entry after she made threats to report him to immigration. He stated Jameela had not actually threatened to kill him. Ahmad agreed to allow Jameela inside to collect her things whilst officers stayed and supervised. Jameela then left the location and returned to her own property.

A short time later, Ahmad called WMP stating that he wished to make a complaint about his ex-partner, Jameela. He explained to the call taker that she had threatened to kill him and would not leave him alone. In addition, Ahmad claimed that Jameela had sent emails to his work colleagues telling them he was a fraud. Officers were dispatched to Ahmad's home address where he showed them text messages, none of which were deemed to be threatening. The communication was two-way. Ahmad also stated that Jameela had not in fact sent any emails.

Ahmad did state that he no longer wanted any contact with Jameela and so officers attended her home address and issued her a First Case Harassment Notice, essentially warning her to cease contact and that she may be prosecuted should she continue to do so. Jameela agreed to this and the matter was then filed.

In March, Ahmad's GP noted that he was 'argumentative' in a consultation.

In mid-May, Ahmad and Jameela called WMP via 999 both alleging assault against the other. Ahmad said that Jameela punched him "really, really badly" and tried to take his dog. Ahmad stated Jameela was inside his property in another room and would not leave. He was heard by the operator calling out to Jameela telling her to stop hitting herself. The operator noted that Ahmad was 'very scared'. He then informed the call-handler that Jameela had left in her car with one of the dogs and his key.

It was prior to leaving and whilst still in her car that Jameela made her call to Police. She alleged that Ahmad punched her three times whilst in the property. She added that whilst this was the first time he had ever assaulted her, she was aware that he had "hurt his child's mum from his previous relationship". The logs were linked and officers dispatched to Ahmad's address**.**

A short time later, attending officers updated the operator advising that they had spoken to both Ahmad and Jameela and that whilst there had been a domestic dispute over the ownership of their dogs, no assaults had occurred. However, Ahmad stated he wished to make a complaint after he found that Jameela had put his passport down the toilet.

An appointment was arranged for Ahmad to attend the station where this could be explored and recorded accordingly, but he did not attend nor did he return any messages left by officers.

Later in June, Nezha's GP recorded that Nezha was not fit for work. A statement was issued referring to depression, and hearing loss. This was the first documented incident that Nezha attended an appointment with her partner, Ahmad.

In late July, Nezha's GP recorded low mood during a consultation. The GP also noted that:

> "Father died suddenly in Syrian war; has had counselling in the past. Not wanting further counselling but clear she wants further medication. Feels unable to work. Combination of mood and also ongoing left sided hearing loss. Seen with partner".

In August 2016, West Midlands Ambulance Service (WMAS) attended an incident whereby Ahmad has called reporting chest pain. WMAS transported Ahmad to the Royal Stoke Hospital.

In October, the Senate (at the University in the United Kingdom) conferred the award of PhD on Nezha.

In mid-December, the MASH Team Manager recorded that Ahmad alleged that Ayesha had attended his place of work with the child (at the University in the United Kingdom). Ayesha reportedly said they were homeless and under financial pressure, and therefore she was seeking reconciliation with Ahmad. Ahmad also alleged that the child had wounds to his face. Ayesha told the Social Worker she had attended Ahmad's work-place. However, this was because the child wanted contact with their Father. Concerns of injury could not be substantiated – Professional agencies had not observed any injuries to the child. No further action was taken.

Within scope
2017

On the 9th of January, Nezha's GP recorded a consultation with Nezha and her partner. The review concerned deteriorating hearing (after effects of a road traffic accident the year before). The GP noted in the consultation that:

> '*patient attended with partner, who did most of the talking'.*

Towards the end of January, Nezha attended the University Hospital of North Midlands. They noted a gradual decline in hearing, with Tinnitus, dizziness and occasional blurred vision. Nezha was seen with her Partner and reported low mood low, but no suicidal ideation was recorded.

Nezha stated at the consultation that she was unable to do her job (she said she was a university lecturer) due to her hearing loss and this caused her to experience depression.

An MRI and CT scan was arranged, along with a referral to audiology for a hearing assessment and hearing therapy. The information discussed was included in a letter to Nezha's GP including Nezha experiencing depression as a result of hearing loss. There was no evidence of signposting Nezha to mental health services, and no evidence that her GP was requested to follow up disclosure of symptoms of depression.

In mid-August, Staffordshire Police recorded an incident concerning Ahmad. It was reported that a neighbour had kicked the door, thrown a bottle at Ahmad's head and made threats. Ahmad rejected the offer of an Ambulance. Ahmad made another call stating that he was suffering headache and feeling dizzy and was going to A & E. The neighbour was arrested, interviewed and issued with a Conditional Caution (S4 Public Order Act). Ahmad was updated with the result.

In September, Nezha commenced an MA in Learning and Teaching in Higher Education at the University in the United Kingdom

In mid-October, Ahmad attended his GP. He wished to lose weight, but declined a referral to weight management service. Ahmad reported insomnia. The GP recorded that Ahmad was keen to wean off tramadol (opioid pain medication); and keen on Orlistat (lipase inhibitor, reduces the absorption of dietary fat). It was agreed to review after 3 months. A prescription of 1 week of zopiclone was prescribed (medication for sleep difficulty).

It was noted that Nezha attended on the same date, also requesting weight advice. The GP recorded that they advised that Nezha was not overweight. There was no recording of any other persons being present at the consultation with Nezha.

In early November, Staffordshire Police recorded an incident involving Ahmad. It was alleged that a neighbour was shining a laser through the window as Ahmad drove away in his car and had shone it into his eye. Personal Nuisance was recorded. An ASB TAG was added to the Incident Report for Local Policing. This incident was cross referenced as a repeat victim of ASB. It was noted on the record: "Not to Visit – Contact by telephone".

In mid-December 2017, WMAS received a call from a person assumed to be Ayesha. The call handler noted that the caller was very distressed. WMAS transported this person (Ayesha) to Russell's Hall Hospital. Ayesha had cut her finger whilst preparing food. She was treated at Hospital and discharged with pain relief. Disclosures

concerning domestic abuse were not made and the other person present at the scene was Ayesha's relative (noted to be her Sister).

2018

In late January, Ahmad visited his GP and reported an adverse reaction to Zopiclone (medication for sleep difficulty); insomnia; anxiety at night and stress with work/PhD. It was noted that Ahmad enquired about medication for Nezha in his consultation.

In mid-March, Staffordshire Police recorded an incident concerning Ahmad. It was alleged that a male had broken the CCTV camera. Ahmad was not approaching them, but they were in the street drunk. Ahmad had been woken up by a noise and thought the male was trying to get into the house. Ahmad then stated that the neighbour had moved the camera so wasn't sure if it was broken.

On the following day, Ahmad made a further call stating that there was no attendance last night. The Call Taker advised that the incident had been marked for the attention of the Local Officer and Ahmad was happy with this.

Ahmad made a further call asking for an update and was advised that the Resolution Centre had ownership of the incident. The Call-Taker explained the process and Ahmad stated that he did feel that it was not being taken seriously but was assured that Officers would be in touch. Criminal Damage was recorded; the incident was Cross Referenced as a repeat victim of ASB. Intelligence checks were conducted on the suspect. Ahmad Declined to Prosecute

In early April (the 9th) Ahmad attended the Urgent Treatment Centre Out of Hours Service (OOH). Ahmad requested anti-depressants and an opioid because he stated he had run out of medication, felt unpleasant and could not function. Medication was not issued by the OOH.

On the 5th of May, Staffordshire Police recorded an incident whereby Ahmad reported an issue with a friend of the neighbour who had nearly reversed into his wife (Nezha). Ahmad did not know if it was on purpose and would like to think that it was not. The purpose of the call was to log the incident. The Police recorded Personal Nuisance. An ASB TAG was added to the Incident Report for Local Policing. It was also noted that Ahmad was a repeat victim of ASB.

Towards the end of June, Staffordshire Police recorded an incident concerning a neighbour of Ahmad. The report described harassment for about 12 months. Ahmad stated that he was Type 1 diabetic and suffered with depression. Ahmad was advised that the Resolution Centre will make contact.

In early July (3rd) Staffordshire Police recorded an incident with 2 calls: the neighbour of Ahmad and Ahmad. One call stated that a neighbour was setting off fireworks at people in the street – this was identified as Ahmad – they were allegedly next to an older person and shouting at people from the balcony.

There was then a call from Ahmad stating that he was being attacked by his neighbours who were being racist because he had set off fireworks when England won a football match. Ahmad stated that he was safe inside the house. Police Officers

confirmed that no one was hurt or injured. Ahmad was spoken to and advised about his conduct; no racist remarks were made and Ahmad made no complaint.

On the 11th of July, the Black Country ICB recorded that Nezha requested co-codamol (opioid) and noted that 100 tablets had been issued only 6 days ago. The Panel did consider whether the issue of over-ordering medication was addressed by the Practice and was encouraged to note that a suitable and appropriate policy was in place at the time.

In August, Ahmad contacted the WMAS and reported that he accidentally swallowed a crown from a tooth. Ahmad was seen and assessed and informed to contact the emergency dentist for a repair.

In October, Ahmad requested a break in his studies at the University in the United Kingdom. The break lasted until August 2019. Ahmad cited 'health reasons' for the request.

At the end of November, NHS 111 received a call from Ahmad on behalf of Nezha. Ahmad reported breathlessness, which was worsening. Nezha made her own way to A&E. Her home address was recorded as Staffordshire. Nezha attended with shortness of breath, chest pain and flu like symptoms since the previous day. Nezha's partner was present. Nezha was diagnosed with a lower respiratory tract infection and was discharged the same day with a course of antibiotics.

On the 1st of December, NHS 111 received a call from a person calling themselves XX (this was Ahmad using an alias) stating that Nezha had shortness of breath. The call then ended (it was unclear who ended the call). 3 calls were made by 111, but these were unsuccessful, and 3 messages left by 111. It was recorded that the patient was with her husband, and her condition was worsening. An Ambulance was despatched.

WMAS received the call concerning Nezha and recorded she was experiencing a panic attack. It was documented that Nezha had an anxiety disorder. Nezha was 'left in the care of her partner with advice for any future episodes'. A letter was sent to her GP. There was no record that domestic abuse was considered by her GP after that alert.

2019

Nezha did not attend her orthopaedic assessment and MRI (for lower back pain). This was the third missed appointment and Nezha was discharged and a letter sent to her GP.

Towards the end of March, Staffordshire Police note an Incident Report. Ahmad stated that his car windows had been smashed. The CCTV was checked and it happened at 03.30. Ahmad reported a number of issues with his neighbour and stated that they had damaged his property in the past.

On the following day, Ahmad made a call asking what was happening. Ahmad was advised that the crime had been allocated and recorded as Criminal Damage. An investigation commenced. It was recorded that the Complainant Declined to

Prosecute. Numerous recorded attempts were made to contact Ahmad and he declined to engage.

On the 11th of April, both Nezha and Ahmad were scheduled to be seen by their GPs but arrived 50 minutes late and could not be seen.

At the beginning of May, Nezha attended her GP. Reference was made to a Department of Work and Pensions letter to support a home visit assessment due to back pain. Nezha stated that she was spending most of the time lying down and needed a wheelchair. The MRI, conducted in April 2019, showed a spinal disc bulge.

On the 6th of June, the GP received a letter from the Dudley out of hours (OOH) service. Ahmad had attended with his partner and stated that he was due a GP appointment on that day but an accident on the M6 had caused a delay and he missed the appointment. Ahmad requested opioid, and anti-depressant medication. It was good practice from the OOH to check Ahmad's appointment, liaise with the Practice in order to limit prescribing.

In Mid June, Ahmad's GP was asked to review a 'not fit for work' letter. Ahmad reported back problems. The duration of the letter was set for the 1st of October 2018 to the 21st of June 2019. A test request was also made for an MRI scan. Ahmad requested mirtazapine (an anti-depressant) which previously helped insomnia and low mood. Ahmad stated that they had received an MRI in Germany 3 months ago. It was noted that Ahmad did not attend three orthopaedic appointments.

Nezha had a GP consultation on the same day. The GP recorded panic attacks, a prolapsed disc, and knee pain.

At the end of July, Nezha visited her GP and stated that she had been in Germany and suffered with abdominal pain. Nezha had been staying with her family. Nezha stated that she had asthma and wished to have the condition reviewed. Asthma was not recorded on the GP record at any point.

Towards the end of October, Staffordshire Police noted that Ahmad had called to make a complaint about the way a previous call was handled. Ahmad was not happy with the way he was spoken to when he had reported damage to his car – which he referred to as a mobility vehicle – and felt belittled. The Control Room Manager telephoned and left a message advising the reason for the call. The Manager stated that they had listened to the initial call and that the call handler was polite and not belittling in any way. This was cross referenced to previous incidents and the incident was closed.

2020

At the end of January**,** WMP received an application for a firearms and shotgun licence from Ahmad. Ahmad stated that he wished to shoot clay pigeons at a Midlands rifle club. He recorded on his application that he had previously held a firearms certificate in Iran between 2002 and 2006 and had two years military service**.** Two referees were listed – one a colleague and the other a neighbour and friend of six years from the Staffordshire area. The required checks were initiated and forms sent out to Ahmad's GP.

Ahmad presented an expired passport as identification which was refused. He later produced another passport which was then accepted. A foreign conviction check was requested from the Criminal Records Office who advised that the 'destination country' did not hold a criminal register.

On the 7th of February, Ahmad's GP received a request for Consent to Release Medical Information. The request was from the Staffordshire & West Midlands Police Firearms Licensing Unit and it was asking for information regarding medical history. A letter was sent to Ahmad requesting consent to release, with an invoice for the fee (for private work, payable to the GP). There was no further record of this on EMIS and no consent to disclose was received.

Note: Following a discussion with the GP, there was no further contact from Ahmad for consent to release information and no contact from the Police around this. No medical information was shared. Hence, Ahmad's GP Practice were unaware that a firearms licence had been granted. Therefore, there was no documentation or safeguarding oversight of this request on EMIS

In late February, Ahmad requested a break in his studies from the University in the UK. The break lasted until October 2020. Ahmad cited COVID as the reason for the request. An extension to his PhD submission date was also made (7 months).

On the 10th of February, Staffordshire Police recorded an Incident whereby Ahmad was arrested at his home address regarding an incident involving Controlled Drugs (an allegation of illegal importation). During the search of his property, a number of other forms of ID were seized:

- An Iranian passport;
- Three visa cards allocated to different names;
- A political party membership card;
- A Dutch driving license;
- A credit card.

A second address believed to be used and/or occupied by Ahmad was also recorded.

On the 10th of February**,** WMP received contact from Staffordshire Police who stated they had Ahmad in custody having been arrested on suspicion of possession of drugs. Ahmad was arrested and held in custody under his alias name. They informed West Midlands Police that a search conducted at his home address in Newcastle-under-Lyme had revealed he had several documents and bank cards in his own name, recorded as being an alias (not the name usually used for Ahmad) and several others in what also appeared to be alias names.

They advised that they were intending to conduct a search of another property in Halesowen (in the West Midlands Police Force Area), because this was Ahmad's linked property. In addition, they requested that WMP conduct intelligence checks on the property and flag the matter for the Counter Terrorism Unit (CTU).

DSW endorsed the WMP log that there was no relevant intelligence to share from a special branch point of view and remarked that from the 'scant' details in the

(Staffordshire) log, there was nothing to support any 'CT-LASIT[6] ideology which may lead to any activity at this time'. DSW recommended contact was made by Staffordshire Police with the agencies and banks relating to the documents and cards found during the search. They asked that if anything of concern was found at the Halesowen address to be fed back. According to the log, nothing was.

Staffordshire Police provided the custody reference number under the name of the alias used. There was no direct contact between WMP and Ahmad.

West Midlands and Staffordshire Police attended the address in the West Midlands. Ahmad was arrested for drugs offences and investigated for having fake documents. It could not be proven that Ahmad had imported Heroin. Ahmad was released with no further action for that offence. The Border Force confirmed that the Passports were genuine. The fake Dutch ID was destroyed.[7]

On the 22nd of May, Nezha attended her GP for a medication review. It was noted that Nezha was still taking anti-depressants; taking co-codamol daily for knee and back pains. It was also noted that Nezha 'did not attend' a previous referral to Orthopaedics.

The GP recorded a 'shortness of breath'. Nezha's Partner stated that Nezha almost chokes in her sleep at night.

On the 1st of June[8], Ahmad attended his GP for a telephone consultation. Ahmad requested an opioid prescription.

A short time later, Ahmad rang again chasing the prescription for the opioid medication. The issue was refused by the GP – they were awaiting Ahmad's regular GP to return. It was recorded that Ahmad:

> 'wasn't happy. Took my name. Said it was neglect and to remember this conversation in case someone rings back to pursue it.'

This was good prescribing practice. It was also noted by the Panel that there was no record of safeguarding oversight following an incident of irritation with the receptionist at the Practice.

On the 8th of July[9], Nezha attended her GP. Anti-depressants were prescribed. Respiratory symptoms were recorded, noting 2-3 months where Nezha reported that it was hard to breath. Nezha's Partner stated that she was choking at night and waking up 5-10 times due to it.

At the end of July, Ahmad met with the Firearms Licensing Officer (FO1) to consider the firearms application. FO1 conducted a general assessment of his behaviour. Questions were asked about Ahmad's previous domestic incidents and about his passport possession. It was recorded that Ahmad presented as 'mature, level-headed

[6] Counter-Terrorism Left-wing Anarchist Single Issue Terrorism
[7] On the 21st of December 2020, following a review by the Supervisory Officer, no evidence of any offences was recorded and No Further Action taken
[8] 15th of June 2020: Non-essential retail businesses were permitted to re-open
[9] 4 July 2020: most remaining national COVID restrictions are removed as pubs and restaurants re-open

and sensible'. The rifle club confirmed that Ahmad was a member and had passed a probationary period. FO1 recorded that in their opinion, Ahmad could 'be permitted to possess a firearm without danger to public safety or the peace'. The licence to possess three bolt action shotguns was granted. Ahmad registered possession of an ATA 12 bore shotgun. This was to be stored in a locked cabinet, bolted to the wall in the bedroom of his ground-floor flat in Halesowen. He agreed to store the ammunition in a separate box inside the main cabinet.

