Safer Sheffield Partnership (SSP)

THE EXECUTIVE SUMMARY

‘Thandi’

November 2022

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INDEPENDENT CHAIR AND AUTHOR

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The review process

1. On behalf of the Sheffield Safer and Sustainable Communities Partnership[1] that commissioned this Domestic Homicide Related Death Review (DARDR)[2] and the people who were involved in this review from London and Sheffield, the author expresses the sincerest condolences to 30-year-old Thandi's[3] family, friends and loved ones for their loss following her tragic death.

2. Thandi was 30 years old and Leo was her 36-year-old estranged husband. They had two children who were living with a maternal aunt at the time of Thandi's death. In addition to Leo and her children, Thandi is survived by her mum and two siblings one of whom lives in the Republic of Ireland (ROI). The remaining family are in South Africa where Thandi and Leo had lived before coming to the UK for work in late 2021. They initially went to London

3. HM Coroner's inquest concluded that Thandi died by suicide.

4. The first meeting of the DARDR panel was in May 2023 followed by four further meetings. The panel met for the final time in November 2023.

1.1 Contributors to the review

5. Seven of the more than 40 agencies contacted in London and South Yorkshire as part of the initial scoping for the review confirmed that they had varying levels of contact with Thandi or Leo and provided information. All were asked to provide chronological information and complete an individual management review with an analysis of their contact.

    a) Central and North West London NHS Foundation Trust (CNWLFT) 0-19 service;
    b) NHS North West London Integrated Care System (NWICB)
    c) NHS South Yorkshire Integrated Care System;
    d) Sheffield Children's NHS Foundation Trust;
    e) Sheffield Teaching Hospitals NHS Foundation Trust;
    f) South Yorkshire Police (SYP);
    g) Yorkshire Ambulance Service (YAS).

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[1] The community safety partnership set up under the Crime and Disorder Act 1998.
[2] The review was commissioned and completed under government guidance that included referring to Domestic Homicide Reviews (DHR). This has changed to DARDR and new guidance will be implemented.
[3] Along with all other names used in this report this is a pseudonym to protect the privacy of the family.

1.2 The review panel members

6. All of the panel members were independent of any involvement or decision-making about the events and people concerned with the circumstances examined by the review.

Name	Role	Organisation
Peter Maddocks	Chair and report author	Independent reviewer
Amanda Boughton-Brown (ABB)	Assistant Director Quality Assurance and Involvement Service	Children's Social Care (CSC) Sheffield City Council (SCC)
Dr Amy Lampard	Designated Doctor for Adult Safeguarding	NHS South Yorkshire Integrated Care System (formerly Sheffield Clinical Commissioning Group) (CCG)
Susan Bray	Perinatal Mental Health Services/Trust Domestic Abuse Lead	C and NW London NHS Foundation Trust
Laura Kefford	Named Nurse Children's Safeguarding Harrow	C and NW London NHS Foundation Trust
Christine Asare-Boscompem	Designated Nurse Safeguarding Adults Adults Safeguarding, MCA & DoLS, Prevent Lead Local Area Contact (LeDeR)	NHS North West London Integrated Care System (NWICB)
Kitty Reilly	Designated Professional Safeguarding Adults	NHS South Yorkshire Integrated Care System (formerly Sheffield Clinical Commissioning Group) (CCG)
Meeta Palawan	Named Nurse and Community Safeguarding Service Lead	Sheffield Children's NHS Foundation Trust – 0-19 Service
Christina Blaydon	Head of Safeguarding	Sheffield Teaching Hospital Foundation Trust (STHFT)
Calisse Martin/Jessica MacKintosh Laura Jones	Case Review and Policy Officer Detective Sergent	South Yorkshire Police (SYP)
Catherine Holliday	Named Nurse for Safeguarding	Yorkshire Ambulance Service (YAS)
Alison Higgins	Strategic Commissioning Manager	Sheffield City Council – Domestic Abuse

		Commissioning Team (DACT)
Pip Chisholme	Commissioning Officer	Sheffield City Council – Drug and Alcohol Commissioning Team (DACT)

1.3 Author of the overview report

7. Peter Maddocks is the independent author of the overview report and chaired the panel. He has worked in local authority, voluntary and national services as a practitioner and in strategic and policy roles. These have included working with families and children harmed by domestic abuse including work on policy and service development as well as direct work. He is a qualified and registered social worker who continues to participate in regular professional training and development that includes domestic abuse. He has never worked for any of the organisations that have contributed to this review nor has he held any elected position in Sheffield or the borough in North West London. He is not related to any individual who either works or holds an elected office in Sheffield or South Yorkshire. He has been an independent reviewer for DARDRs in Sheffield on two earlier occasions and none in the North West London borough.

1.4 Terms of reference

8. The timeline of the DARDR is from February 2022 while Thandi was registered with a GP in London. Information was therefore sought from services in both areas to provide history and context before the contact with services in Sheffield.

    a) What contact, knowledge and information did services have that indicated, or could have indicated, that Thandi was vulnerable to, or could be at risk from domestic abuse and what response was there? This should include whether relevant history was inquired about and considered alongside any enquiries or assessment of risk.

    b) Was there evidence that Thandi was a victim of a pattern of sustained domestic abuse including non-fatal strangulation (NFS) and economic abuse? Were these issues fully explored and inquired about?

    c) What contact, knowledge and information did services have with Thandi that could have indicated a risk of self-harm and what response was there?

d) What enquiries were made about the two children and was there sufficient attention given to determining whether they were children in need or required safeguarding?

e) Were there issues about the capacity or resources of services that had an impact on the ability to help Thandi or to prevent domestic abuse, or had an impact on the ability to work with other services?

f) Were there any issues about the impact of any organisational changes covered by the period under review that influenced how the agency or partnership arrangements were operating?

g) What can be identified as good practice in this case?

h) Are there action(s) by the agency that in retrospect and with reflection might have led to better outcomes in this particular case? Why were these not considered/not taken at the time from the agency's perspective?

i) Any lessons to be learnt from the review for the agency to promote greater knowledge and understanding of domestic abuse processes and services. This should be explicit if any shortfalls in meeting standards have been identified as well as any gaps in policy, protocols or professional practice and understanding. This section should also link to any action the agency takes or recommendations being made. Are there any repeated issues that were identified in earlier DARDRs?

1.5 Summary chronology

9. The time that Thandi lived in the UK was limited with extended visits back to South Africa. Thandi's mum and sister provided information and background about Thandi that was not known by any of the services and is an important context for understanding the level of stress that Thandi was experiencing including being separated from her children. Thandi had not felt able to talk to her family or friends in detail about her relationship with Leo which she had described as toxic.

10. Thandi's description of being a victim of Leo's abuse in her letter to her family in March 2022, provided more historical information than was disclosed to the police in Sheffield in November 2022. In her letter, Thandi described what she felt lay behind her behaviour and significantly how she felt that she had become isolated by a narrative that was dominated by Leo's account.

11. The information given to the DARDR describes the profound complexity and distress that Thandi was experiencing. The interconnection of poor

mental health and the use of alcohol and other substances with domestic abuse is well-known and discussed in the overview report. The police were the only service to have completed any risk assessment about domestic abuse. None of the health professionals who saw Thandi at different times and were told of "relationship difficulties" or about explicit physical assault and being a victim of domestic abuse recorded any further inquiries. The referral by the hospital was limited to information being sent to the police to check on the immediate location and safety of a patient who had left the ED and information to social care that was processed as recording information and passing it to services in ROI.

12. There were opportunities to encourage Thandi to disclose more information; during the only GP consultation while in London soon after arriving in the UK and when she was admitted to hospital following an overdose at a hotel in Sheffield when she had returned to the UK before the relocation back to South Africa.

13. The GP in London made a referral to the community mental health team (CMHT) but it was declined because CMHT believed that Thandi needed to be referred to the alcohol and drug service. Although the CMHT say they advised the GP there is no record of any contact with the GP and no further action including follow-up by the GP.