On the 12th of August, Staffordshire Police noted an Incident where Ahmad called to state that his Partner had been assaulted by a neighbour and was bleeding and needed an Ambulance. The Call Taker contacted WMAS.

On investigation, it was recorded that the incident was an assault between neighbours. Both parties had been aggressive toward each other; the victim slapped the offender's hand out of the way as they were pointing at each other; the offender had then slapped the victim causing reddening. A Community Resolution and advice was given to both parties. The incident was recorded as 'Violence Against the Person'.

WMAS attended the scene and noted that Nezha did not wish to go to A&E. Nezha's partner was happy to look after Nezha.

On the 15th of August[10], Staffordshire police recorded an incident. Ahmad stated that the glass on his car has been broken; it has been captured on CCTV but the offender was wearing a hooded top. It was believed to be linked with the incident on the 12th (when Nezha was assaulted). The incident was cross referenced and the Call Taker recognised an ongoing problem with the same named persons for attention by Local Officers. Ahmad included a Threat to Kill by the identified male and a history of complaints.

Ahmad confirmed he had informed Police Officers previously attending the incident concerning Threats to Kill and damage to his car. Ahmad sent in the CCTV. The officer spoke to Ahmad about ongoing neighbour disputes. The CCTV did not assist in identifying the person responsible for the damage.

2021[11]

[10] 14 August. Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play centres
14 September 2020: 'Rule of six' – indoor and outdoor social gatherings above six banned in England
22 September 2020: PM announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector
31 October 2020: PM announces a second lockdown in England to prevent a "medical and moral disaster" for the NHS From the 5th of November, the UK was in its second national lockdown.
2 December 2020: Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions
15 December 2020: PM says Christmas rules will still be relaxed but urges the public to keep celebrations "short" and "small"
19 December 2020: PM announces tougher restrictions for London and South East England, at Home' alert level. Christmas mixing rules tightened.
21 December 2020: Tier 4 restrictions come into force in London and South East England
26 December 2020: More areas of England enter tier 4 restrictions
[11] 4 January PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher

On the 16th of January, West Midlands Ambulance Service were called. Ahmad advised the call handler that they had muscular pain in left side. Ahmad was not conveyed to Hospital. Ahmad stated that they would visit their GP. A short time later, Ahmad called stating that the chest pain had worsened. Ahmad was deemed to have capacity and refused transport to hospital. Ahmad was left in the care of his partner who was recorded as next of kin.

On the 23rd of January, Ahmad called for an Ambulance and reported ongoing chest pain for 8 days, which was gradually worsening. Once again, after the attendance, Ahmad was left in the care of his partner.

On the 13th of February, West Midlands Ambulance Service were called by Ahmad who advised that he had:

> "….gone into fridge that morning to get a bottle of Pepsi. A friend had put approximately 30-30ml of methadone in the fridge and he had accidentally consumed it".

There was no evidence of analysis around who the methadone belonged to, or if there were other residents in household.

On the 26th of February[12], Staffordshire Police noted an incident involving Nezha. It was reported that Nezha had suffered the loss of £9,351.65. During the recording of this report, Nezha disclosed she was disabled. The incident was recorded as a complaint of theft. Nezha named a suspect as an Egyptian National who, over the last four months, had lived at the address and had now left. An appointment was made for a Police Officer to attend Nezha's home address. Nezha was recorded as having COVID symptoms and was awaiting an appointment for a test and requested the Police call when she was better. Over the following 3-4 weeks, several attempts were made to confirm appointment times and dates. The matter was reviewed and a short time later filed as 'Nezha declined to engage'.

On the 5th of May[13], Ahmad requested an urgent appointment with his GP. Ahmad reported that since having the AstraZeneca vaccine, he had chest pain, oedema (swelling), and inflammation. The GP reviewed the matter and noted: "

> *Looking back patient was having these pains before the vaccine, spoke to him in January about this and that he Did Not Attend two double appointments with the GP. Ahmad stated that he had blood samples taken 2 days after speaking to the GP in January, but there were no results on the system".*

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6 January 2021: All areas of England are moved into Tier 4's stay at home restrictions. This is the third national lockdown

[12] 8th of March. Schools in England re-open for primary and secondary students. Recreation in an outdoor public space will be allowed between two people. 'Stay at Home' order remains in place.
29th of March. Outdoor gatherings of either six people or two households will be allowed. 'stay at home' order ends, but people encouraged to stay local

[13] 12th of April: Pubs, restaurants, gyms etc reopen. Self contained holiday accommodation opens. No indoor mixing between different households.
17th of May: Limit of 30 people allowed to mix outdoors. Up to 10,000 spectators can attend the largest outdoor-seated venues (football stadiums).

It was recorded that Ahmad stated that he told reception he wasn't coming when he was recorded as not attending. Ahmad requested a chest X-ray – though he had previously declined this from the ambulance crew. Ahmad agreed that he would not 'DNA' the appointment.

On the 14th of June[14], Staffordshire Police received an anonymous call concerning Ahmad and Nezha's property. The Housing Association had changed the locks on the property following the previous Police visit. The caller stated that a man had returned to the property, called the Housing Association who did not give them keys or codes to the key safe. The man returned with a woman (presumed to be his partner and presumed to be Nezha). The call was made to the Police because they think they have broken into the property and were not sure if the Police needed to know.

Police Officers attended and spoke to Ahmad and Nezha outside the property. They stated that they were waiting to hear from Aspire Housing. They had been away for 30 days in Birmingham and returned to find the door to the flat had been forced open due to the council forcing entry after serving a notice on the property.[15]

On the 8th of September**,** Nezha reported she had returned to her room within a Home of Multi-Occupancy at which she was residing, to find an unknown person had entered by unknown means and stolen jewellery and mobile phones. Nezha reported the matter using Ahmad's mobile phone. Her friend, presumed to be Ahmad, was spoken to briefly during the call and stated that the occupant of another room at the location had attempted to force entry to Nezha's room just weeks before.

An entry within the incident log states that Nezha 'is disabled and so is vulnerable' and that she would be staying at her friend's (presumed to be Ahmad). It was also noted that Nezha and the friend advised they would be contacting the landlord and support worker about having the locks changed.
It was noted by contact staff that another burglary had been reported by another resident and as such, Forensic Scene Investigators were tasked with attending both rooms in order to secure any forensic evidence.

The incident log was later passed to an officer within the Initial Investigation Team to make further contact with Nezha and on the 11th of September, they attempted to speak with her on the phone. Nezha did not answer. Three further calls were made over the next two days but Nezha did not answer or respond to texts sent asking for a call back. The burglary was crimed in line with HOCR and the incident log was closed

Nezha failed to return any messages and the matter was filed on the 14th of September pending any further information coming to light.

Towards the end of September, the University in the UK agreed (via appeal) another extension to Ahmad's PhD submission deadline (6 months).

[14] 14th June: PM confirms that Step 4 of the roadmap will be delayed by four weeks, until 19th of July as the vaccination programme accelerates
[15] The Panel noted that Nezha's employment at the University in the United Kingdom ceased in 2021. She had reported the theft of approximately £10,000 and could not pay her rent to the Housing Association. The Housing Association issued notice to vacate the property and were operating under the assumption that Nezha had returned to Syria (the reasons for this were not clarified for the Panel)

On the 2nd of November[16], the Social Work Team Manager made contact with Ayesha on the telephone. During the call, Ayesha said Ahmad had previously abused her, which was why she had left him 6 years ago. Ayesha declined to give any details of Ahmad's whereabouts to the Social Worker. She went on to say that the child had not seen their father in 6 years. The Team Manager agreed not to contact Ahmad just yet because Ayesha was getting anxious about it. Ayesha was informed that the Social Worker would need to address this issue at a later date.

2022

On the 7th of January[17], Ahmad reported an incident (an offence of taking without consent – TWOC) that actually occurred on the 26th of August 2021. Ahmad reported this offence using an alias. Ahmad contacted WMP via web chat reporting that his car had been taken without his consent by his partner's cousin whilst he was away in London.

When asked why he did not report the matter at the time, he informed he was unaware that he had to do so. His insurance company had since advised him to contact the police. Ahmad was advised to contact his insurance company and the log was closed.

Three days later, Ahmad contacted WMP via web chat once more. He requested the log number and explained that the offender had collided with a parked car prior to returning the vehicle to his address.

Ahmad was advised that an officer would contact him within approximately twenty four hours for further details. The second log reference was generated and provided to Ahmad. Contact staff called Ahmad for further information.

The matter was recorded as a crime and the reference number sent to Ahmad along with notification that the matter would be sent to the Investigation Hub to progress. An officer from the hub attempted to contact Ahmad several times and after the third failed attempt, the report was filed.

On the 22nd of March, there was a text message exchange between the Social Worker and Ahmad. Ahmad sent a text message back to the Social Worker, requesting Ayesha (mother of the child) to contact him due to a "very urgent matter."

[16] 8th December: PM announces a move to Plan B measures in England following the spread of the Omicron variant.
[17] 5th of January 2022: As figures suggest one in fifteen people in the UK had COVID on New Year's Eve, PM confirms that Plan B measures in England will stay in place for a further three weeks.
13th of January 2022: The Health Secretary confirms the period of self-isolation in England following a positive COVID test is to be cut to five full days from Monday 17 January.
19th of January: PM announced that the requirements to present COVID passes at certain venues and events and to wear face coverings on public transport and in certain indoor locations, along with the guidance to work remotely, would cease to apply after 26 January
9th of February 2022: PM tells MPs he hopes to bring all of England's domestic COVID rules to an end, including the requirement for those testing positive to self-isolate, later in the month providing the positive trend in the data continues. The measures were due to expire on the 24th of March.
24th of February 2022: All domestic legal COVID restrictions are officially lifted in England.

On the 23rd of March, the University in the United Kingdom approved a final extension to the deadline for Ahmad's PhD submission.

On the 24th of March, The Social Worker confirmed with the school Safeguarding Lead that they had passed Ayesha's number to Ahmad, and Ahmad's number to Ayesha.

A short time later, the critical incident occurred.

Section 4
Overview of what the services involved knew

Hindsight bias
The Panel recognised that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do what we might consider – with hindsight – as "the right thing". It would be unwise not to recognise that a DHR will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid this inherent bias and has, as best it can, viewed the case and its circumstances as it would have been seen by the individuals involved at the time.

A number of agencies that submitted reports to this Review were involved with Nezha and/or Ahmad far less frequently than other agencies. In these cases, those agencies have described their interactions in the form of a short-report. The Panel used these short reports as a basis to build a composite picture of the contacts with Nezha and/or Ahmad. Those agencies that had more frequent contact, for a longer period of time, have addressed each 'key line of enquiry' in turn – described fully in the next Section.

All the agencies involved in this review provided candid accounts of their involvement in order to identify the lessons to be learned, which are considered later in this Report. The involvement of each agency is captured in different periods of time and it is important to note that some of the contacts contained in the IMRs, that are reflected here and later in the report, hold more significance than others.

4.1 Staffordshire and Stoke-on-Trent ICB

4.1.1 Nezha was registered with her GP practice for approximately 9 months. During the scope of this Review, she visited the surgery 4 times in total, once to drop off a specimen for testing and 3 times for a GP appointment with 2 different GPs. There was evidence in the records of some letters from other healthcare providers which related to onward referrals that the GPs had made for Nezha's physical medical conditions, which were mostly caused by a road traffic accident prior to her being registered. There was no evidence within the GP records of any external organisation sharing information regarding domestic abuse or any other kind of safeguarding concern.

4.1.2 It would be usual for GPs to note the overall presentation of the patient within the consultation record – for example, if they appear to be in pain, avoiding eye-contact or if they were anxious. The records viewed by the author of the submission were clear and detailed. No such observations were noted and there is no evidence that either of the GPs noticed anything particularly unusual in their interactions with Nezha.

4.2 Staffordshire Police

4.2.1 Staffordshire Police did not respond to any Domestic Incidents between Nezha and Ahmad. There are limited specific references to Nezha, the majority of the Staffordshire Police record concerns Ahmad – using some of the different names held on record for him.

4.2.2 Links and cross references were made between incidents which were, primarily, concerned with disputes that Ahmad and latterly Nezha were having with neighbours – all of whom were identified. A number of the disputes recorded Ahmad and/or Nezha as a victim whilst others were counter complaints which identified one or the other as potential perpetrators.

4.2.3 Whilst evident across all years, during 2019 in particular, investigations were Filed as "*Complainant Declines to Prosecute".* On those occasions, attempts to make contact with Ahmad were unsuccessful as Ahmad declined to engage with investigating Officers.

4.2.4 Whilst the efforts to make contact are recorded and accepted as genuine attempts to further complaints, the author of the submission noted that it was disappointing that the lack of engagement resulted with investigations being recorded in that way.

4.3 Dudley Children's Social Care

4.3.1 The Local Authority's involvement with the family has largely been in relation to the child. The Local Authority did not have any involvement with Nezha, and there is no information held in respect of Nezha on the Dudley Children's Services system.

4.4 Dudley Integrated Health and Care NHS Trust (DIHC)

4.4.1 Neither of the key subjects of the Review were known to DIHC services. The systems have been checked for all names and aliases.

4.4.2 The child was known to School Nursing Services.

4.5 West Midlands Police

4.5.1 As noted, in July 2010, Ayesha reported she had been assaulted by Ahmad and had injuries consistent with such. This was Ayesha and Ahmad's first contact with West Midlands Police (WMP). Ahmad was arrested and charged. However, Ayesha withdrew from the Criminal Justice process and the case was withdrawn. Ahmad was subsequently never convicted. The couple resided together in the Dudley area for the next two years.

4.5.2 February 2016 saw the first recorded domestic incident between Ahmad and Jameela.

4.5.3 Nezha made an application in 2017 to Newcastle Council for special aids at her home address, which at that time was still in Newcastle-under-Lyme. After this point, Nezha moved into Ahmad's address.

4.5.4 Both Nezha and Ahmad were open to the Vulnerability Hub in Newcastle-under-Lyme following issues with their neighbours.

4.5.5 Staff at the council called Nezha on the 23rd of January 2019 informing her that she was required to contribute towards her council tax bill. During the call, her unnamed carer was present and described as 'speaking for her'.

4.5.6 WMP received a firearms licence application from Ahmad on Friday the 31st of January 2020. Ahmad gave his occupation as a 'demonstrator and doctoral fellow'. On the form, Ahmad noted that he had a disability.

4.5.7 Ten days after WMP received Ahmad's firearm application, he was arrested in Staffordshire on suspicion of importing heroin into the UK. Ahmad was arrested by Staffordshire Police under a different name and listed with a different date of birth. Ahmad gave his home address as Newcastle-under-Lyme. This was Nezha's registered home address.

4.5.8 Following checks conducted by the enquiry officer, it was decided that Ahmad could 'be permitted to possess a firearm without danger to public safety or the peace'.

4.5.9 In February 2021, Ahmad informed his GP he had suffered from an accidental poisoning of 30-50mg of methadone that a friend had put in the fridge. During the same month, Nezha reported she had been victim of a fraud resulting in the loss of her life savings. At that time, she stated she and her unnamed partner were disabled and in receipt of disability payments (the panel presumed this was not correct). Efforts were made to meet with Nezha to obtain the full details of the allegation (in March 2021). It was noted that Nezha would need to be seen at home due to her inability to leave her home without the assistance of mobility aids. However, when officers visited the address, it appeared that it was no longer occupied. Neighbours informed officers that the occupants had not been seen for months.

4.5.10 Ahmad was issued a firearms and shotgun licence on Monday 12th of April 2021. The certificate granted him the authority to own up to three weapons. The weapons were for use at ranges suitable for the specified class of firearm whilst he was a member of the Rifle Club.

4.5.11 Nezha had her last contact with Staffordshire Police in June 2021 when an anonymous caller reported she and her partner, referred to by an alias, were back at the property in Newcastle-under-Lyme. For reasons not clear to the Panel, the caller, like the Housing Association, assumed that Nezha had returned to her home country and subsequently a 'notice to quit' had been served on the property in May. Officers attended and Ahmad provided his name as an alias.

4.5.12 On 21st of October 2021, Ayesha sent historical pictures of injuries she claimed were caused by Ahmad when they were together. Ayesha sent these to the child's school and her Social Worker. Ayesha informed her allocated social worker that she had never reported the assaults to police.

4.5.14 At this time, Nezha was still listed as a tenant of the property in Newcastle-under-Lyme.

4.6 The University in the United Kingdom

4.6.1 Nezha had been a student at this University since 2011.

4.6.2 Background/issues prior to January 2017. During the period of her PhD, Nezha informed the University, via an extension request for her studies in 2015, that she was from Syria, and that her father and fiancé had passed away. This led to her needing to take a break from her studies and following this she encountered some financial issues.

4.6.3 Nezha progressed through her studies until August 2020 when she submitted an appeal regarding a failed assessment. The reasons for the appeal were related to exceptional circumstances and Nezha disclosed family illness, stating that she had to take care of her Mother during a hospital stay from June 2019 to June 2020. Nezha also said she had health problems herself. This appeal was not upheld as Nezha did not engage with the process or provide evidence. Between the 14th of May 2019 and the 2nd of July 2020 there was correspondence between the academic school and Nezha regarding needing an extension for work and again, there were periods within this when Nezha left gaps in responding to emails.[18]

4.6.4 Ahmad had been a postgraduate research student at this University since 2015 but did not complete his PhD before his death.

4.6.5 Disability Information In October 2016 Ahmad submitted a Student Progress Report in which he stated he had a disability and that he would provide evidence to support this. No record of any information could be found to suggest he provided this evidence. There is also an email from a member of staff within the Academic School to Ahmad in May 2019 to say that they were aware he had mobility issues and required a Personal Emergency Evacuation Plan (PEEP). The author of the submission could not find any evidence of a response to this. In an Extension Request dated 01/09/2021 Ahmad again noted he had a disability and stated in the request that he was receiving Personal Independent Payment (PIP) – this has not been confirmed.

4.6.6 Supervision. In 2016 there were some concerns and issues around Ahmad's supervision. Ahmad complained that he had been asked to leave laboratory sessions in October 2016. The communications from the member of staff stated that Ahmad was asked to leave because he had not completed the appropriate lab training. It seems the relationship with his supervisor had broken down and changes to his supervision were made. In the same month, Ahmad also said he had an operation on his back, and that it had become infected. This did not reflect in his GP record.