14. The admission to the hospital emergency service in Sheffield in November 2022 was an opportunity to have signposted and refer Thandi for help. The circumstances of the hospital's limited response are discussed in the overview report.

15. Thandi left the hospital before being seen by a doctor. She had however been assessed by a nurse and had had an ECG[4] and a set of clinical observations including neurological observations. Thandi had also been given pain relief. There was a documented intention to complete a mental health risk assessment with Thandi although this did not happen. The mental health liaison team had not been contacted before Thandi had left the department. The hospital contacted the police to alert them to Thandi's contact with the service and the police subsequently visited the hotel where Thandi was staying and having spoken with Thandi had no cause to return Thandi to the hospital against her wishes.

16. Given the difficulty Thandi had in fully disclosing to anybody what had been happening in her relationship with Leo, she may have felt unable to engage with a professional. It is noted that Thandi had sought further contact with the police officer she talked to on her first contact in November 2022.

[4] An ECG (electrocardiogram) is a test that records the electrical activity of the heart, including the rate and rhythm.

17. With the benefit of all the information provided to the DARDR, Thandi's level of vulnerability and risk was greater than was probably realised at the time of individual professionals' contact with her. Thandi was at a point of crisis in a city where she did not know anybody and was not registered or known to GP services.

18. The only reference to Thandi having a history of self-harm or thoughts of suicide was recorded in a DASH by the police when Leo contacted them as the victim of abuse from Thandi.

19. The decision to arrest and take Leo to the police station to be interviewed left Thandi alone for several hours. Thandi asked the police to keep Leo in custody until she had left Sheffield.

Key issues arising from the review

20. Thandi described being the victim of Leo's abuse in her letter to her family referring to what she believed was his narcissistic behaviour. She did not disclose or describe this behaviour in further detail and it was not a term she referred to when talking with a police officer or health professionals.

21. The term narcissism is commonly used to describe self-absorbed people. This is not a diagnosis of a disorder. That can only be done by an appropriately qualified, registered and experienced psychiatrist based on careful assessments. Personality disorders are often found among perpetrators of domestic abuse the most commonly being anti-social, borderline and narcissistic. The discussion of narcissism in the overview report and referenced in this executive summary is to inform learning for professionals responding to domestic abuse rather than a discussion of Leo specifically.

22. The impact on the partner (often women) who are the victims of narcissistic abuse is multi-faceted. A feeling of isolation and being on their own, emotional trauma, loss of trust and self-identity, and lack of understanding about what was happening by others (family and friends).

23. Professor Jane Monckton-Smith and other academic researchers highlight that many suicides are the "hidden victims" of domestic abuse. Several DARDRs in Sheffield (as well as other areas in England[5]) have concerned women who were abused by their partner and who died by suicide. A 2018 study of 3,500 women accessing services that support women and children experiencing domestic abuse estimated that about

[5] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews

one-third of female suicides were women who had experienced domestic violence. The study reported that 24 per cent had felt suicidal and 18 per cent had made plans to end their life[6].

24. Thandi's relocation to the UK removed her from the support of mental health services and her family and friends in South Africa. It was a move precipitated by financial difficulties and being offered work in the UK.

25. The barriers facing Thandi in leaving the relationship included her children and feelings of guilt about her struggles. Maintaining contact with her children was important to Thandi (and to her family). Thandi was worried about the potential for court proceedings in South Africa where she feared she would be presented as an adverse influence by Leo without any scrutiny of him. In Thandi's first contact with the police in November 2022 she described Leo as resentful about the separation, and that he had recently made threats of suicide due to the separation.

26. The police response in Sheffield when Thandi made her initial disclosure of assault and domestic abuse was influenced by Thandi saying she was leaving the UK imminently. This would not have prevented a DVPN from being used; Thandi's assertion that she had a flight arranged to leave Sheffield and the UK was understood as removing her from further risk. All of the subsequent contacts with the police were part of a continuum that would have been better understood by the specialist DARA team, although their secondary assessments were completed after Thandi had died. Each of the contacts was dealt with by different officers on duty at the time.

27. The reason for Thandi unexpectedly still being in the UK despite telling the police in her first contact that she was booked on a flight out of the UK was not explored at the time and remains unknown.

28. The absence of referral to mental health or safeguarding professionals in the hospital removed an opportunity for better engagement with Thandi. The hospital trust has invested in developing policy, providing training and establishing additional capacity including the care navigator service which includes follow-up community contact and home visits. The absence of mental health assessment or alcohol screening, asking for Thandi's consent to make a referral to the IDAS or signposting her to the domestic abuse helpline are identified in the hospital IMR. Any of those measures would have offered an opportunity for Thandi to talk with somebody who could have offered immediate support and how to access longer-term help.

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[6] Aitken, R and Munro, V (2018) Domestic abuse and suicide: exploring the links with Refuge's client base and work force. London: Refuge.

29. Leo was arrested by officers who attended the home address to arrange a voluntary interview with him. The voluntary interview was on the basis that Thandi was no longer in the UK and there would be no necessity to arrest Leo without a victim to protect. The police had attempted phone contact with Thandi to check that she had left the UK as stated during the first contact but the calls had not been answered As Thandi was at the address and not in South Africa, that then brought back the necessity to arrest Leo, and as such he was arrested and taken into custody.

30. When the officers unexpectedly found Leo and Thandi together at the property they decided to arrest Leo for the allegation of ABH and take him to the police station for an interview. The potential for the arrest to escalate the risk of further abuse with Thandi in the same property and what would happen after Leo had been interviewed were significant issues to risk assess. Having a strategy for dealing with the unexpected presence of a victim and risk assessing the potential for escalation is an area of learning.

31. The last telephone contact with Thandi was the police informing her that Leo was being released from custody after being interviewed about her allegation. The log of the phone call with Thandi records that she was concerned that Leo was going to make it difficult for her to see the children when they returned to South Africa. Thandi was worried that Leo would make “life difficult” about seeing the children and taking legal action against her. Although she asked for Leo to remain in custody until she had left for the airport, she was not scared of him and was “happy for him to return to the property”. Putting a victim in the position of giving consent to an alleged perpetrator returning to the same property is a dubious practice. Arresting and interviewing any alleged perpetrator of domestic abuse represents a potential for escalation of abuse.

32. There is no record of the officer being aware of Thandi’s recent overdose and the very recent concerns for safety following her overdose and attendance at the hospital.

33. The officers who returned Leo, drove him to the address and dropped him off outside, which is acknowledged by SYP to be poor practice. There should have been more consideration to providing Thandi with ongoing safeguarding, the officers should have escorted Leo into the property given they knew Thandi was present and ensured that everything was okay between Thandi and Leo.

Conclusions

34. Thandi sought help while living in South Africa which had included in-patient treatment that ended when she discharged herself. The review has no further information over and above what has been summarised earlier in the report. Thandi told her family she had learnt some tools and

techniques to help her cope better. The diagnosis in South Africa described a major depressive disorder with general anxiety; the GP in the UK in the referral to the CMHT referred to mixed anxiety. The letter from South Africa referred to marital difficulties but there is no evidence of any more direct inquiry in South Africa or by the London GP. More substantial help would have included addressing the drivers and stressors behind her symptoms. The referral to mental health services was declined and the advice was given for the GP to refer Thandi to alcohol and drug services which was not followed up. Although CMHT provided evidence of sending this advice the GP patient system has no record of the outcome of the referral or the advice to refer to local alcohol and drug services.

35. A more trauma-informed approach to understanding what lay behind Thandi's poor mental health and her use of substances with greater curiosity and inquiry about domestic abuse would have been a better response. There is no recorded evidence that health professionals whom Thandi consulted about her poor mental health and use of alcohol inquired about her relationships or made routine enquiries about domestic abuse.

36. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?' or 'How do we stop their unwise or risky behaviour?'