4.6.7 Concern regarding ex-partner. In December 2016 there was a report that Ahmad's ex-partner (Ayesha) came to the University campus stating that she had arranged to meet with him. Ahmad was informed of this, and he called the police (or a number that he had for a specific police contact). He commented that he had not arranged to meet her, and he believed that there was a restraining order against her. He was advised to contact Student Support for

[18] As an aide-memoir, between June 2019 and June 2020, various incidents of Ahmad requesting medication had occurred, Nezha had requested medication for back pain, Ahmad had applied for a firearms license and had been arrested for an allegation of illegal importation and Nezha was assaulted by a neighbour in August 2020

advice/support or the Advice and Support at the Students' Union. There is no evidence to suggest he made contact with these services for support.

4.6.9 In February 2019, a concern was raised within the Academic School that Ahmad had failed to attend a meeting and advice was provided to submit a Concern Form. A Concern Form allows students and supervisors to raise concerns for the Faculty Director to consider and arrange a way forward.

4.6.10 There was some correspondence in February 2020 regarding the non-payment of fees to the University and in March 2020 Ahmad stated that he needed an extension for his work due to being a carer and the Covid-19 pandemic. Ahmad then submitted an LOA request form for the period from the 25th of March 2020 to the 24th of July 2020, with the reasons for the request being the Covid-19 pandemic and being responsible for the care of his disabled mother and child (though the correspondence did not clarify whether this was his child). Ahmad noted that support will be in place for them in two weeks.

4.6.11 Ahmad submitted another LOA request form dated the 5th of October 2020 to ask for an LOA until the 24th of October 2020. He stated the reasons for his request as being that he had had Covid twice since June, due to the pandemic and lockdown, taking care of disabled mother and son, and noted that support will be in place in two months' time. There is further correspondence in December 2020 regarding Ahmad dealing with disabled family members and illness.

4.6.12 On the 25th of February 2021 an extension request was submitted. The reasons for the request were the Covid-19 pandemic, having Covid, the loss of family members, and that he had had a new supervisor. The member of staff completing the form had completed it on Ahmad's behalf, in recognition that Ahmad was going through a stressful period.

4.6.13 Another extension request was received on the 1st of September 2021, citing difficulties with academic work, surgery on his back, being a carer, losing his mother and brother, but stating that he wanted to continue with studies.

4.6.14 There was further correspondence between the 10th of October 2021 and the 17th of November 2021 in which Ahmad cited problems with his email account, health issues and concerns regarding lack of supervision. Ahmad had a number of supervisory changes during his time at University in the UK, including periods where it was unclear who was providing supervision.

4.6.15 In August 2021, the academic school made contact with Ahmad to check on progress with his studies. He stated he had lost his mother and brother, had had a gum infection, and was mentally unwell/stressed. He asked for a LOA. Ahmad also said he had to go to Iran, contracted Covid and was in hospital for over 40 days. At this point there were concerns raised that any further extension would result in Ahmad being beyond the maximum period of study.

4.6.16 The result of Ahmad's LOA's and extension requests was that he was given a final date for his thesis submission, set as the 28th of March 2022. This had to

be granted by the Pro-Vice Chancellor (Research and Enterprise) because an extension would take Ahmad past the maximum period of study for a PhD. It was considered at an appeal and the final date of the 28th of March 2022 was granted. *It was noted by the Panel that this deadline was only a short time following the critical incident in March 2022*.

4.6.17 From correspondence and conversations with relevant members of staff, they commented that Ahmad appeared confident in his abilities, but there was a concern that his academic work was not made available to staff as requested. Colleagues within the Academic School tried to support Ahmad by offering to help analyse raw data, look at chapters of his work and by setting a plan and timelines for submission of the work. He also took breaks from his studies when his personal circumstances meant he could not study. Students are not required to keep in touch with the University during an LOA, but it is best practice for them to provide evidence on their return to ensure they are well and have access to support. The author of the submission did not see any correspondence or documentation to suggest that Ahmad accessed support internally or externally, apart from the GP note following his operation. Unfortunately, Ahmad did not submit his thesis before his death in March 2022.

4.6.18 Neither Nezha or Ahmad engaged with internal support services within the University and there is no evidence to suggest the University was aware of any domestic violence.

4.7 Black Country Healthcare NHS Trust (BCHFT)

4.7.1 BCHFT had no contact with either Nezha or Ahmad during the scoping period of this Review.

4.8 Black Country Integrated Care Board (Dudley Place)

4.8.1 Nezha registered with a GP in 2017 and from that time Nezha accessed the Practice on a regular basis, predominantly for repeat medication for musculoskeletal pain management.

4.8.2 Nezha disclosed a history of trauma, including being involved in a road traffic accident in 2016, to which she attributed some of her ongoing health needs. Additionally, in 2016, Nezha disclosed a bereavement following the sudden death of her father during the Syrian war. GP records stated that Nezha accessed counselling at that time and had been prescribed antidepressants.

4.8.3 The Panel noted that a number of the health needs experienced by Nezha were some of the recognised themes from previous domestic homicide reviews and can be linked with domestic abuse (IRIS, 2022).

4.8.4 Ahmad accessed the same Practice on a regular basis for issues including pain management, weight management, mental health, orthopaedic and gastrointestinal concerns. Relevant contacts prior to 01/01/2017 include, in 2013, a contact for mental health, insomnia, bereavement, “problems with ex-partner and access to his child”.

4.8.5 It was noted on EMIS that the mobile phone numbers of Nezha and Ahmad are identical except for the last digit.

4.9 West Midlands Ambulance Service

4.9.1 WMAS had minimal involvement with Nezha and/or Ahmad. The 999-emergency service provided means that unfortunately the same clinicians did not attend to Ahmad and Nezha which does not allow for the provision of rapport building which may lead to disclosures of domestic abuse. In this case, no such disclosures were made. The 999 calls were also distributed over the scoping period, with there being one every 8-12 months apart.

Section 5
Responses to the Key Lines of Enquiry

It is important to note that the responses set out below are determined by the line of enquiry and the agencies that were able to respond to the enquiry. If an agency (listed elsewhere in this report) had no pertinent comment to make, and described their involvement more fully in the narrative and/or chronology, then no response is offered in this section.

It should be noted that a number of agencies have produced 'single agency action plans that address specific lines of enquiry. Hence, not all of the services involved in this review have made full submissions against each specific line of enquiry.

A. To establish what contact agencies had with Ahmad and/or Nezha

5.1 Staffordshire and Stoke-on-Trent ICB

5.1.1 Nezha ceased being a patient in September 2017.

5.1.2 However, between March 2017 and September 2017 there were a number of routine appointments and it was noted that a man attended with her. However, there is no name noted and no way of knowing if this was Ahmad or not. It is not known if the male attending with her at both consultations was the same person. He was described only as 'partner', on the 9th of January 2017 and 'boyfriend' on the 18th of January 2017.

5.1.3 It is possible that Nezha – bringing someone to her appointment in this instance – would not have been deemed unusual due to her reported hearing difficulties and issues with communication.

5.1.4 Nezha's presenting problems at the appointments related to physical issues because of the road traffic accident and appropriate referrals were made for X-ray, Musculo-skeletal clinic and ENT, as expected.

5.1.5 It was noted by the GP during the consultation on the 18th of January 2017 that: '*hearing is a challenge, not language'*

5.1.6 Additionally, the GP noted that:
'consultations are sensitive to issues of race, culture and heritage'

5.1.7 The Panel learnt that the GP Practice has access to language support and translator services when needed.

5.1.8 The GP who made the submission is also the Lead GP of the practice and when asked about domestic abuse, he stated:
'This wasn't part of Nezha's presentations but we are sensitive to this issue and have other patients where it is the main concern'…. Adding… *'we have access to domestic abuse support services including counselling, adult safeguarding and the police'.*

5.1.9 Nothing in the records indicated that there had been a need to carry out a risk assessment of any sort for Nezha.

5.1.10 In terms of mental health issues, it was noted that Nezha had a repeat prescription of citalopram which is commonly used to treat anxiety and depression. There was no detail recorded of any discussion of this condition specifically. There was, however, a note that there was a medication review undertaken with her at the appointment on the 18th of January 2017 which would have included a discussion of the citalopram along with another 3 medications which were being taken for other conditions, including pain management.

5.1.11 There was mention of depression in a letter from the ENT Department at the University Hospitals of the North Midlands NHS Trust (UHNM) and stamped as received on the 31st of January 2017.This was part of an overall description of her presentation rather than a disclosure of a new concern specifically highlighted to the GP for any action. It was noted on this letter that the depression was related to Nezha being unable to work due to her hearing issues.

5.1.12 There was no indication within the records that Nezha needed to be safeguarded for any reason. The practice staff were and are aware of domestic abuse and the lead GP stated that:
'as GPs we are used to, occasionally, needing to isolate patients to get their true story'.

5.1.13 This would suggest that had the Practice been concerned about Nezha, they would have attempted to speak to her alone. There was no disclosure of any kind of abuse made by Nezha about herself or from any other party.

5.2 Staffordshire Police

5.2.1 The majority of Staffordshire Police contact with Ahmad and Nezha occurred between 2017 and 2020 as a consequence of disputes with neighbours from 3 different addresses.

5.2.2 The majority of the contact was with Ahmad. Responses included further telephone discussions and Officer deployment. Whilst some positive action was taken, some investigations were curtailed as a result of Ahmad, and latterly Nezha, declining to engage with Police.

5.2.3 None of the calls for service made to Staffordshire Police disclosed or revealed any mental health issue or diagnosed mental illness.

5.2.4 As an aide-memoir, the record noted a number of key elements, thus:

- On the 25th of October 2019 – Ahmad referred to a mobility vehicle – this was not explored further and the complaint was dealt with by a Control Room Manager.
- On the 10th of February 2020 – At the time of arrest for an allegation of illegal importation, a woman at the location (not confirmed as Nezha) was described by the attending Officer as: "believed to be the wife of Ahmad sitting on a chair in the living room, she was not well, looked frail and possibly some breathing apparatus next to her. She was not arrested."

- On the 26th of February 2021 – a complaint of theft contained reference to a Disability and the receipt of benefits – for both Nezha and Ahmad. The initial assessment included potential vulnerabilities but, as indicated, further investigation was frustrated as a result of a lack of engagement.

5.3 Dudley Children's Social Care

5.3.1 Under the period of consideration, Dudley Children Services had some contact with Ahmad. On the 11th February 2022 (*see chronology on page 36)*, an email was sent to Ahmad from the allocated Social Worker in relation to the child. The purpose of the email was to update Ahmad in relation to Children's Services involvement with the child, and to gain his views. Email communication was followed up by phone calls, which were unsuccessful. Communication was then received from Ahmad on the 22nd of March 2022, where Ahmad sent a text to the allocated Social Worker stating;
"Hi, I had an email from you. Can I please ask you to tell the child's mum to contact me ASAP. It is a very urgent matter. This is Ahmad, Dad. Has an email from you that the child is under protection."

5.4 the University in the United Kingdom

5.4.1 the University in the United Kingdom engaged with Nezha and Ahmad as postgraduate taught and research students of the University.

5.4.2 There was an awareness that Nezha and Ahmad were in a relationship. The author of the submission – following an examination of their records – did not identify any concerns regarding their relationship.

5.4.3 In 2021, Ahmad mentioned being mentally unwell and stressed following a particularly challenging period (*see chronology on page 35*).

5.4.5 Neither Nezha nor Ahmad accessed any of the University support services available to them.

5.5 Black Country Integrated Care Board (Dudley Place)

5.5.1 Contacts with this GP Practice occurred between the 23rd of August 2017 and the date of the incident. These were ten in-person appointments, three telephone consultations, four unattended appointments, emergency department attendances and NHS 111 calls. There were four contacts with NHS 111 and an Ambulance, where Nezha's partner was present. Nezha was last seen at the Practice on the 26th of February 2021.

5.5.2 There were occasions where the Practice experienced difficulties contacting Nezha, for example when medication reviews were due. A follow-up system was evident within Nezha's EMIS records for failed contacts, demonstrating good practice.

5.5.3 Contacts for Ahmad included twelve in person appointments (one with Ahmad's partner present), eight telephone consultations, ten missed appointments. Other contacts included NHS 111 and WMAS. Ahmad was last seen on 06/05/2021. The GP Practice reported that Nezha and Ahmad often attended appointments together. The Panel recognised that recording and consideration

of the rationale for co-attended appointments would be beneficial as a domestic abuse indicator (see IRIS, 2022). However, this could not be identified on the EMIS record.

5.5.4 During the formal scope of the Review, three safeguarding checks/notifications were noted on Ahmad's records, completed by the Multi Agency Safeguarding Hub (MASH) Nurse. One cites 'domestic violence with partner and the child'. The other two entries do not specify any context around the safeguarding concerns. EMIS shows one safeguarding alert, thus:

'child safeguarding concern'

5.5.5 There was no evidence that these safeguarding checks or notifications were reviewed by the safeguarding lead from the Practice. This oversight is required for consideration because of the possibility of transferable risk to other partners or children. The Practice Safeguarding Vulnerable Adults Policy states that:
'management of the Practice is responsible for the identification and reporting of any suspicions of abuse'.

5.5.6 The Practice Safeguarding Policy for Children and Young Persons states a requirement that:
'all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member'.

5.5.7 The Panel noted the comment from the Author making the submission that safeguarding entries directly placed onto EMIS from external agency professionals do not necessarily receive this oversight from the Practice. The scrutiny of patient records at each consultation to identify safeguarding entries would be beneficial so that an 'alert' or 'warning' could be added. This would ensure that historic concerns are visible and avoid pertinent history being 'lost' amongst consultation records.

5.5.8 There were subtleties associated with the contacts with Nezha that indicated the presence of a male partner, most likely (given the dates of consultations) Ahmad. In a consultation for Nezha with the University Hospitals of North Midlands NHS Trust (which was referred to in correspondence with Nezha's GP in 2017), Nezha's 'husband' stated that he felt that the Syrian conflict was what makes his wife: "virtually unresponsive". The Panel considered this a curious remark to make.

5.5.9 During a consultation in 2017, Nezha was recorded to be struggling to lose weight even though her BMI was highlighted as being 'ok'. It is unclear whether the rationale for 'struggling' to lose weight was explored in more depth.

5.5.10 In 2018, the EMIS record states that Ahmad was enquiring about skin medication for his partner at his own consultation. There is no context recorded as to why Ahmad would be discussing this on behalf of Nezha. Furthermore, during this year, it is noted on the records that on two occasions Ahmad contacted NHS 111 on behalf of Nezha. On the second occasion, the call handler put down the telephone and recorded that "the patient was talking over

the call handler". Two further consultation notes state that Nezha's partner says that she chokes in her sleep.

5.5.11 The GP confirmed that neither Nezha or Ahmad had any formal diagnosis of a mental health condition by a consultant. The GP informed the Author of the submission that Ahmad had requested anti-depressants to help him deal with everyday life pressures. Nezha and Ahmad experienced long term mental health symptoms. Both accessed Practice medication reviews, but there is no evidence of being signposted for talking therapies or a management plan for their long-term mental health difficulties.

5.5.12 In 2016 Ahmad was documented to be argumentative at an appointment with his GP (*see chronology on page 25)*. In 2020, Ahmad exhibited irritation towards Reception staff at the Practice when attempting to obtain a prescription. It would be a reasonable expectation for these instances to have received safeguarding lead oversight and for an 'alert' or 'warning' to be added to Ahmad's EMIS records.

5.6 West Midlands Police (WMP)

5.6.1 Prior to the critical incident, WMP had no face-to-face contact with Nezha. It was recorded that Nezha reported a burglary and theft via telephone and subsequent attempts to engage with her to pursue the investigations were not successful. This was the only contact between Nezha and WMP before her death.

5.6.2 WMP had contact with Ahmad regarding five incidents, in addition to his firearms license application. Three of these incidents were of a domestic nature concerning Jameela, all of which were responded to in person by WMP officers.

5.6.3 WMP had no reason to suspect that Nezha and/or Ahmad were subject to any form of domestic abuse during the period of review. The incidents reported concerned each subject in their own right and for separate issues.

5.6.4 Whilst the aggravated taking of a motor vehicle without consent offence (TWOC) was linked to Nezha in that Ahmad stated the offender was his partner's cousin, she was not named within the report. As the incident was not of a domestic nature, there was no necessity to speak with Ahmad's 'partner'.

5.6.4 Following his application for a firearms licence, GP records for Ahmad were requested in line with the statutory guidance when assessing an applicant's suitability to be granted the licence. No information was received from the GP to suggest Ahmad had been diagnosed with any mental illness or other condition described in the guidance current at the time of his application.

5.7 West Midlands Ambulance Service (WMAS)

5.7.1 During the scope of the Review, WMAS had contact with Ahmad and contact with Nezha. The calls and attendances were spaced over the scoping period and do not have a particular pattern or consistent type.

5.7.2 As noted in the abridged chronology, WMAS attended to Ahmad on the 29th of August 2016 (chest pain); the 17th of January 2017 (assaulted at a nightclub); the 14th of June 2018 (accidentally swallowed a crown from his tooth); on the 16th of January 2021 (two face to face assessments concerning chest pain); on the 23rd of January 2021 (for chest pain) and on the 13th of February 2021 (when he accidentally consumed a quantity of methadone);

5.7.3 As noted in the abridged chronology, WMAS attended to Nezha on the 1st of December 2018 (Nezha was suffering a panic attack); the 31st of July 2019 (for D&V); the 12th of August 2020 (Nezha had been assaulted by her neighbour);

5.7.4 Neither Nezha nor Ahmad disclosed any mental health disorders and neither disclosed any incidents of domestic abuse and, consequently, there were no indicators suggesting the necessity for referral to other specialist services.

5.7.5 At no point was any domestic abuse suspected during the contacts had with Ahmad or Nezha.

B. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Nezha and Ahmad.

5.8 Staffordshire Police

5.8.1 As noted in the chronology, Nezha was recorded as a victim of assault by her neighbour on the 12th of August 2020 (*see chronology on page 32*). Action was taken on the date of reporting and this included a Police response. However, the neighbour disputes did not cease. A counter allegation was made against Nezha by the neighbour.

5.8.2 Ahmad was a victim of assault on the 11th of August 2017 *(see chronology on page 26*) – the alleged perpetrator was a neighbour. The action taken resulted in the arrest of the perpetrator and the serving of a Conditional Caution for an offence of Public Disorder.

5.8.3 As previously noted, efforts to make contact were often frustrated by a lack of engagement from Ahmad. Despite the actions taken by the Police – and the range of responses they made – the disputes between the identified neighbours and Ahmad and Nezha continued.

5.9 The University in the United Kingdom

5.9.1 The University informed the Panel that they can make safeguarding referrals to external agencies, in appropriate circumstances, where it becomes aware of a risk of harm against which a student cannot protect themselves. It is the statutory agencies, however, which are the appropriate bodies to assess risk and, if necessary, meet the care needs. The University has no statutory powers or duties analogous to those which have to be exercised and discharged by those agencies.

5.9.2 No safeguarding referrals were made internally regarding either Nezha or Ahmad, and there were no safeguarding concerns found in the investigation by

the Author of the submission. The Panel noted that it was important to acknowledge that both Nezha and Ahmad were at the University for a number of years, and so processes will have been adapted over that period.

5.10 Black Country Integrated Care Board (Dudley Place)

5.10.1 One safeguarding alert had been added to Ahmad's EMIS records which related to his child who did not live at his address. As noted previously, the EMIS record does not highlight all of the safeguarding notifications received for Ahmad. Consequently, there is no evidence on the EMIS records for Nezha that transferrable risk from Ahmad had been considered. The Panel noted that this was disappointing, particularly in light of Ahmad's dominance at some appointments, which could reasonably have led to concern. By way of example, and noted earlier in this Report, Ahmad was recorded to "do most of the talking", most appointments were attended together, there was an occasion of Ahmad being irritated with GP staff and being argumentative towards practice staff, and domestic abuse notifications received for Ahmad relating to a previous partner and child were not flagged on the system for Nezha.

5.10.2 The Panel noted that Ahmad also had an alert concerning 'possible over-ordering of tramadol (an opioid pain medication)'.

5.11 West Midlands Police

5.11.1 Following the burglary, Nezha informed the officers that she would be staying with a friend, so despite being recorded as having a disability and being vulnerable, she was not considered to be in need of any additional safeguarding actions. The primary reason for this conclusion was that – during the scope of this Review – it was not known to WMP that Ahmad was in a relationship with Nezha.

C. To establish whether there were other risks or protective factors present in the lives of Nezha or Ahmad.

5.12 Dudley Children's Social Care

5.12.1 As noted, Dudley CSC were concerned with the care of the child. They did note that Ayesha had said that she was scared of Ahmad being contacted as part of the Child Protection Plan. Ayesha alleged that Ahmad was the perpetrator of physical and mental abuse.

5.13 West Midlands Police

5.13.1 As noted elsewhere in the Report, Ahmad had been accused of assault by Ayesha and also by Jameela (in 2016) but this was not substantiated and Ahmad was not convicted of any offence.

5.13.2 When Ahmad applied for his firearms license, he recorded on the application that he had a disability. There was no further information recorded about what this was, how it affected him or if he required any support for this. His GP did not provide any information on this disability when invited to make a disclosure during the application process.

5.13.3 Ahmad was not recorded as being vulnerable on the WMP system for any reason prior to his death. WMP was not aware that Ahmad was residing with anyone. There were no reported incidents involving Ahmad and Nezha prior to their deaths that indicated that either posed a risk to the other.

5.13.4 As noted elsewhere, Ahmad was in possession of a gun following a suitability assessment conducted by an enquiry officer.

5.13.5 Ahmad had been arrested on suspicion of importing heroin into the UK and was arrested using one of his several aliases. Had the staff at the joint WMP/Staffordshire Firearms Licensing Unit known this, it may have meant Ahmad could have posed a risk to the public and the application would have been declined.

D. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

The Panel noted that all of the agencies contributing to the Review confirmed that they had safeguarding, domestic abuse, whistle-blowing and other relevant policies and procedures in place during the scope of this Review.

Set out below are a number of examples that demonstrate the range of policies and escalation procedures in place.

5.14 Staffordshire Police

5.14.1 An internal mechanism for the reporting of potential Corruption, Dishonesty and Serious Misconduct exists within Staffordshire Police. The Professional Standards Department communicates relevant Policy and Procedure – which include reporting mechanisms – to Line Managers and offers confidential and anonymous direct communication with the Professional Standards Department.

5.14.2 An external mechanism – a Complaints Procedure – also exists.

5.15 Dudley Integrated Health and Care NHS Trust (DIHC)

5.15.1 DIHC has a whistle blowing policy in place (Freedom to speak up: Raising concerns whistle blowing) policy).

5.16 The University in the United Kingdom

5.16.1 Nezha began her studies at the University in the UK in 2011 and Ahmad began his studies at the same University in 2015. Hence, it is important to point out that policies and processes will have developed and changed from that period to the date of the incident occurring. The current Safeguarding policy can be found here:
https://www.keele.ac.uk/policyzone/data/safeguardingpolicy/
and there is further information here:
https://www.keele.ac.uk/safeguarding-responsibilities/
The whistleblowing policy can be found here:
https://www.keele.ac.uk/policyzone/data/whistleblowingpolicy/
The whistleblowing procedure can be found here:

https://www.keele.ac.uk/policyzone/data/whistleblowingprocedure/

5.17 Black Country Integrated Care Board (Dudley Place)

5.17.1 The 'Domestic Abuse Policy – Patients' is comprehensive and was updated in June 2021. Health indicators of domestic abuse are included. The process for responding to domestic abuse states that when domestic abuse has been identified, the patient should be "seen alone at future appointments". In prevention, all patients should routinely be offered the opportunity to be seen alone as a safe space to disclose domestic abuse. The policy acknowledges that domestic abuse can be present in "other potential sources of support". There is also a current Domestic Abuse Policy for staff.

5.17.2 The 'Repeat Prescribing - Prevention of Misuse Policy' was updated in May 2021.

5.17.3 The 'Repeat Prescribing Protocol' is current.

5.17.4 The 'Vulnerable Adults' Policy' – was reviewed in January 2021.

5.17.5 The 'Whistleblowing Policy' is current.

5.18 West Midlands Police

5.18.1 WMP had and have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways. In addition, WMP has appropriate policies and procedures in place to identify, refer and escalate any performance and conduct issues to both internal and external investigation teams.

E. To identify clearly what the lessons to learn are and how they will be acted upon.

5.19 Staffordshire Police

5.19.1 Predominantly, the response from Staffordshire Police concerned an ongoing dispute between Ahmad and/or Nezha with identified neighbours. There was, as described in Sections 3 and 4, a mixture of resolutions offered to those disputes and, as noted, there was some difficulty engaging with Ahmad and, latterly with Nezha, in order to reach a more complete conclusion.

5.19.2 It was noted that, despite the efforts of the Police, the disputes continued and the Panel was not clear as to why this would be the case. Indeed, there is a contention that as time moved on, the nature and characteristics of the disputes changed, culminating in an assault against Nezha. This may have been coded as a 'hate crime' and more assertive action could have been considered. The Panel did note that this is dependent entirely upon the 'victim' engaging with the Police and consenting to the crime being coded and recorded as a 'hate crime'.

5.20 Dudley Children's Social Care

5.20.1 In terms of learning, a reflection for the service relates to the sharing of information between parents where domestic abuse has been a concern. The

Social Worker had given Ahmad the telephone number of Ayesha and vice versa – this could, potentially, have placed Ahmad/Ayesha at risk of harm. The Panel noted that caution needs to be exercised when sharing information in the context of domestic abuse, in order to properly balance risk and promote the safety of the victim and in this case, The child.

5.21 Dudley Integrated Health and Care NHS Trust (DIHC)

5.21.1 The author of the submission would question the decision to issue a firearms licence to an individual who had been reported – on more than one occasion – to have been the perpetrator of domestic abuse. Ahmad's former partner had disclosed domestic abuse within the relationship on several occasions. However, the Panel noted that this was not accepted by the judge within the family court, no charges were brought and Ahmad was not prosecuted for any crime.

5.22 The University in the United Kingdom

5.22.1 The University has produced a single agency action plan to address these points. This is appended to this Report. There are five recommendations for action covering student documentation; review of leave of absence procedures; support for post-graduate students; due process regarding research progress; and supervision.

5.23 Black Country Integrated Care Board (Dudley Place)

5.23.1 The consideration of domestic abuse and routine enquiry about whether a patient is experiencing domestic abuse, should be explored when safe to do so.

5.23.2 There were a number of points highlighted by the Author of the submission which describe a number of issues that (may) merit further exploration, thus:

- Ahmad requested that his GP Practice changed his title to 'Dr'. This was not accurate. Patient status could have the potential to be a barrier to considering whether domestic abuse was a factor in the relationship.
- It is clear from the records that Nezha's voice was not heard as she was not regularly seen by herself. There is evidence that Ahmad often spoke to professionals about her health.
- *Think family*: the notification of domestic abuse concerning Ahmad and his ex-partner and the child was received by the Practice on the 3rd of July 2018. While the Practice confirmed that Ayesha and the child were not registered at the same Practice, there was no evidence of enquiry with Ahmad as to whether there was current contact with any other children, whether there were other children living in the household or consideration of transferrable risk to Ahmad's current partner. The methadone overdose for Ahmad should have prompted a question concerning whether there were any children at home.

5.24 West Midlands Police

5.24.1 Intelligence checks conducted when processing applications for a firearms license need to be more robust and repeated prior to being issued, regardless of how long the process takes.

F. To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

5.25 Dudley Children's Social Care

5.25.1 There is some learning in relation to the quality of information-sharing from the Police, particularly at the point of their contact with Children's Services following the death of Ahmad and Nezha[19].

5.26 Dudley Integrated Health and Care NHS Trust (DIHC)

5.26.1 The author of the submission highlighted two points, thus:

- To consider the criteria when issuing a firearms licence, particularly when there are allegations of domestic abuse.
- To improve recognition of the impact on children who have potentially witnessed domestic abuse

5.27 The University in the United Kingdom

5.27.1 As noted previously, the University has produced a single agency action plan to address these specific points and the delivery of this Plan will be monitored by the Community Safety Partnership.

5.28 Black Country Integrated Care Board (Dudley Place)

5.28.1 The Board has produced a single agency action plan to address these points. The action plan is appended to this Report and this will be monitored by the Community Safety Partnership.

G. Events and incidents may have occurred during the attempts to manage the COVID Pandemic. We would like to understand the impact of the COVID-19 Pandemic and address any improvements to service delivery

5.29 Staffordshire Police

5.29.1 Staffordshire Police noted that on the 26th of February 2021, Nezha stated that she (potentially) had contracted COVID and this delayed contact with her. Subsequently, efforts to investigate the report of theft were constrained by a lack of engagement.

5.30 Dudley Children's Social Care

5.30.1 With regard to the child, there was an impact in terms of the child being taken out of education during the periods of 'lock-down' and also due to Ayesha's anxieties about the child contracting Covid-19 when they were at School.

5.31 The University in the United Kingdom

5.31.1 The University has a comprehensive range of support services, all of which remained operational during the initial phase of the management of the pandemic. The University followed national guidelines regarding restrictions and therefore the delivery and organisation of teaching and research was adapted during this period, as per the guidelines and legal restrictions. Support

[19] The information contained within The Domestic Abuse Response Team (DART) Notification (received following the critical incident) was incorrect. Social Workers attempted to make contact with the Police to clarify the referral, but this proved to be difficult to achieve.

services were all offered remotely during periods where the University was unable to deliver face-to-face support (and in addition to face-to-face support, when possible).

5.31.2 From the information gathered by the Author of the submission, there was evidence to suggest that the emergence of the COVID Pandemic affected both Ahmad and Nezha, but Ahmad more significantly.

5.32 Black Country Integrated Care Board (Dudley Place)

5.32.1 During the covid pandemic, in-person consultations were changed to telephone consultations. EMIS records for Ahmad indicate that he had eight telephone consultations and Nezha had three telephone consultations during the periods of lockdown.

5.32.2 Covid restrictions could have had the potential to make Nezha and Ahmad less visible to professionals. This could perpetuate safeguarding risks, including domestic abuse, and exacerbate their mental health conditions.

5.33 West Midlands Police

5.33.1 The two incidents whereby WMP had contact with Ahmad and/or Nezha occurred after the pandemic was declared in the UK.

5.33.2 The management of the COVID-19 pandemic, including the restrictions associated with it had no impact on the delivery and provision of service offered to Nezha or Ahmad by WMP following these reports. Ahmad made his firearms application prior to the UK going into lockdown. Despite restrictions being in place, a face to face meeting went ahead in July 2020 between Ahmad and the enquiry officer from the firearms licensing team. This meeting was conducted at Ahmad's home address enabling a full security check to be undertaken.

5.33.3 There was nothing recorded on WMP systems to suggest that the pandemic or restrictions associated with it were affecting Nezha and Ahmad individually or as a couple. Following their deaths, it became apparent that their mental health may have deteriorated and their reliance on drugs (prescribed) had escalated. It could be inferred that the restrictions in place exacerbated both of these elements.

5.34 West Midlands Ambulance Service

5.34.1 There was no restriction of face to face contacts for WMAS during the Covid-19 pandemic in the case of 999 calls. There was an increase in call volume, but this did not have an impact on the face to face assessments conducted and reported to this Review.

H. The Perpetrator was a licensed shotgun holder and his certificate was registered with the West Midlands Police. The Panel is not aware of any information to suggest that the Perpetrator's ownership of a shotgun was anything other than lawful. He was granted a license to own and use a shotgun because of the nature of his hobby and pass-time

5.35 The University in the United Kingdom

5.35.1 Regulation B1 (Student Discipline) prohibits the possession of firearms. The Regulation states that a major offence would include:
'possession of firearms, other weapons and explosives, either real or imitation, on University premises.

5.35.2 The full regulation can be found here:
https://www.keele.ac.uk/legalgovernancecompliance/governance/actcharterstatuteso rdinancesandregulations/regulationsandpoliciesindex/regulationb1/

5.36 Black Country Integrated Care Board (Dudley Place)

5.36.1 On the 7th of February 2020, a request for consent to release medical information was received by Ahmad's GP Practice from the Police Firearms Licensing Unit asking for information regarding Ahmad's medical history. A letter was sent to Ahmad requesting consent to release this information. Discussion with the GP outlined that no further communication was received from Ahmad or the Police, suggesting that Ahmad's medical history was not shared with the Police. The GP informed the Author of the submission that the Practice was unaware that a firearms license had been granted.

5.36.2 When considering the EMIS records, there were concerns noted for Ahmad in respect of this request. This included high alcohol intake in 2013, a history of military training, allegations of domestic abuse towards his ex-partner and the child, child safeguarding concerns, a long term history of mental health difficulties, irritation and argumentative behaviour with reception staff and GP, possible opioid dependency, often accompanying Nezha to health appointments for no apparent reason, having underlying health issues and possible substance misuse. When viewed as a collective, the risks outlined are of concern when considered in conjunction with a request for a firearms license. The West Midlands Police Firearms Licensing Officer was entirely unaware of these elements of Ahmad's behaviour and history.

5.37 West Midlands Police

5.37.1 Ahmad's firearms application was sent to the WMP section of the Firearms Licensing Agency (which is a joint West Midlands/Staffordshire Police unit) as Ahmad resided in the WMP force area. Enquiry officers within the department were responsible for conducting his 'suitability assessment'. This included a background check, a home visit, the obtaining of details for referees and information about medical suitability. Background checks are checks made on police information and intelligence systems. They also include establishing the purpose of the request, such as farming or social activities.

5.37.2 Only once the enquiry officer had conducted the aforementioned checks and carried out the necessary visits, including an assessment of character done via a face-to-face meeting with the applicant, will a license be granted to an applicant deemed to 'be permitted to possess a firearm without danger to public safety or the peace'[20].

[20] Changes to the statutory guidance concerning firearms licensing were made in December 2021.

5.37.3 It was recorded on the WMP system that Staffordshire Police arrested Ahmad on suspicion of importing heroin into the UK. This information was recorded on the WMP systems prior to the background check being completed by the enquiry officer, but was not considered as part of the assessment of the application. The Enquiry Officer from the joint Firearms Licensing Unit did not identify that the incident concerning the arrest of Ahmad in February 2020 (by Staffordshire Police) was the same Ahmad that was applying for a firearm. At the incident of the arrest in 2020, Ahmad was arrested by Staffordshire Police using one of his aliases. Had the link been made, the Enquiry Officer would have been prompted to conduct a check on the Police National Computer which would have revealed that he was actually arrested (under an alias) and was under investigation for allegedly importing heroin into the UK. This meant Ahmad's aliases were also missed. No checks were subsequently made directly with Staffordshire Police. These checks would have revealed that Ahmad had several seemingly fraudulent passports and/or bank cards raising several questions about his motive for possessing a firearm and in essence, his honesty. Such checks would have also meant WMP had access to information about several additional incidents concerning Ahmad under one of his alias names which would have provided a fuller picture of his behaviour and possible offending history. In addition, WMP would have learned that Ahmad was in a relationship with Nezha.

5.37.4 Whilst the author of the submission understands that there are no recorded DA incidents in Staffordshire that relate to Ahmad and Nezha, it could have been explored by WMP and taken into consideration when conducting his suitability assessment, whether that be in favour of or against the decision to issue the licence.

5.37.5 Had WMP known that Ahmad was arrested on suspicion of importing heroin into the UK and under investigation, he would not have been granted a licence.

5.37.6 Whilst one cannot rule out that Ahmad would have killed or seriously injured Nezha by other means, given his now known mental state and drug abuse, had he not had a firearm within the property he could not have shot her or himself.

Section 6
Good practice

Throughout the work of the Review and the production of this Overview Report, references have been made to examples of good practice exercised by the services in contact with the subjects of this case. It should be stressed that in this Review, 'good practice' is defined as practice which accords with the standards set by the professional bodies of the staff delivering the service. It is not always about 'going the extra mile'. The Panel wished to focus upon a number of these examples and these are set out below. The learning from the Review is described in later Sections.

6.1 West Midlands Ambulance Service

6.1.1 All practice was within WMAS scope and policy. Cases involving Nezha and Ahmad were to a good standard and expected practice. During the case involving MH on 20/10/20 the crew showed excellent professional curiosity, they questioned well and as a result they raised a safeguarding referral.

6.2 Black Country ICB

6.2.1 IRIS: the GP Practice became IRIS trained in 2019, and this has enhanced staff awareness concerning domestic abuse, violence, coercion and control.