37. If practitioners focus on substance misuse for example, then they will focus on a solution to stop or reduce the substance misuse. This means that agencies are not identifying sources of stress such as being a victim of abuse and it focuses on removing the very coping mechanisms people think are keeping them "safe" (as in dissociated rather than protected) from the real drivers of risk (abuse, trauma, loss, social isolation, fear and poverty) that cause mental and physical ill health. The coping mechanisms may have become part of the problem, but to someone like Thandi, they are survival strategies that have kept them going for several years.

38. Responding to domestic abuse requires effective management of a perpetrator's behaviour to protect the victim combined with person-centred relationship-based care that addresses trauma.

39. The importance of primary health care professionals inquiring about underlying stressors including domestic abuse has been described in research and evidence from DARDRs.

40. The police implemented the Right Care Right Person[7] policy (RCRP) in late March 2023 and therefore was not in place at the time of their contact with Thandi. Even with the policy in place, the police would have responded to Thandi's situation due to her hospital disclosures, as this would have been deemed as a threat to life.

41. The main focus of the RCRP approach being implemented was to recognise that police were increasingly involved in mental health circumstances where they may not be the most appropriate agency to respond. The police are not always able to then handover care to a more appropriate professional promptly and that impacts on them being able to respond and carry out their statutory duties effectively. It also results in people who are likely experiencing a crisis in their mental health, being distressed at the involvement of the police and having a poor experience of mental health services.

42. The national partnership agreement[8] states that the RCRP is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training and experience to best meet their needs. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs.

43. The national partnership agreement identifies that to successfully adopt the approach, strong partnerships need to be formed between police forces, health bodies and local authorities to identify how to implement this approach in a way that best meets the needs of the local population and the shared aims of the agencies involved.

44. The policy is intended to ensure that people in mental health crisis at immediate risk are not left without support (includes walk-outs from health care services such as hospital ED and management of mental health incidents) it requires a clear understanding by partners that the police have a limited role in above responding to criminal matters or immediate risk but not for ongoing care and treatment. From comments and incident forms being raised in SHSC and comments at the initial Tactical Working Groups across the region, health colleagues were having to react to the change rather than having time to educate staff about the changes. Staff are being supported to understand the process and threshold that police have so that clear requests for support are made within the criteria. In some areas, mental health practitioners are

[7] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp
[8] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp

working alongside the police and can assist in that decision-making, but is not a resource in Sheffield.

45. The adverse impact of domestic abuse on children is increasingly understood through research[9]. The impact can be short-term in terms of behaviour for young children that can include bed wetting, increased sensitivity and crying, difficulty in sleeping and separation anxiety. School-aged children's participation in school activities or academic performance can be poorer than their peers, they may get into trouble more often and may present with physical ailments such as headaches and stomach aches. For older children in adolescence, the impact can be acting out in negative ways, having low self-esteem, having difficulty making friends, and tending to engage in risky behaviour such as the use of alcohol and drugs. The longer-term impact can be poor mental health, developing disorders, low self-worth and using alcohol and drugs to cope. This is exacerbated if and when they find themselves in a relationship with a partner who abuses them.

46. The lack of curiosity by several although not all professionals about where the children were, who they were living with and what they were witnessing is a feature in this case. For clarity, members of the respective extended family were concerned with ensuring the children were physically safe and for example, the paternal grandmother came to the UK to provide care for the children in Sheffield until they moved to their aunt's home in the ROI before returning to South Africa where they now live.