6.2.2 Prescribing and medication review: Practice Nurses and General Practitioners demonstrated good practice when managing requests for repeat prescriptions for opioids from both Nezha and Ahmad. On the 9th April 2018, the Out of Hours Service declined to prescribe anti-depressants and opioids when Ahmad requested them. On the 6th of June 2019 – Ahmad attended the OOH Service and asked for opioids and anti-depressants. It was good practice from the OOH Service to check the patient appointment (that Ahmad had said he'd missed), and limiting the prescribing. The Panel noted that Ahmad was, possibly, trying to obtain medication via an alternative route. However, this matter is covered in the Repeat Prescriptions Misuse Policy of the Practice. There were occasions where the Practice experienced difficulties contacting Nezha, for example when medication reviews were due. A follow-up system was evident within Nezha's EMIS records for failed contacts. The practice also has a "Did Not Attend" policy which is accessible to all staff.

6.2.3 Firearms applications: Discussion between the author of the ICB submission and the practice GP focused, in part upon the new national process that is in place for firearms applications. This revised guidance involves the GP being requested to complete a more comprehensive report as part of the application process.

6.2.4 Safeguarding: The Safeguarding Lead from the Practice oversees incoming DART and safeguarding notifications that are received via email.

6.3 Staffordshire Police

6.3.1 There is evidence of accurate incident and crime recording. Cross references and links between reports were made.

6.3.2 The report of assault and harassment from Ayesha was handled promptly and Staffordshire Police made attempts to ensure that safeguarding matters were addressed. It was noted by the Panel that Nezha did not engage with the efforts made by the Police to involve her in the pursuit of a prosecution. Relevant

referrals were made with Children's Services in both the area in which the child and Ayesha had resided in and moved to following the incident of alleged assault.

6.3.3 Following the anonymous call concerning activity at the property resided in by Ahmad, there were clear lines of established communication and information sharing with Aspire Housing.

6.4 West Midlands Police

6.4.1 The West Midlands Police (WMP) have recently re-written the domestic abuse policy, which was released in December 2022. There is a focus on equality, diversity and ensuring inclusivity in all matters of domestic abuse. Whilst a large volume of work has been and continues to be completed in respect of Violence Against Women and Girls (VAWG) this does not detract from work being conducted in respect of recognising and understanding that men can be victims of domestic abuse, also ensuring that male victims should be treated equally in reports of this nature. WMP understand that, when dealing with victims of domestic abuse, officers must be aware of protected characteristics and must treat everyone with dignity and respect regardless of background or lifestyle choices. The policy applies to all adults regardless of gender.

6.4.2 Details for a number of agencies are provided to officers within the policy, five of which focus on or incorporate help and assistance for male victims of domestic abuse.

6.4.3 Additionally:

- Offences reported within the terms of reference were recorded in line with Home Office Coding Regulations.
- When Ahmad reported that his car being taken and crashed, it was correctly identified that the offence was aggravated and required further investigation. Investigating officers made every effort to contact Ahmad and progress the matter.
- When Nezha reported her burglary, officers provided appropriate safety advice and adhered to the WMP 'Contact Counts' policy, which dictated the frequency of contact that should be held between investigating officers and victims of crime.
- When Staffordshire Police contacted WMP following Ahmad's arrest (in February 2020), as requested, the matter was flagged with WMP's Counter Terrorism Unit who conducted the relevant checks. The results of those checks were fed back and advice given to Staffordshire Police.

6.5 Staffordshire and Stoke on Trent ICB

6.5.1 There were only 3 consultations that Nezha had with GPs during the short time she was registered at the surgery. However, it appeared from the review of records that the care and advice given and the referrals made to other specialists were appropriate for the medical issues that Nezha attended with. The records concerning Nezha's healthcare needs are well documented, and the actions taken by each GP at the time are clearly noted.

6.5.2 The Lead GP of the practice was asked about domestic abuse by the author of the submission, and they stated that domestic abuse:

*'Was not part of Nezha's presentations but we are sensitive to this issue and have other patients where it is the main concern'…. The GP a*dded… *'we have access to domestic abuse support services including counselling, adult safeguarding and the police'.*

6.5.3 There was no indication within the ICB records that Nezha needed to be safeguarded for any reason. The practice staff were and are aware of domestic abuse and the lead GP stated that:
'as GPs we are used to, occasionally, needing to isolate patients to get their true story'.

6.6 The University in the United Kingdom

6.6.1 The University has a Doctoral Academy, which provided a central place for research students to access advice, information and support. The details can be considered at this website: (https://www.keele.ac.uk/study/postgraduateresearch/kda/)

6.6.2 The University in the UK was able to adapt quickly to the initial phase of the Covid-19 pandemic to ensure students were able to access support. Additional resources were also developed, and some of those particularly targeted research students and signposted students to internal and external support. The details can be found at this website: (https://www.keele.ac.uk/study/postgraduateresearch/kda/covid-19resources/)

6.6.3 Examples of specific resources available include (but are not limited to):
- PGR Covid-19 Resources webpage
- PhD during the Pandemic

6.6.4 In 2021, the University in the UK enhanced the student support services with the introduction of a dedicated Student Experience and Support Team, who work with Academic Schools to ensure support is accessible to students and so that staff have a named point of contact for student support. This also includes the introduction of contacts for PGR support.

6.6.5 The University has also introduced a Student Assistance Programme. The details of which can be fund at this website: (https://www.keele.ac.uk/students/lifeoutsideofstudy/welfareandwellbeing/healthassured/)

6.6.6 This is in addition to the other services provided by the University. The University provides a 24/7 confidential hotline to access a range of external support and advice, including support for issues such as: stress and anxiety; Counselling; low mood; family issues; bereavement; financial wellbeing; childcare support; relationship advice; domestic abuse; legal information; medical information; tenancy and housing concerns; alcohol and drug issues; consumer issues.

Section 7

Lessons learnt from this case by the agencies submitting information.

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are some of the lessons learnt that have been identified by the Panel and by the agencies that had contact with Nezha and/or Ahmad and submitted information to the Review.

These lessons, and the matters raised by the scrutiny of the Panel, help to refine the emerging themes and the action plan agencies will be expected to address at the end of this Review. The lessons learnt are set out below by those agencies that have identified specific opportunities for development:

7.1 Staffordshire Police

7.1.1 Predominantly, the response from Staffordshire Police was focused upon an ongoing dispute between Ahmad and/or Nezha with identified neighbours. As noted elsewhere in this Review, there was a mixture of attempted resolutions to these disputes but they were not entirely successful and the dispute continued.

7.1.2 The Panel did note that at least one incident involving the identified neighbours could have been coded as a 'hate crime' and that a lack of engagement with victims of such crimes can be countered by more direct (but sensitive) enquiry with them and a more assertive service directed towards the perpetrators of such crimes.

7.2 Dudley Children Services

7.2.1 Dudley Children's Services informed the Panel that there is learning in relation to the sharing of information, specifically contact numbers, between parents where domestic abuse is, has been, or may be a concern. Further, Dudley CSC noted that there is a learning opportunity in relation to the quality of support and intervention in relation to safeguarding the child. A number of referrals were received from family members, raising concerns about the child's safety. A more robust assessment of the child's care and Ayesha's parenting capacity may have led to more timely intervention.

7.3 Dudley Integrated Health and Care NHS Trust (DIHC)

7.3.1 The author of the submission questioned the decision made to issue a firearms licence to an individual who has been reported to have been the perpetrator of domestic abuse.

7.4 West Midlands Police

7.4.1 With regard to the response provided by WMP on the day of Ahmad and Nezha's deaths, the author of the submission was not in a position to comment at the time the Review was underway (due to the Review being undertaken by the Professional Standards Department).

7.4.2 At the time of publication of this Review (June 2024), the final report of the PSD case concerning the deaths of Nezha and Ahmad was being written. The lead reviewer from the PSD confirmed that 'recommendations were being made for the force' and that these recommendations will be considered by the Appropriate Authority in the PSD.

7.4.3 West Midlands Police did identify a number of learning opportunities from their involvement with the Review, concerning specifically Ahmad's application for a firearms license. These are set out below:

- Intelligence checks conducted when processing applications for a firearms license need to be more robust and repeated prior to being issued regardless of how long the process takes.
- It is evident that the missing of information meant that Ahmad was granted a firearms licence and held a shotgun.
- Had all available information been obtained, Ahmad would not have been granted the licence.
- Background checks for applicants must be repeated at the point the applicant is deemed suitable and before the supervisor grants the license. These must include checks with an applicant's GP so that any changes are noted and considered.

7.5 The University in the United Kingdom

7.5.1 Details are provided within the five actions described in the single agency action plan, appended to this Report.

7.6 Black Country Integrated Care Board (Dudley Place)

7.6.1 From discussion with the GP, it is understood that Nezha and Ahmad often accompanied each other to their appointments. The GP described Ahmad as polite, rational, and educated and that there were no concerns noted by the GP about the relationship dynamics between Ahmad and Nezha. Nezha and Ahmad's joint attendance at appointments was not always recorded on EMIS, therefore was not identifiable by future professionals as a possible risk factor.

7.6.2 Nezha and Ahmad both had a history of physical and mental health difficulties for which they took medication including long term anti-depressants, opioid medications and the Panel considered that it may be possible that Nezha and Ahmad lived with a degree of opioid medication dependency.

7.6.3 Discussion with the GP around Ahmad's mental health raised that Ahmad had no formal mental health diagnoses. Ahmad requested Selective Serotonin Reuptake Inhibitors (SSRIs) and low dose antidepressants were prescribed to help Ahmad with the stresses and strains of everyday life, busy work, and study.

7.6.4 Previous domestic homicide reviews have highlighted a link for victims with attending A&E, patient stress and anxiety, unexplained pain (including allegedly from a car accident), concerns about weight, stress, urinary problems, and issues with digestion (IRIS, 2022), all of which Nezha experienced. Perpetrators presented with recurrent symptoms of anxiety and depression, attended the practice more than average, reported having problems with

partners and children, had access to a weapon (IRIS, 2022), all of which could be applicable to Ahmad.

7.6.5 Safeguarding checks had been completed by BCHFT (Black Country Healthcare Foundation Trust) MASH Safeguarding Nurses and documented on EMIS. As noted, these safeguarding entries do not receive GP safeguarding lead oversight and can be missed amongst consultation text. Current alert systems on EMIS could be more effective in highlighting historic safeguarding concerns. Safeguarding checks are an essential information source to highlight potential risk to staff and transferrable risk to other adults and children. In historic domestic homicide reviews, General Practice was the main professional that both the victim and perpetrator were engaged with.

Section 8
Scrutinising events and identifying emerging themes.

This section of the Overview Report is a consideration of the responses to a number of key incidents described by what the services knew about Nezha, the responses to the key lines of enquiry, coupled with observations from the Panel.

The Panel considered the key elements from the aforementioned sections of the Report for some time in order to distil the information shared by the agencies during and prior to the formal scope of the Review.

This consideration illuminated a number of complex points upon which the circumstances that led to the death of Nezha and Ahmad seem to turn. These points are not in any order of priority.

8.1 The incidence of traumatic events in adolescence and early adulthood

8.1.1 The 'pen-picture' generated by the Panel from the submissions made by the agencies in contact with Nezha and Ahmad and from the information provided by the Family Liaison Officer, indicated that Nezha arrived in the UK seeking asylum and fleeing conflict in her country of birth. For Nezha, the Panel believes that she left Syria in 2010, or thereabouts.

8.2 Was there a formal recognition of disability

8.2.1 The Panel received submissions concerning the gradual loss of hearing endured by Nezha. There was no evidence to suggest that Nezha was formally registered as being disabled.

8.2.2 The Panel noted that, on reviewing the records from the Black Country ICB, there appeared to be a little inconsistency. In 2017, the GP Practice noted that Nezha's 'husband' said Nezha was unable to work. On the 29th of September 2017 at Nezha's new patient health check with her new Practice, Nezha said that she spent most of her time at work standing or walking. It was noted, however, that in 2019, a GP from the same Practice wrote a supporting letter to the Department for Work and Pensions for a home visit assessment due to Nezha's back pain, stating that she was spending most of the day lying down and needed a wheelchair.

8.2.3 When Nezha reported a burglary, she informed officers that she had a disability but did not offer any further clarification. At another incident, Nezha suggested that both she and Ahmad were registered as disabled and were in receipt of disability benefit. The Panel received no evidence to support this suggestion.

8.2.4 Following the incident whereby Ahmad's car was taken without his consent, he later referred to the vehicle as a Motability vehicle – though the Panel received no evidence to suggest that this was accurate.

8.2.5 The Panel did not receive any information to suggest that Ahmad was formally registered as disabled. He did not access the services offered to him by his employer when he referred to his disability (this is clear from the submission received from the University in the United Kingdom).

8.3 Hearing the voice of Nezha

8.3.1 In 2017, Nezha's new patient health check referred to a statement made in correspondence from the University Hospitals of the North Midlands NHS Trust that Nezha's main language was English and that Nezha's English was: "reasonable when she engages". Professional curiosity around inconsistencies of language is unclear as was whether the use of an interpreter was ever considered.

8.3.2 There were occasions when – in a literal sense – Nezha's voice was not heard. The Panel received submissions noting that Ahmad would 'do most of the talking' when joint visits to the GP were made. It is noteworthy, of course, that joint visits to the GP were the most frequent mode of contact for Nezha.

8.3.3 The Panel noted that – as time moved on – Nezha's voice became less obvious. The opportunities available to her to, perhaps express concern and to 'tell her story' diminished significantly. At the same time, it appears from the accounts received (particularly from healthcare providers and from Staffordshire Police) that Ahmad became more visible and more dominant.

8.4 Knowing the full history of Ahmad

8.4.1 There was a history of notifications for Ahmad, including detail of Domestic Violence with the child and his ex-partner, Ayesha.

8.4.2 Importantly, of course, the Staffordshire Police and West Midlands Police were aware that Ayesha (Ahmad's first Partner and Mother of the child) had made a number of allegations that Ahmad had assaulted her when they were in a relationship. Some years later, these allegations were considered at the family court and dismissed.

8.4.3 Additionally, as noted, the Staffordshire Police arrested a person (who was in fact Ahmad, using an alias) on suspicion of importing heroin. For evidential reasons, no prosecution occurred – but the use of the alias had implications.

8.4.4 Medicines Management records for Ahmad noted that he was over-ordering an opioid medication. The Panel noted that Ahmad's attempt to order repeat prescriptions for pain-relief medication – including a request at a NHS Walk-In Centre – were clearly identified by his GP Practice and the requests were denied. The Panel worked on the assumption that Ahmad may have been preoccupied with attempting to receive this form of medication, but that his behaviour did not demonstrate a dependency on opioid medication and none of the submissions indicated that Ahmad was addicted to any prescribed or illicit substances.

8.4.5 The consideration and management of potential opioid dependency would have been applicable for Ahmad and also for Nezha.

8.5 The Taking With-Out Consent incident reported in January 2022.

8.5.1 In light of Ahmad's apparent reluctance to engage, the lack of available information about the offender and loss of potential CCTV, the decision was

taken that there was insufficient information for WMP to pursue the investigation any further and the matter would be filed pending any future contact from Ahmad.

8.5.2 The author of the submission from WMP noted that, because the TWOC was aggravated by the fact the offender crashed the vehicle, the matter required further investigation.

8.5.3 Ahmad was not home when his vehicle was taken but did provide details about what happened. It is not recorded how he knew the offender was indeed responsible. It is fair to suspect this information was provided to him by his partner who was therefore a key witness in the case. In addition, Ahmad told contact staff that he had been approached by neighbours who spoke of the collision. Despite such, these witness enquiries were not explored and, for the Panel, the full details of this incident remain a mystery. What the Panel could garner from the chronology is that, whilst the incident was reported in January 2022, it actually occurred in August 2021. In February 2021, Nezha reported the theft of approximately £9,400 and on the 8th of September 2021, Nezha reported that she had returned to her room within an HMO to find that an unknown person had entered her room and stolen property. These incidents may or may not be related.

8.6 Subtle signs of coercion and control

8.6.1 As noted, a frequent mode of contact with General Practice was for Nezha and Ahmad to make joint visits. The GP noted that Ahmad would often lead the conversation and speak on behalf of Nezha and – at telephone consultations – the Panel noted that he referred to Nezha exhibiting signs of sleep apnoea and sounding as though she were choking.

8.6.2 The recording and consideration of the rationale for co-attended appointments would be beneficial as a domestic abuse indicator (see IRIS, 2022).

8.6.3 While in isolation, the softer signs of potential safeguarding risk are less visible, but when domestic abuse and safeguarding concerns are viewed as a whole, they can provide a picture that may otherwise go unseen. Identification of these subtle signs is key.

8.7 Transferring abuse from one partner onto another

8.7.1 There was a period when Ayesha (who made allegations of abuse) would make contact with Ahmad – frequently this concerned the care and welfare of the child. Contact between Ayesha and Ahmad also occurred when Ahmad was in a relationship with Jameela and also Nezha. Ahmad would often refer to this contact as harassment and it appeared to cause considerable distress and distraction for him.

8.8 Anti-social behaviour and discrimination from neighbours

8.8.1 Ahmad and Nezha both endured episodes of discrimination and disputes with their neighbour(s). It is not clear whether this constituted a ‘hate crime’. The Panel learnt that counter allegations were made by the neighbour about Ahmad.

8.9 Nezha's accommodation and lived experience

8.9.1 Nezha was registered as a resident in one property that she shared with Ahmad. However, toward the end of the scope of the Review, there is reference to Nezha living in a house of multiple occupation. This occurred approximately six months after the reported theft of approximately £10,000.

8.9.2 The Panel noted that Nezha's employment with the University in the United Kingdom ceased in 2021. This, no doubt, had significant financial implications and the representative from the University in the United Kingdom did confirm that Nezha's income will have fallen notably from this point. Nevertheless, there are questions concerning why she was living in an HMO at this time – what caused her to move, was she attempting to move away from Ahmad, was she living in the HMO temporarily for work purposes?

8.10 The incident of the Burglary on the 8th of September 2021.

8.10.1 It is unclear whether or not Forensic Services did eventually visit the address where the burglary occurred. There is nothing to suggest that they did and nothing relating to forensic evidence, or lack of, documented within the rationale for filing the case.

8.10.2 Despite there being an entry within the incident log that states Nezha was vulnerable due to her self-disclosed disability, this is not referenced anywhere within the crime investigation log. There was no "reason for vulnerable" recorded within the risk assessment tab within the investigation log (this is required to be completed for all incidents being recorded as a crime).

8.10.3 It is subsequently not clear what Nezha's disability was or indeed her level of vulnerability. As such, no referrals were made or seemingly considered. However, this may have been explored with Nezha on the phone had she answered one of the several calls made by WMP. However, because efforts to engage with Nezha failed, there is no way of knowing.

8.11 The licensing of the firearm

8.11.1 The Panel was informed that Ahmad's GP reported that they received a 'consent to disclose medical information form' and invited Ahmad to provide consent, along with a fee for payment. This was not received and the GP did not share any information about Ahmad with West Midlands Police (WMP).

8.11.2 As noted in paragraph 5.37.3, the Enquiry Officer from the joint Firearms Licensing Unit did not identify that the incident concerning the arrest of Ahmad in February 2020 was the same Ahmad that was applying for a firearm. At the incident of the arrest in 2020, Ahmad was arrested by Staffordshire Police using one of his aliases. Had the link been made, the Enquiry Officer would have been prompted to conduct a check on the Police National Computer which would have revealed that he was actually arrested (under an alias) and was under investigation for allegedly importing heroin into the UK.

8.11.3 It was possible – though the Panel were acutely aware of the dangers associated with hindsight – that enquiries could have been made with

Staffordshire officers, such as obtaining custody photos and information from the seized documents and this would have confirmed that the alias was in fact Ahmad. At the time, there was no rationale for doing so.

8.11.4 Had this been confirmed, and given the nature of the offence, WMP was clear that Ahmad would not have been granted a firearms licence.

8.11.5 At the time of Ahmad's application, referee contact was discretionary. However, there is now strict guidance following the Plymouth shootings which stipulates that at least one referee must be contacted.

8.11.7 The Panel also learned that the Licensing Department had – from March 2020 for around twelve months due to the management of the COVID Pandemic – frozen grant applications and this affected the application process. The application process was re-opened after intervention from both the Offices of Executives and Commissioners due to pressure from the public, the press and shooting associations. The enquiry was done by a restricted police officer as many of the licensing team were working from home under the COVID restrictions.

8.11.8 As noted elsewhere in this Report, the guidance concerning the issuing of firearms licenses was amended in December 2021. If an individual has applied for a firearms license and is the subject of a PNC or PND check, it will show that they have applied for a license. The firearms licensing department are now informed if an applicant has been arrested and license holders are recorded on PNC and PND in accordance with this regulation. At least one referee must now be contacted as part of the application process. No one will be given a firearms licence unless the police have reviewed information from a registered doctor setting out whether or not the applicant has any relevant medical history – including mental health, neurological conditions or substance abuse issues. individuals are now required to provide a medical pro-forma alongside their application, filled out and signed by a registered doctor.

8.12 The effect of dominance.

8.12.1 The Panel learnt that the GP noted that Ahmad often arrived late for appointments, requested medication late, had poor compliance with medication, did not attend for some appointments and requested that his name was changed on EMIS to include the title 'Dr.' This may be seen as someone who wished to control their circumstances.

8.12.2 As noted in the key lines of enquiry, the Author considered the remark made by Ahmad during a consultation with the University Hospitals of the North Midlands (that he felt that the Syrian conflict was what makes his wife: "virtually unresponsive") to be a curious remark to make about a woman who appeared, from other accounts, to be perfectly competent and confident when doing her job.

8.12.3 There was no evidence on the EMIS records for Nezha that transferrable risk from Ahmad had been considered. In the view of the Author making the submission, this was disappointing in light of Ahmad's dominance at some

appointments. For example, Nezha and Ahmad attended most appointments together; Ahmad was occasionally irritated and argumentative towards practice staff, and, of course, there were domestic abuse notifications received for Ahmad relating to a previous partner and the child.

8.13 Nezha's healthcare history

8.13.1 As noted elsewhere in the Review, Nezha presented to her GP with a variety of healthcare needs. A number of these consultations concerned advice and prescribing to tackle pain relief. There were 33 prescriptions for pain relief issued during the scoping period, although there was no evidence to suggest that there was any over prescribing.

8.13.2 Nezha received medication reviews, but it is unclear whether medication dependency was considered. Co-codamol at 30/50mg, although less addictive than some other opiates, remains an addictive substance and results in the need for larger doses to achieve the same level of pain relief. Even those who take it as directed are at risk of addiction, if it is taken for long enough.

8.13.3 As noted elsewhere, Ahmad was quite involved in Nezha's healthcare. The degree of intrusion into the healthcare record of a partner could be seen as a form of coercion and control. The recognition and response to these less subtle indicators is specified in current training provided to healthcare professionals.

8.13.4 When the Panel considered these matters, it became apparent, of course, that Nezha and Ahmad attended the practice, had similar tests completed on the same dates or for similar symptoms. This occurred on ten occasions during the scope of this Review. Similarities in consultations included bloods tests, reports of weight loss, musculoskeletal pain, mental health and COVID vaccinations. Recognition and analysis of these themes was not evident in line with domestic abuse training and policy.

8.14 Alerts and safeguarding oversight:

8.14.1 A visible chronology of safeguarding indicators could have made a difference in this case. Consideration should be given to what constitutes a 'safeguarding incident' and the difference between 'EMIS coding' and an 'alert'. For example, a DART notification would potentially be coded each time one was received, whereas a safeguarding alert is usually a one-off pop-up that can be seen whilst the patient notes are loading. It would be beneficial to code individual incidents so on the patient's 'summary record', an overview of the frequency and timeline of events would be evident. In this case, safeguarding concerns were sometimes so subtle (for example, Ambulance, NHS 111 calls, A&E attendances) they were not highlighted, therefore making the recognition of domestic abuse indicators difficult. It may be the case that a more robust flagging system could initiate peer discussion at multi-disciplinary team meetings.

8.15 Ahmad's behaviour in the 12 months prior to the incident

8.15.1 The Panel concentrated upon just three specific examples.

8.15.2 In 2021, Ahmad contacted the Ambulance Service when he accidentally consumed methadone when he mistook it for a soft-drink in his fridge. The incident was attended by the ambulance service and notification was sent to Practice X. Critical thinking and safeguarding oversight on receipt of this notification could not be seen. Expectations would be to invite Ahmad to the surgery, establish who the person was that prescribed the methadone and whether there was transferrable risk or drug dependency issues for Ahmad.

8.15.3 Ahmad was also prescribed pain relief (Tramadol) initially in 2017 and again in 2022. This opioid analgesic painkiller is a highly effective medication for pain relief and is a controlled drug. Common mental health disorders co-occurring with Tramadol addiction include depression. Analysis around the ongoing use of anti-depressants and the 'accidental' methadone overdose could have initiated a GP consultation and onward referral to mental health services and substance misuse services.

8.15.4 In 2021, Ahmad contacted his GP Practice on a number of occasions reporting that he was concerned about the possible effect of his Astra-Zeneca COVID vaccination. Ahmad stated that it was having an effect on his facial hair, that he was developing enlarged breast tissue and that – on a recent trip to Germany – he had received a testosterone test and told his GP at the Practice that it was low. None of these symptoms could be confirmed by his Practice.

8.16 The incident in Plymouth

8.16.1 The Panel set aside some time to discuss the tragic incidents that occurred in Plymouth in August 2021. The Office of the Coroner held an Inquest into those events and in February 2023 the Inquest Jury returned a verdict of unlawful killing of all of the victims.

8.16.2 The Panel noted, from the press release from the Plymouth Coroner, that a comprehensive Preventing Future Deaths Report had been completed and that recommendations had been made to the Home Office. Additionally, the Panel noted that the failings highlighted by the jury's findings, which contributed to the shootings and which will likely be used to make widespread changes to UK gun laws, included:

- That Devon & Cornwall Police [Firearms and Explosives Licensing Unit (or 'FELU') made serious errors in granting Jake Davison's application for a shotgun licence and by failing to revoke it in 2020;
- Following the assault on two children in 2020, the force made an unreasonable decision to charge the assault as one of battery and to properly investigate whether it was safe to return the shotgun and certificate, after initially seizing them;
- The force did not have robust systems in place concerning the training of FELU staff, or to ensure decisions were made at the correct level;
- Sufficient medical information was not taken in respect of the initial shotgun licence application;
- FELU (Firearms and Explosives Licensing Unit) failed to properly obtain and consider all the relevant evidence before deciding whether to grant the licence;

- A lack of national accredited firearms licensing training failed to equip police staff to protect the public;
- There was a catastrophic failure in the management of the FELU, with a lack of managerial supervision, inadequate and ineffective leadership.

8.16.3 The Independent Office for Police Conduct (IOPC) has also stated that a criminal investigation into possible health and safety breaches by Devon and Cornwall Police was underway at the time of writing this Report.

8.16.4 The Senior Coroner in Plymouth noted in his Preventing Future Deaths Report that the Home Office, and each of the 43 Chief Constables in England and Wales, should respond to his detailed examination of gun laws by the 3rd of May 2023. The Home Office has applied to the Office of the Coroner for an extension to the deadline.

Section 9
Conclusion

9.1 This Domestic Homicide Review concerns the death of Nezha, who died in March 2022, and of Ahmad – who died at the same incident. The working hypothesis of the West Midlands Police was that Ahmad murdered Nezha with a licensed firearm and then took his own life. This was confirmed by the Office of the Coroner at the Inquest held into the deaths. The Inquest was concluded in July 2022.

9.2 Therefore, the Domestic Homicide Review Panel that completed this Review recognised that this was a murder, followed by a suicide. This situation generates a particular response from the services that are available to support the family of the victim. In accordance with policy, a Family Liaison Officer was appointed to support the family of Nezha and contact was made with the family of Ahmad.

9.3 As noted in the Preface, the circumstances surrounding the review being undertaken by the Professional Standards Department (PSD), meant that the Review Panel would not make direct contact with any member, friend or associate of the family of either Nezha or Ahmad and that all communication must go via the FLO and their colleague from the PSD. The information acquired by the Review to provide a 'pen-picture' of the subjects of the case was verified by the FLO and the Panel are grateful for their help and support.

9.4 The Panel noted that the agencies contacted in relation to this Review identified a specific diversity issue concerning Nezha. The agencies recorded and noted that Nezha was Syrian and had fled conflict in her country of birth and sought asylum in the UK. It was encouraging to the Panel that it became clear that the agencies involved in the Review were aware of equality legislation and the potential for discrimination as it pertains to the Equality Act 2010. During the completion of the Review, the Panel identified no examples of direct or indirect discrimination.

9.5 Nezha made a visa application to the UK from Aleppo and arrived in Staffordshire in 2011.

9.6 The Panel learnt that Nezha has two siblings – a Sister and a Brother. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

9.7 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences. The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

9.8 During her studies, the Panel learnt that Nezha engaged with the University to undertake a variety of work. This included working as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

9.9 In August 2015, Nezha was living in a property in Newcastle-under-Lyme and she was registered as the sole occupant of the Property. The Panel learnt that, when Nezha and Ahmad formed their relationship (in approximately 2015), from time to time, Ahmad would also reside at the property.

9.10 During this period, Nezha's studies at the University in the UK were progressing very well. She had passed 6 (out of 9) modules concerning the study for a MA in English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. Nezha was awarded her PhD in October 2016.

9.11 The Panel learnt that in November 2018, Nezha's status as a refugee ceased. However, it was noted that Nezha received 'leave to remain' and so remained a resident in the UK.

9.12 Nezha left the University in the United Kingdom in 2021. Whilst she had completed her studies, she did also undertake occasional teaching and laboratory support work for the University. The representative on the Panel from the University in the United Kingdom confirmed that, once this work ceased and Nezha left the University, her income will have been reduced significantly. This may explain why Nezha was residing (in September 2021) in a House of Multiple Occupation (HMO) and it may suggest that, to some degree, Nezha was becoming financially dependent upon Ahmad.

9.13 Following an allegation of an incident of domestic violence, Ayesha – Ahmad's first Partner – described Ahmad as a violent and dangerous man and Ayesha stated that her Mother, who she said was with her when the incident occurred, would not provide a statement without a guarantee of protection from the police. There is no context recorded within the log around the comments made by Ayesha that Ahmad was violent and dangerous and there was no record that suggests if or how this was explored, despite Ayesha being worried for the safety and protection of the child and her Mother.

9.14 The Panel noted that the report of assault and harassment from Ayesha was handled promptly and relevant safeguarding procedures were undertaken. Relevant referrals were made with Children's Services in both the area in which the child and Ayesha had lived when the incident occurred and the area they moved to following the incident. Contact was maintained with Ayesha throughout the investigation and her expectations managed accordingly.

9.15 The Panel noted that, whilst the record states that a DASH was completed, there is no detail of the answers within the investigation log. Entries within the report confirm that the child was checked for injuries but there is no indication that they were spoken to. Whilst The child was three years old at the time, one would expect they were verbal to a degree. There was no reference to any support services having been offered to Ayesha.

9.16 The Panel learnt that Ahmad applied to West Midlands Police (WMP) for a firearms license at the end of January 2020. At this time, the WMP were using an intelligence system called FLINTS. Following discussion of the application process, it became apparent that if an intelligence log had been submitted to include Ahmad's 'aliases', this would have shown up on FLINTS. However, of course, as noted by the author of the WMP submission, the enquiry officer was unaware that Ahmad was known in Staffordshire Police because he had been arrested under an alias and this alias was completely unknown to WMP.

9.17 As a part of the licensing procedure, a letter was sent to Ahmad requesting consent to release relevant medical information. The Panel received a copy of the licensing guidance in operation at the time of the application and this element of the procedure was in accordance with that guidance. Discussion between the GP and the author of the submission from the relevant ICB, outlined that no further communication was received from Ahmad or the Police. This suggested that Ahmad's medical history was not shared with the Police. in addition, the GP informed the Author of the submission that Practice X was unaware that a firearms license had been granted to Ahmad.

9.18 As noted in Section 8 of this Report, the submissions received from the agencies in contact with Ahmad tend to generate an image whereby Ahmad's behaviour, in the 12 months prior to the critical incident, can be described as unusual or at least out of character. Whilst each individual feature did not generate a concern acute enough to consider a safeguarding referral, or discussion at a multi-agency arrangement, when taken together they portray a person experiencing some degree of trauma or mental distress, the precise causes of which are not entirely clear. There may have been significant stress associated in his relationship with Ayesha and the child, the stress of academic study and the leaves of absence he required to try to keep abreast of his PhD programme. Coupled with this, there may have been a strong desire exercised by him to control those elements of his life that he could control – and that included Nezha.

9.19 Throughout this Review, the voice of Nezha has been very difficult to discern. The Panel valued the information provided via the Family Liaison Officer, which, in turn, came from Nezha's Siblings. This information, coupled with the submissions received from the one or two agencies in contact with her prior to 2015, gave a clear impression of a woman strong enough and resilient enough to flee the trauma of violence in her country of birth and make a new life in the UK. However, when Nezha began her relationship with Ahmad in 2015, more agencies began to record contacts with her – including Staffordshire Police, the Ambulance Service and NHS primary and secondary care services. Nevertheless, it appeared to the Panel that as Nezha was becoming known to more services, simultaneously her presence was becoming less obvious to the extent that she seems to have lost her autonomy.

9.20 Nezha was murdered by Ahmad and the weapon used by him to kill her was a legally held licensed firearm. The Panel await the response of the Home Office to the request made by the Coroner in Plymouth to review the guidance concerning the issuing of firearms licenses.

9.21 The Panel extends its condolences to the family, friends and colleagues of Nezha.

Section 10
Recommendations approved by the Panel

1. Sharing information concerning risk and vulnerability with Higher Education institutions.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Investigate the development of a 'disclosure form' which will require the agency making the submission to the MARAC (or other relevant multi-agency arrangement) to secure the consent of the client to disclose necessary information to other MARAC Partners prior to the MARAC submission being made. The disclosure form – with the relevant information – could then be shared securely with each Partner on the MARAC prior to the meeting taking place. This disclosure form may allow – where necessary – information to be shared with institutions of Higher Education;
- Consider whether safeguarding training could be shared across the interface with higher education services within the CSP area to help share knowledge of local agencies and their threshold for providing support;
- To consider forging links with the Staffordshire and Stoke-on Trent CSPs to share their training across the interface with the Universities within their organisational footprint.

2. Firearms Licensing

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the West Midlands Police that the DARA[21] is applied for first responders and the use of DASH is promoted as a dynamic assessment, specific to the client, used for conducting secondary risk assessments;
- Consider the development of a multi-agency assessment of firearms applications and invites the MARAC Governance Group to act as the assessing Panel;
- Invite the West Midlands Police to apply a resolution to any GDPR issues at the point of application by explicitly informing the applicant that their application will be referred to a multi-agency forum for assessment;
- Apply due diligence to a process whereby, as necessary, applications that may have potential for risk to transfer to children, colleagues, family members, etc. to be referred to the appropriate safeguarding authority and the employee alert system across Dudley MBC

[21] the Domestic Abuse Risk Assessment (DARA) has been identified by the College Professional Committee and the NPCC as the preferred risk tool for first responders to domestic abuse. The NPCC supports forces adopting the DARA for first responders to domestic abuse. The DARA has been designed and evaluated for use by first responders. Specialist police officers and staff conducting secondary risk assessment are expected to continue using the DASH. Similarly, as the DARA has been evaluated in a frontline policing setting, partner agencies are expected to continue to use the DASH.

3. Adverse experiences in early adulthood

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from partners that trauma informed practice is being embedded across the Borough
- Assess the development of trauma informed practice, specifically for people seeking asylum

4. Use of the Pathfinder Toolkit and NICE Guidance.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from all Partners that they have suitable and effective domestic abuse and safeguarding training which is available to their staff

5. Suicide and the impact on family and friends

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with the Black Country Healthcare NHS Foundation Trust and supports the Trust in its endeavour to secure 'real-time-surveillance' (RTS) data on suicide and supports the Trust to develop a plan to promptly deliver support to family and friends, as appropriate;
- Seek support and guidance from the Offices of HM Coroner to deliver the ambition to secure 'real-time surveillance' data and also to drive the delivery of the recommendations from the National Confidential Inquiry into Suicides and Mental Health (NCISH);
- Deliver these particular recommendations in tandem with the Recommendations made by the Panel for DHR-9, specifically:
    - To promote the connection between suicide and domestic abuse;
    - Include domestic abuse as an explicit priority within the suicide prevention strategy;
    - Ensure that the RTS system asks specific questions about domestic abuse.