Learning

47. The learning is summarised;

a) Arrest and interview strategies for alleged perpetrators where victims are still on the same property need to take account of the potential for escalation;
b) Victim care and ongoing safeguarding; when officers arrested Leo, they left Thandi at the address on her own following a significant mental health episode. The attending officers might have been unaware of all the information surrounding Thandi, which they should have been as this information was significant, SYP should make an effort to know their victim; allowing Leo to return home without any direct face-to-face contact with Thandi and

[9] https://www.cheshirewestandchester.gov.uk/documents/crime-prevention-and-emergencies/domestic-abuse/resources/child-safety-resources/impact-of-domestic-abuse-on-children-by-developmental-level.pdf

establishing that it was safe to leave both in the same property was poor practice;

c) Emergency healthcare recording of follow-up action with patients at risk who disclose domestic abuse and/or self-harm should include completing relevant risk assessments and referrals to services;

d) The Sheffield Right Care, Right Person concern for safety request to the police about patients who are at risk is not a substitute for safeguarding referrals to other services such as social care and mental health;

e) Damaging adverse emotional and psychological experiences exacerbated by domestic abuse need competent and effective risk assessment and intervention alongside trauma-informed care and support; responding to incidents of self-harm requires effective clinical care for physical recovery (provided in this case) and attention to identifying underlying stressors that will require longer-term trauma-informed care;

f) Opportunities for disclosure are missed if inquiries by health professionals about domestic abuse are limited or not completed when patients present with symptoms of low mood and substance use or make explicit statements about domestic abuse;

g) DVPNs provide the police with important powers to arrange protective measures that have an immediate effect; if there are grounds for a DVPN the general assumption should be to use a DVPN; in this case the police could have used the DVPN but did not on the basis that Thandi was leaving Sheffield within hours; however plans change or victims may not be allowed to leave; the Domestic Abuse Act (DAPN) introduces new Domestic Abuse Protection Notices (DAPN) and the new civil Domestic Abuse Protection Order (DAPO);

h) Domestic and sexual abuse are major determinants of poor mental and physical health for people presenting to health and related services; the importance of professional curiosity and professionals in emergency and primary health settings knowing how to ask about domestic abuse and respond sensitively and how to use local protocols; routine enquiry about relationship and experience of abuse are valuable for encouraging disclosure and diagnosis when discussing poor mental health, self-harm and substance use for example; opportunities to query potential control such as whereabouts and status of both

parents, queries if contact with the service is through a partner's phone, potential financial dependence; transitory residence in the UK prompting curiosity about history, relationships and potential isolation from established family and friend networks as a result of relocation to the UK (although Thandi was in South Africa more than was known at the time); caution about euphemistic language such as "marriage difficulties";

i) Impact of cultural dissonance and dislocation[10] when moving to the UK with cultural, health, and legal systems that are very different to other countries can influence how victims seek advice and engage with services such as the police;

j) The pace of referrals to social care being processed and closed without active inquiry or discussion in the local safeguarding Hub.

Recommendations

1. The Safer Harrow Partnership should consider if any further recommendations or actions are required in response to findings from the DARDR and ensure a copy of the report is provided to relevant people and organisations in the borough.
2. The Sheffield Domestic Abuse Coordination Team (DACT) should ensure that learning from this DARDR is used to build on the work already being taken in response to other local DARDRs concerning the death by suicide of women abused by intimate partners.
3. Sheffield Teaching Hospitals NHS Foundation Trust should consider and as necessary improve how emergency healthcare staff routinely record non-clinical risk-based follow-up action in a patient's notes such as completing a DASH, a referral to IDAS, or a mental health assessment.
4. The relevant practice subgroup of the Sheffield Adult Safeguarding Partnership for adults in Sheffield should ensure that the Right Care Right Person policy is sufficiently linked with safeguarding pathways for adults and that when concerns about an adult at risk are raised with the police a referral to social care/mental health services should also be completed in when

[10] Potential confusion, uncomfortableness, and/or disagreement experienced by someone in a novel cultural environment.

there are concerns about the safety of a patient self-discharging from hospital care.

5. SYP should ensure that information on police systems about recent self-harm or mental health concerns is routinely checked and considered during contact with a victim or perpetrator of domestic abuse.

National issues

1. There is an absence of national guidance on the recording and management of linked patient records for children and people with parental or care responsibilities.
2. There are no arrangements for requesting the history and records of patients from outside the UK registering with primary health care services in the UK.
3. There are no arrangements for border force services to notify local areas about the arrival of children in local areas or ensure that people arriving in the UK are aware of how to register for education and health services.