6. Prescribing practice

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the Pharmacy Clinical Network that systems are in place to support safe and effective prescribing, particularly for drugs that can be abused and/or may lead to dependency

7. Hate Crime, Anti-Social Behaviour and Domestic Abuse

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seeks assurance that all officers – Police, the ASB Team, housing services and others – consider domestic abuse when receiving referrals concerning hate crime and/or anti-social behaviour and vice versa; and
- That there are clear routes into appropriate services when hate crime and/or anti-social behaviour coupled with domestic abuse is identified.

8. Placing 'alerts' onto EMIS

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with IRISi and seek clarification for the decision to step-down the use of certain READ codes, which results in them no longer being promoted on the IRIS training;
- Invites IRISi to consider supporting the re-introduction of key domestic abuse related READ codes into the training programme;
- Ensure IRISi continues to promote in its training programme specific codes for people subject to a history of domestic abuse (14XD, 14X3); domestic abuse in the household (13Wd); being a victim of domestic abuse (14XG).

9. Family Safeguarding

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Work with the Children's Social Care Service to support the ongoing work regarding 'Think Family' and other 'strength based' models;
- Offer particular support to the implementation of "Family Safeguarding", which commenced within the Borough from July 2023;
- Encourage partners to work together and with other Partnerships (including the Safeguarding Board) to promote and deliver a programme to support the adoption of the 'Think Family' ethos and model of delivery.

Appendix 1

Domestic Abuse

The new Domestic Abuse Act 2021 defines domestic abuse as a behaviour by a person towards another and:

a) Both persons are each aged 16 or over and are personally connected, and
b) The behaviour is abusive

Where perpetrators direct their conduct towards another person (e.g., the child of a victim), this is also considered to be abusive behaviour towards the victim. Behaviour is considered abusive if it consists of any of the following:

- Physical or sexual abuse.
- Violent or threatening words or actions.
- Controlling or coercive activity.
- Economic abuse (see notes below).
- Psychological, emotional, or other abuse.

Economic abuse means any behaviour that has a substantial adverse effect on a victim's ability to acquire, use, or maintain money or other property, goods, or services.

Personally Connected

The new definition seeks to ensure that opportunities for identifying domestic abuse are not limited and includes where people:

- Are, or have been, married to each other.
- Are, or have been, civil partners of each other.
- Have agreed to marry one another (whether or not the agreement has been terminated).
- Have entered into a civil partnership agreement (whether or not the agreement has been terminated).
- Are, or have been, in an intimate personal relationship with each other.
- Is a child in relation to whom they each have a parental relationship.
- Are relatives.

Section 63 (1) states that a "relative" in relation to a person means:

a) the father, mother, stepfather, stepmother, son, daughter, stepson, stepdaughter, grandmother, grandfather, grandson or granddaughter of that person's spouse, former spouse, civil partner or former civil partner, or
b) The brother, sister, uncle, aunt, niece, nephew or first cousin (whether of the full blood or of the half-blood or by marriage or civil partnership) of that person or of that person's spouse, former spouse, civil partner or former civil partner.

For further information on this subject, please refer to the College of Policing, Authorised Professional Practice (APP) on Domestic Abuse.[22]

Positive Action

Police officers have a positive obligation to take reasonable action, within their lawful powers, to safeguard the rights of victims and children. This includes the duty to:

- make an arrest where it is necessary and proportionate to do so, see the authorised professional practice (APP) on detention and custody, lawful arrest
- protect the victim and vulnerable people within the household from harm

[22] College of Policing, Authorised Professional Practice (APP) on Domestic Abuse

Children as victims in their own right

Under section 3(2) of the Domestic Abuse Act 2021, a child is a victim of domestic abuse **for the purposes of the Act** where they see, hear, or experience the effects of domestic abuse and are related to either a perpetrator or victim of abuse, or either individual has parental responsibility for the child

The 2021 Act does not create a specific offence of domestic abuse against a child and there are no requirements to record a crime on the basis of a child either being present or residing at the location of the abuse.

The purpose of this Act is to ensure that children's needs are appropriately assessed and met. **Existing safeguarding, risk assessment and referrals processes and procedures should be followed** to ensure children receive support and remain visible in the multi-agency response to domestic abuse. Statutory guidance in Working Together to Safeguard Children sets out expectations for inter-agency working to safeguard and promote the welfare of children, including those experiencing domestic abuse.

Stalking or Harassment

Stalking and/or harassment are clear indicators of future harm to a victim and can be very common in domestic abuse incidents. Offences of stalking or harassment are classed as "as well as crimes" and must be recorded in addition to any other offences under NCRS/HOCR.

Stalking

Stalking is a pattern of fixated, obsessive, unwanted, and repeated behaviour which is intrusive and causes fear of violence or serious alarm or distress. Stalking tends to focus on a person, rather than a dispute.

Harassment

Harassment is unwanted behaviour which can be found offensive, or which makes the victim feel intimidated or humiliated. Harassment tends to focus on a dispute rather than a fixation with a person.

Controlling or Coercive Behaviour

Section 76 of the Serious Crime Act 2015 provides the offence of controlling or coercive behaviour where the perpetrator and victim are personally connected. In this legislation, 'personally connected' means intimate partners, or former intimate partners, or family members who live together. The Domestic Abuse Act 2021 introduced an amendment to the legislation which removes the co-habitation requirement. This ensures that post-separation domestic abuse and familial domestic abuse is accounted for when the victim and perpetrator do not live together.

Acts of controlling or coercive behaviour may include: isolating a person from their family or friends; monitoring a person's time; using spyware to monitor a person; taking control over aspects of a person's everyday life (such as where they can go, who they can see, what they can wear, and when they can sleep); repeatedly putting a person down (such as telling them they are worthless); threats to harm a child; and many other types of behaviour.

Harmful Traditional Practices

This is a broad term used to describe a combination of practices used principally to control and punish the behaviour of a member of a family or social group, to protect perceived cultural and religious beliefs in the name of 'honour'. There is currently no statutory definition of honour-based abuse.

Appendix 2
The MARAC National Dataset

There are approximately 290 MARAC across the UK. MARAC data is data submitted to SafeLives, by individual MARAC, on a quarterly basis. It comprises the date of meetings held within the quarter and basic information about the cases discussed at each meeting date (for example, the total number of cases, number of cases referred by a certain agency, number of cases where the victim has a disability, etc). Each quarter the data is collated and published to create the national dataset shown below.

Overview	**Latest Quarter 12 months 01/07/2021 to 30/06/2022**	**Previous Quarter 12 months 01/04/2021 to 31/03/2022**
Total number of MARAC who submitted data	293	290*
Number of cases seen at these MARAC	120,634	120,495
Year-on-year change in number of cases	+4%	+6%
Number of children	152,504	151,207
Number of cases per 10,000 adult females	46	47
% of repeat cases seen at these MARAC	33%	33%
% of partner agency referrals to these MARAC	33%	33%

Key statistics about domestic abuse in England and Wales

- Each year nearly 2 million people in the UK suffer some form of domestic abuse - 1.3 million female victims (8.2% of the population) and 600,000 male victims (4%)
- Each year more than 100,000 people in the UK are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse
- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- In 2013-14 the police recorded 887,000 domestic abuse incidents in England and Wales
- Seven women a month are killed by a current or former partner in England and Wales
- 130,000 children live in homes where there is high-risk domestic abuse.
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others
- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help
- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse

What are the characteristics of victims that mean they are more likely to be abused?

- **Gender:** Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- **Low income:** women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000

- **Age:** Younger people are more likely to be subject to interpersonal violence. The majority of high risk victims are in their 20s or 30s. Those under 25 are the most likely to suffer interpersonal violence
- **Pregnancy:** Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant [6]
- **Separation:** Domestic violence is higher amongst those who have separated, followed by those who are divorced or single
- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction (whether or not it is related to domestic abuse)
- **Drug and alcohol abuse:** Victims of abuse have a higher rate of drug and/or alcohol misuse (whether it starts before or after the abuse): at least 20% of high-risk victims of abuse report using drugs and/or alcohol
- **Mental health issues:** 40% of high-risk victims of abuse report mental health difficulties

How long do victims live with domestic abuse?

- On average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help

Appendix 3

Glossary of common acronyms

CPS	Crown Prosecution Service
CSI	Crime Scene Investigator
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking/Harassment, Honour-Based Abuse
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
FLO	Family Liaison Officer
IDVA	Independent Domestic Violence Advisor
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
PNC	Police National Computer
PND	Police National Database
ICB	Integrated Care Board
EMIS	The system of electronic patient record used by General Practitioners
WMAS	West Midlands Ambulance Service
PSD	Professional Standards Department
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability, Engage

Dudley DHR 10 SINGLE AGENCY RECOMMENDATIONS FOR ACTION

Please note: This action plan is a live document and subject to change as outcomes are delivered

Name of Agency: Dudley Children's Services	IMR Report Writer: Sophie Rees, Advanced Social Work Practitioner
Dates as given in Terms of Reference:	
Name of the Victim: Nezha Name of the Perpetrator: Ahmad	Ethnic Origin:

Nº:	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer / Target date to complete**	**Progress / RAG rating**
1.	Practitioners from core Social Work Teams to attend the mandatory Assessment and Analysis Training.	Expectations in terms of attendance at training will need to be set out by the Heads of Service and Service Managers, and shared with the service.	Dudley's Centre for Professional Practice (CPP) will collate the attendance data of practitioners, and report to Heads of Service monthly, on the 8th of every month.	Practitioners will have an increased understanding of analysing evidence to assess the level of risk faced by children, leading to improved safeguarding and more effective intervention. The attendance data at this training will increase to 100%.	6th April 2023 Nicola Hale (Principal Social Worker), Cornelia Heaney (CPP)	Amber Assessment and Analysis training continues as a core offer, more recently with additional training from the implementation of Family Safeguarding (since July 23). Assessment guidance has been updated 2024 and circulated.

						The training plan will be revised in 2024 to set out expectations for mandatory training according to role.
2.	Practitioners from core Social Work Teams to attend Dudley's Safe and Sound Domestic Violence Training Programme. This programme includes, 'Responding to Domestic Abuse for Frontline Practitioners', 'Working with Families and Understanding the Impact of Domestic Abuse on Children', and, 'Awareness of Domestic Abuse Perpetrator Behaviour'.	Expectations in terms of attendance at training will need to be set out by the Heads of Service and Service Managers, and shared with the service.	Dudley's Centre for Professional Practice (CPP) will collate the attendance data of practitioners, and report to Heads of Service monthly, on the 8th of every month.	Practitioners will have an increased understanding of working with families where domestic abuse is a concern, working with perpetrators, and understanding the impact of domestic abuse upon parenting capacity and the care of children. This should increase the confidence and skills of practitioners, and lead to more effective intervention for children and families. The attendance data at this training will increase to 100%.	6th April 2023 Nicola Hale (Principal Social Worker), Cornelia Heaney (CPP)	Amber Training is promoted with BCWA who present the attendance data at Safe and Sound DA Board. The training plan will be revised in 2024 to set out expectations for mandatory training according to role. Domestic Abuse guidance was updated in 2023 and circulated. BCWA DA training is

						promoted routinely in the Head of Safeguarding newsletters to the workforce

Name of Agency: West Midlands Police	IMR Report Writer: DC 21231 Lucy Pilgrim
Dates as given in Terms of Reference:	
Name of the Victim: Nezha Name of the Perpetrator: Ahmad	Ethnic Origin: Syrian

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer / Target date to complete	Progress / RAG rating
1.	During the firearms licensing process, in the event that an application has not been granted within three months of conducting background checks, further checks should be completed prior to granting the licence.	These further checks can be recorded on the 'Background Search' form.	Documented evidence that checks have been completed and recorded on the case notes	Improved safeguarding of the public	March 2024 Head of Operations – Sarah Burton	Escalated to Force level Awaiting update
2.	A part of the Firearms Licensing Process, a check of the Police National Database should be performed for every applicant who has a home or work address outside of the WMP area	The 'date checked' tab must be altered to states 'dates checked'. Currently, there is just one tab where this information is entered and the reader would assume on reading the information, that all the checks were conducted on the same date. The form should have a box that allows the enquiry	Documented evidence that checks have been completed and recorded on the case notes	Improved safeguarding of the public	March 2024 Head of Operations – Sarah Burton	Escalated to Force level Awaiting update

		officer to input the date for each individual check for precision and to satisfy the authorising officer that the checks are up-to-date.				
3.	WMP IT&D department to ensure that the Firearms Licensing Unit are prioritized for access to information and intelligence systems to ensure continuity and accuracy of the conducted background checks for each firearms licence applicant	As a matter of policy, IT&D should ensure that this team are prioritized as the risk of missing relevant information if the team's access to systems is not forthcoming	All FLU staff have access to intelligence systems and are using this effectively	Improved safeguarding of the public	March 2024 Head of Operations – Sarah Burton	Escalated to Force level Awaiting update

Name of Agency: Keele University	IMR Report Writer: Katie Laverty
Dates as given in Terms of Reference:	
Name of the Victim: Nezha Name of the Perpetrator: Ahmad	Ethnic Origin: Syrian

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer / Target date to complete	Progress / RAG rating
1	All process documentation related to individual student cases to be kept in one secure digital location	Ensure that roles, responsibilities and process are clear, with clear follow-up actions and recommendations for individual cases.	Written, approved and communicated processes which include record keeping guidance	All student concerns followed up and processes followed	May 2024 Doctoral Academy Director and Doctoral Academy Manager	In progress: Complete - New system implemented specifically for PGR students to support this. Ongoing – work being undertaken to ensure this joins up with other internal systems (Sep 2024).
2	Review the return from an LOA process for PGR students, ensuring evidence received.	KDA and Student Services to review process to ensure evidence is received and that students are	Published policy and procedure	That medical documentation is received and reviewed by Student Services to ensure students are receiving the	March 2024 Doctoral Academy Director / Doctoral Academy	In process: Complete - New process has been

		able to access appropriate support.		appropriate support, ensuring an LOA supports their recovery and continuation of studies. That medical documentation is received to ensure a student is well enough to return to their studies, allowing internal and external support to be put in place where required.	Manager / Head of Student Wellbeing	reviewed and agreed. Ongoing - Process will be administered via new system as per recommendation 1 (Sep 2024). Revised information re LOA process for students to be provided on web pages. (Sep 2024)
3	Review PGR support process to ensure referrals are made to internal support services, rather than recommendations that the student makes contact.	To develop a PGR referral process to Student Services. Refresher training and ongoing development of supervisory teams, particularly in the areas of mental health and resilience. Ensure support is available to PGR students is reinforced through communications,	Written process in placed and communicated. Training delivered. Communications plan developed and implemented.	Not relying on a student to make their own referral, therefore ensuring Student Services are aware of support needs / requirements via the Academic School. Increase in support and continuation / success for students. Training will ensure academic colleagues are aware of the referral process and when to	March 2024 Doctoral Academy Manager / Head of Student Wellbeing.	In process: Complete - Online supervisor and PGR Administrator training has been updated to reflect recommendation. Complete - Training provided to

		presentations (for example at induction events) and in the training of student representatives.		refer, ensuring referrals happen.		supervisors from Student Services regarding referral processes. Now part of mandatory training. Ongoing - System noted in recommendations 1 & 2 will also be used for referrals (Sep 2024) Communications plan being developed (Sep 2024).
4	Ensuring due process is followed when there are concerns regarding academic / research progress.	Enhance process to review outcomes from the interim report scores to determine appropriate interventions to support students to completion and to highlight good practice. Review progression rates against sector	Written process / policy	Review process means students with progression concerns are identified and appropriate support is put in place and early intervention support accessed.	May 2024 Doctoral Academy Director / Academic Registrar	Complete PGR Code of Practice revised. PGR Progress Review Handbook also revised.

		benchmarks, with a particular focus on identifying whether further support is needed for gradings.				Process in place to identify best practice.
5	Ensure students have supervisors and supervisory issues are resolved.	Process developed to ensure regular monitoring is in place. Policy to support students who have difficulty with supervisors, including mediation support, how to request a change to supervisor/process to assign a new supervisor.	Policy in place	No gap in supervision, so continued support delivered to students.	March 2024 Doctoral Academy Director.	In progress: Complete - PGR Code of Practice revised to be clearer regarding process and timeframe to replace supervisors. Complete - Increased the expected number of supervisory meetings to provide opportunities to provide support. Complete - New system (noted in recommendations above) allows us to

						review supervisory teams and meeting frequency. Ongoing - Requests for change in supervisor will be made via this system (Sep 2024).

Name of Agency: BCHFT	IMR Report Writer: Donna Robinson
Dates as given in Terms of Reference:	
Name of the Victim: Nezha Name of the Perpetrator: Ahmad	Ethnic Origin:

Nº:	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer / Target date to complete**	**Progress / RAG rating**
1.	Once the Overview Report is complete, BCHFT will note lessons learnt, recommendations/actions suggested to consider if any are pertinent to our trust	To review DHR10 once completed and identify any actions pertinent to BCHFT	To be agreed once the learning is identified	No learning for BCHFT identified	Not applicable	DHR10 reports reviewed - no learning for BCHFT identified

Name of Agency: Black Country Integrated Care Board (Dudley Place)	IMR Report Writer: Louise Powell
Dates as given in Terms of Reference:	
Name of the Victim: Nehza (Alias) Name of the Perpetrator: Ahmad (Alias)	Ethnic Origin: Syrian (from WMP record – though unclear from EMIS)

Nº:	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer / Target date to complete**	**Progress / RAG rating**
1	To review and refresh domestic abuse training and policy to include learning from this DHR Report. For staff to complete IRIS update training.	Recognise and respond to domestic abuse. Apply trauma informed practice. Identify domestic abuse indicators, including reliance upon prescription medication. Ensure prominent alerts/ flags on patient records to highlight patient vulnerabilities to practitioners. To incorporate standard practice of seeing patients alone as initial consultation to allow a safe space for disclosure.	Training compliance and evaluation. Robust safeguarding and domestic abuse policy. IRIS referrals being submitted. Patients vulnerable to or experiencing domestic abuse. discussed at Multi-Disciplinary Team meetings and minuted	Improve prevention and identification of early signs of domestic abuse, including coercion and control.	Practice Manager/ Safeguarding Lead	IRIS Training completed for all staff admin/clinical Updated safeguarding policy Patients discussed at clinical meetings-to include this in the records too (hidden from pt) Recruitment of asst manager with safeguarding experience who will be

		Clear documentation of who attends appointments. Safeguarding lead oversight of all safeguarding notifications or risks. Access standalone training around coercive control. Practice to update knowledge on carrying out safe telephone consultations.				overseeing safeguarding Admin Role
2	To review patients who have been on longstanding medications that can create a dependency.	Liaise with Practice-Based Pharmacist (PBP). PBP to complete IRIS training.	Referrals to IRIS.	For PBP to understand the dynamics of substance misuse in domestic abuse situations and to be able to ask the routine questions when completing medication reviews.	Senior Clinical Pharmacist & Designated Safeguarding Team	DHR – Summary and learning shared at the Clinical Pharmacist Team Meeting and refresher IRIS training to be arranged with the pharmacist Team
3	Policy review and development	For practice to review policies, specifically in relation to domestic abuse, safeguarding, did not attend and medication management.	Policies reviewed and updated.	To improve processes for identification and support for patients and staff.	Practice Manager/ Safeguarding Lead	Policy reviewed as above to include DNA policy and meds management.

Dudley DHR 10 Multi-Agency Action Plan for Safe and Sound, Dudley's Community Safety Partnership

Please note: This action plan is a live document and subject to change as outcomes are delivered

No:	Topic	Recommendation	Key Actions	Evidence	Key Outcomes	Date Due and Lead Officer	Progress
	The theme as discussed by the Panel	**As they are written in the Overview Report.**	**Indicate the actions or series of actions to be taken to achieve the expected outcomes; these must be Specific, Measurable, Achievable, Realistic and Timely**	**Describe the evidence you will provide to the Board to show the actions are being undertaken or achieved.**	**What improvements in service should result from actions.**	**Designation of lead officer charged with implementing the actions**	**Update on how the action is proceeding**
1	Sharing information concerning risk and vulnerability with Higher Education institutions	1.1 Investigate the development of a 'disclosure form' which will require the agency making the submission to the MARAC (or other relevant multi-agency arrangement) to secure the consent of the client to disclose necessary information to other MARAC Partners prior to the MARAC submission being made. The disclosure form – with the relevant information – could then be shared securely with each Partner on the MARAC prior to the meeting taking place. This disclosure form may allow – where necessary – information to be shared with institutions of Higher Education.	To understand when information can be shared with additional partners in respect of MARAC and ensure that all partners are aware of the relevant policies.	Evidence that policies and processes have been re-shared with relevant partners.	Partners are reminded about when to share information with additional relevant stakeholders to increase the safety of Domestic Abuse victims / survivors	March 2024 Gill Davenport (WMP)	Part of the existing MARAC process is that if there is a disclosure at MARAC an action can be set to share as appropriate if the chair deems it to be necessary. A decision to share information more widely before a MARAC takes place

							would never be made. The current BCWA Dudley Safe and Sound training offer includes 'Responding to Domestic Abuse' (4-hour core e-learning) which includes a section on risk that takes a case through the DASH risk assessment, and subsequent MAARC process, including example completed documents such as DASH risk assessment and MARAC referral and an interactive MARAC meeting.

		1.2 Consider whether safeguarding training could be shared across the interface with higher education services within the CSP area to help share knowledge of local agencies and their threshold for providing support.	There are no Higher education establishments within the brough, however promotion of safeguarding and domestic abuse training will be shared across the education providers within the borough.	Evidence that Safeguarding and DA training promoted amongst educational settings.	Increased knowledge and therefore response in respect of safeguarding processes and Domestic Abuse across education establishments in the borough	March 24 Kat Lafferty (Community Safety Team) and Dudley Safeguarding People partnership (DSPP)	There are no Higher education establishments within the brough, however promotion of safeguarding and domestic abuse training is regularly shared across the education providers within the borough.
		To consider forging links with the Staffordshire and Stoke-on Trent CSPs to share their training across the interface with the Keele University	To contact Staffordshire and Stoke-on Trent CSPs and request they share their training across the interface with the Keele University	Confirmation from Staffordshire and Stoke-on Trent CSPs that training has been shared with Keele University	Increased knowledge and therefore response in respect of safeguarding processes and Domestic Abuse across within Keele University	March 2024 Kat Lafferty (Community Safety Team)	DA training is available to all professionals working within Staffordshire through commissioned provider New Era, you can access the courses for free on

							Eventbrite - https://www.eventbrite.co.uk/o/new-era-ending-relationship-abuse-372511242 53 - information shared with Keele University with contact for any additional training requirements 27.03.24
2	Firearms Licensing	2.1 Seek assurance from the West Midlands Police that the DARA[23] is applied for first responders and the use of DASH is promoted as a dynamic assessment, specific to the client, used for conducting secondary risk assessments	Review the use of the DARA to inform the risk assessment when considering Firearms licensing or revocation	Evidence that policy has been reviewed and reflects this recommendation	Improved information sharing resulting in a more robust licensing process and improved safeguarding.	March 24 Gill Davenport (WMP)	Escalated to Force level Awaiting update
		2.2 Consider the development of a multi-agency assessment of firearms applications and invites the MARAC Governance Group to act as the assessing Panel	Seek assurance that the firearms application process uses all information available when making decisions	Evidence that policy has been reviewed and reflects this recommendation	Improved information sharing resulting in a more robust licensing process and improved safeguarding.	March 24 Gill Davenport (WMP)	Escalated to Force level Awaiting update

[23] the Domestic Abuse Risk Assessment (DARA) has been identified by the College Professional Committee and the NPCC as the preferred risk tool for first responders to domestic abuse. The NPCC supports forces adopting the DARA for first responders to domestic abuse. The DARA has been designed and evaluated for use by first responders. Specialist police officers and staff conducting secondary risk assessment are expected to continue using the DASH. Similarly, as the DARA has been evaluated in a frontline policing setting, partner agencies are expected to continue to use the DASH.

		2.3 Invite the West Midlands Police to apply a resolution to any GDPR issues at the point of application by explicitly informing the applicant that their application will be referred to a multi-agency forum for assessment	Seek assurance from West Midlands Police licensing team that they will consider all information before issuing firearms licenses and will follow up with all relevant agencies if information is not provided to further inform the risk assessment	Evidence that policy has been reviewed and reflects this recommendation	Improved information sharing resulting in a more robust licensing process and improved safeguarding.	March 24 Gill Davenport (WMP)	Escalated to Force level Awaiting update
		2.4 Apply due diligence to a process whereby, as necessary, applications that may have potential for risk to transfer to children, colleagues, family members, etc. to be referred to the appropriate safeguarding authority and the employee alert system across Dudley MBC.	Seek assurance that the process is correct for notifying safeguarding concerns	Evidence that policy has been reviewed and reflects this recommendation	Improved information sharing resulting in a more robust licensing process and improved safeguarding.	March 24 Gill Davenport (WMP)	Escalated to Force level Awaiting update
3	Adverse experience in early adulthood	3.1 Seek assurance from partners that trauma informed practice is being embedded across the Borough	To ensure that trauma informed training is being delivered across the borough and the broad spectrum of the partnership	Evidence of training delivered and accessed.	Increased knowledge and therefore response in respect of trauma informed practice	March 24 DSPP / CPP	The current BCWA Dudley Safe and Sound training offer has a trauma informed approach embedded in both its content and delivery- appropriate trigger warnings and encouragement to seek support are

							included, as well as specific reference to trauma and its impact for victims and the consequent response required by professionals. For instance, the 'Responding to Domestic Abuse' (4-hour core e-learning) includes a section on the use of trauma informed language. In the review in August a stand alone eLearning course focusing on trauma informed practice using a domestic abuse case study as an example will

							be added. In addition, whilst the briefing topics for this financial year have yet to be finalised, in the last financial year briefings were held on the topics 'Trauma-informed language and domestic abuse: What is it and why does it matter?' and 'No one size fits all: a trauma informed lens for DA'. Trauma informed practice training specifically looking at DA as a factor Introduction to Trauma Informed Practice

							(thinkific.com) is available via Black Country Womens Aid. Dudley safeguarding People Partnership (DSPP) have a specific webpage around Trauma informed practice: https://dudleysafeguarding.org.uk/trauma-informed-practice/. They also promoted Trauma informed practice through their networks via a thematic learning month and offers trauma informed practice training across the system:

							https://dudleysafeguarding.event-booking.org/event-detail/%3DIDNyYjM/ACE39s--Trauma-Informed-Practice-full-day This is open to anyone who works with Dudley residents free of charge from any agency
		3.2 Assess the development of trauma informed practice, specifically for people seeking asylum.	To seek assurance that trauma informed practice in respect of asylum seekers is being developed within the borough	Evidence that trauma informed practice is included in the local pathway for people who are seeking asylum	Trauma informed practice is used when working with people seeking asylum within the brough	March 24 TBC	A number of Officers including the Team Manager in the Resettlement Team have completed Trauma Informed Practice Training. Work is also taking place to explore routes to

							offer trauma informed practice training to hosts of refugee/asylum seeker families and staff at temporary placements such as hotels within the borough
4	Use of the Pathfinder Toolkit and NICE Guidance.	Seek assurance from all Partners that they have suitable and effective domestic abuse and safeguarding training which is available to their staff.	To seek assurance that where staff are not accessing the Dudley's Safeguarding or Domestic Abuse training offer, that the internal training is appropriate and accessible to all staff	Evidence that safeguarding and DA training is accessible by staff in all organisations across the borough	Increased knowledge and therefore response in respect of safeguarding and Domestic Abuse	March 24 Gill Davenport (chair of DDALPB)	A comprehensive training offer is available via Black Country Women's Aid – any individual that works or volunteers within the borough and work continues to take place to promote this offer across the workforce. Several partners

							have confirmed that they also include DA within their internal training or provide specific DA training
5	Suicide and the impact on family and friends	Establish links with the Black Country Healthcare NHS Foundation Trust and supports the Trust in its endeavour to secure 'real-time-surveillance' (RTS) data on suicide and supports the Trust to develop a plan to promptly deliver support to family and friends, as appropriate; Seek support and guidance from the Offices of HM Coroner to deliver the ambition to secure 'real-time surveillance' data and also to drive the delivery of the recommendations from the National Confidential Inquiry into Suicides and Mental Health (NCISH); Deliver these particular recommendations in tandem with the Recommendations made by the Panel for DHR-9, specifically: o To promote the connection between suicide and domestic abuse;	To convene a task and finish group to address the links between Suicide and Domestic abuse to address this recommendation. This will include members from both Dudley's Domestic Abuse Local Partnership Board (DDALPB), Members of Dudley's Suicide Prevention Group	• Task and finish group to meet Terms of reference and action plan developed • Further realistic timescales to be agreed in respect of the action plan • Action plan delivered	Improved response and communications across the borough in respect of Domestic abuse related suicide	Kat Lafferty (Community Safety Team) to coordinate initial meeting. Lead moving forward TBC	Work has already begun within the borough around suicide and DA, with the DA lead being an active member of the Suicide Prevention Group. The decision has been made between DALPB and Suicide Prevention group to refer relevant actions from strategy and various DHRs to suicide

		○ Include domestic abuse as an explicit priority within the suicide prevention strategy; ○ Ensure that the RTS system asks specific questions about domestic abuse.					prevention group to ensure completion and negate need for separate group. Ongoing work to address actions DA and Suicide Action Plan april 2024
6	Prescribing practice	Seek assurance from the Pharmacy Clinical Network that systems are in place to support safe and effective prescribing, particularly for drugs that can be abused and/or may lead to dependency	Request assurance from Black Country ICB Pharmacy Team, that policies and processes are in place to ensure high risk medications are assessed regularly.	Evidence of policies in place	Individuals do not become dependant on prescription medications that may affect their health and well being	March 24 Jane Atkinson (ICB)	Designated Team have been invited to Clinical Pharmacists Training session to share learning for this DHR and refresher training for IRIS to be arranged
7	Hate Crime, Anti-Social Behaviour and Domestic Abuse	Seek assurance that all officers – Police, the ASB Team, housing services and others – consider domestic abuse when receiving referrals concerning hate crime and/or anti-social behaviour and vice versa and that there are	Reminder to all staff to consider potential of domestic abuse when called out for other issues such as ASB or hate crime and ensure they are aware of specialist	Creation of a safer 7 (or similar) communication to highlight the potential of more than one issue linked to calls for service, in addition to information around	Greater awareness of staff and increased professional curiosity	March 24 Kat Lafferty (Community Safety Team) / DSPP	The current BCWA Dudley Safe and Sound training offer core eLearning's

		clear routes into appropriate services when hate crime and/or anti-social behaviour coupled with domestic abuse is identified	services available in the borough in respect of hate crime, ASB and Domestic Abuse.	specialist services available in the borough in respect of hate crime, ASB and Domestic Abuse.	Individuals signposted to appropriate specialist support services		for both entry level and more specialist staff include a section on spotting the signs of domestic abuse and what to then do, dependant on role. The briefing topics for the current financial year are yet to be finalised but are planned to include a session on links between ASB and DA. Black Country Healthcare Foundation Trust: These themes are highlighted in L3 Safeguarding children and

							Adult training.
8	Placing 'alerts' onto EMIS	Establish links with IRISi and seek clarification for the decision to step-down the use of certain READ codes, which results in them no longer being promoted on the IRIS training; Invites IRISi to consider supporting the re-introduction of key domestic abuse related READ codes into the training programme; Ensure IRISi continues to promote in its training programme specific codes for people subject to a history of domestic abuse (14XD, 14X3); domestic abuse in the household (13Wd); being a victim of domestic abuse (14XG).	IRISi is invited to engage in discussion regarding the following READ codes:	That the IRIS training reflects the re-introduction of the relevant codes.	EMIS records begin to reflect the revised training programme	March 24 Jane Atkinson (ICB)	Read codes have been simplified to one snomed code to ensure consistency of recording Domestic abuse in GP records
9	Family Safeguarding	Work with the Children's Social Care Service to support the ongoing work regarding 'Think Family' and other 'strength based' models; Offer particular support to the implementation of "Family Safeguarding", which commenced within the Borough from July 2023;	Report and findings to be shared with Children's Services Report and findings to be shared with the DSPP Evaluation of the impact of Family Safeguarding model and adult practitioners role in multi-agency teams specifically in relation to mental	Evaluation reports from Family Safeguarding, via the Family Safeguarding Partnership Board and updates to Safe and Sound	Earlier intervention for families experiencing domestic abuse, parental mental health and substance misuse. Fewer children becoming in need of protection.	Ongoing Safe and Sound/Head of Children's Safeguarding	To share DHR report when published – Childrens services already sighted due to being part of panel

		Encourage partners to work together and with other Partnerships (including the Safeguarding Board) to promote and deliver a programme to support the adoption of the 'Think Family' ethos and model of delivery	health and domestic abuse risks.		Multi-agency plans across Adult and Children practitioners to support sustained change for families.		Evaluation report of the impact of Family Safeguarding model to be shared with board - ETA near end 24-25

Home Office

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Katriona Lafferty
Community Safety Officer
Dudley Council
Brierley Hill Police Station
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23rd April 2024

Dear Katriona,

Thank you for submitting the Domestic Homicide Review (DHR) report (Nezha) for Dudley Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th March 2024. I apologise for the delay in responding to you.

The QA Panel felt that report benefitted from the flexibility of the panel in taking account of information prior to the review time frame and including this in the report.
The report also helpfully includes a well populated and SMART action plan. Additionally, section 1.6 provides a good summary of the work of the panel.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- The explanation as to why the family and friends of Nezha were not engaged with and that correspondence/contact with family needed to go through Family Liaison Officer (FLO) and Professional Standards Department (PSD) representative should be included earlier in the report, for transparency.

- Suitable pseudonyms should be used instead of C1, W1 and W2.

- The equality and diversity section is underdeveloped. The ethnicities of the victim and perpetrator are absent, and the section does not state that that English was not their first language and that there may have been cultural barriers to accessing services. This is a missed opportunity to highlight any particular issues and barriers that they may have faced.

- Given that the victim was a migrant woman who came to the UK fleeing the civil war in Syria, panel representation on this would have been beneficial. This may have helped paint a fuller picture of the victim.

- Information around women being disproportionately impacted by domestic abuse is included in the appendix, but the review would be stronger if it was also included within the equality and diversity section.

- It is not clear why the review suggests that Nezha's income fell when she finished her PhD studies – was this because the work she did alongside her PhD for the university finished? If so, this could be made clearer.

- It is stated under the panel membership that names will be removed prior to publication – this goes against the current guidance. A panel member role (for North Midlands Partnership NHS Foundation Trust) is also missing.

- The Preface explains that the precise circumstances leading to the deaths of the victim and perpetrator were determined by the Office of the Coroner in July 2022. There should be some further explanation on the circumstances at this point.

- 1.10.3 and 7.4.1 will need updating prior to publication, which relates to the PSD review.

- There were issues relating to the granting of the firearms licence. It was granted before the police received the information from GP and it is unclear if the police information that was held regarding the perpetrator's drug trading and supplying and different aliases were taken into consideration in relation to granting the firearms licencing. More detail in this section would be beneficial.

- The perpetrator had problem alcohol and opioid addiction that was not identified as a vulnerability in the data collection form and was not analysed within the report.

- There is no information on whether the review contacted the two previous partners of the perpetrator, which is a missed opportunity. It would be helpful to understand the decision making surrounding this.

- The report states that the judge deemed W1 fabricated allegations against Ahmand. Given the other records of abuse by him against her are referred to, it would be useful to also reference these in this section.

- Para 9.15 reveals the sex of C1.

- The contents in the executive summary use a different name (not Nezha).

- 1.14.9 includes information on 'key elements' such as low income, separation and drug and alcohol abuse but it does not explicitly link these to Nezha's circumstances, so it is not clear if they are relevant or not.

- The inclusion of an 'address' column for the subjects of the review (para 1.2) is unnecessary. Also, including the month and year of birth for the subjects is unnecessary and the age (where relevant) should just be included. The age of the child should not be included at all.

- Given that this case relates to a suicide, it would be useful to include Public Health England on the dissemination list (1.15).

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review. Yours sincerely,

Home Office DHR Quality Assurance Panel